Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Service Coordination Organization and Managed Care Performance Measure Report

Accountability Implementation Status

Substitute Senate Bill 5147, Section 3; Chapter 209, Laws of 2015; RCW 70.320.050

Substitute Senate Bill 5883, Section 204(4)(a); Chapter 1, Laws of 2017, 3rd Special Session

December 1, 2017

Washington State Department of Social & Health Services

Transforming lives

Service Coordination Organization and Managed Care Performance Measure Report

Medicaid Program Operations and Integrity
P. O. Box 45530
Olympia, WA 98504
Phone: (360) 725-2053
Fax: (360) 586-9551
www.hca.wa.gov

Behavioral Health Administration
P.O. Box 45330
Olympia, WA 98504-5330
Phone: (360) 725-1400
Fax: (360) 725-2280
www.dshs.wa.gov/bha/division-behavioral-health-and-recovery

Aging and Long-Term Support Administration
P.O. Box 45600
Olympia, WA 98504-5600
Phone: (360) 725-2300
Fax: (360) 438-7903
www.dshs.wa.gov/altsa

Table of Contents

Executive Summary

Since 2013, the Washington State Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) received legislative directives to identify and report performance measures, to document variation in performance, and present expected performance measure outcomes. Among the legislative actions:

1. By December 1, 2014, Engrossed House Bill 1519 required DSHS and HCA to identify performance measures and expected outcomes established for Service Coordinating Organizations (SCOs).
2. By July 1, 2015, Substitute Senate Bill 5147(2) directed DSHS and HCA to require contracts with SCOs and included the following provisions:
    - Conduct an initial health screen for new Medicaid enrollees; and
    - Submit an annual report to the Washington State Legislature by December 1 each year.
3. By December 1, 2016, DSHS and HCA were directed to report on the incorporation of performance measures developed under Chapter 70.320 RCW into SCO contracts and progress toward achieving identified outcomes. The joint report was amended by SSB 5147(3), C 209 L 2015, which required the two agencies to report annually by December 1 and to include the following items, in addition to the existing statutory requirement:
    - The number of Medicaid clients enrolled over the previous year;
    - The number of enrollees receiving a baseline health assessment over the previous year;
    - An analysis of trends in health improvement for Medicaid clients in accordance with the measure sets established under RCW 41.05.690 and RCW 70.320; and
    - Recommendations for improving the health of Medicaid enrollees.
4. By December 1, 2017, DSHS and HCA were directed to identify to the Legislature:
    - All performance measures used for Behavioral Health Organizations (BHOs) and Managed Care Organizations (MCOs), and the variation in performance among these entities;
    - Performance measures included in BHO and MCO 2018 contracts and whether these measures are connected to payment; and
    - Any performance measures planned for inclusion in BHO and MCO 2019 contracts and whether the measures will be connected to payment during that contract period.

The 2017 Legislature also required DSHS to update the state Medicaid Managed Care Quality Strategy (QS) required under federal managed care regulations, 42 CFR 438.340, and submit the QS to the Center for Medicaid and Medicare Services (CMS) by October 1, 2017. DSHS is required to report to the Washington Office of Financial Management and the appropriate legislative committees by December 1, 2017, which includes a copy of the QS submitted to CMS. The QS is a

joint product of both DSHS and HCA; the QS is provided as Appendix C to this report, as required by 2017 legislative action.

The purpose of this report is to identify and report performance measures, to document variation in performance, present performance measure outcomes and discuss inclusion of performance measures in 2018 and 2019 BHO and MCO contracts. This report provides an update on past reports of performance measure results, adding Apple Health Managed Care (AHMC) performance measures.

Performance Measures in State-Purchased Health Care Services

Introduction

Two agencies manage and monitor contracts, which are required by state legislative directives and/or federal regulations to report performance measures:

- Department of Social and Health Services (DSHS), Behavioral Health Administration (BHA), Division of Behavioral Health and Recovery (DBHR), responsible for management of Washington Behavioral Health Organizations (BHOs);
- Department of Social and Health Services, Aging and Long-Term Support Administration (ALTSA), Home and Community Services (HCS), responsible for management of Washington Area Agencies on Aging (AAAs) contracts; and
- Health Care Authority (HCA), Medicaid Program Operations and Integrity Division, Compliance Review and Analytics (CRA) section (hereafter, MPOI), responsible for management of the Apple Health (Medicaid) Managed Care Organizations (MCOs).

The agencies developed this combined report on performance measures. The report builds on the 2016 Service Coordination Organization report (https://www.hca.wa.gov/assets/service-coord-orgs.pdf). The 2016 report provided information on legislative requirements described above. This report provides updated information and adds new, legislatively-required measurement results from the 2017 legislative session. The DBHR and MPOI prepared the QS attached to this report.

The DSHS and HCA have access to numerous performance measures for use in contracts. Over many years, both agencies required performance measure reporting as a result of federal requirements for performance measurement, such as those required in federal managed care regulations. MCO and BHO contracted performance measures are validated by the External Quality Review Organization (EQRO), Qualis Health and are generated by DBHR and DSHS-RDA annually.

Measurement reports are produced and made publically available on agency websites. This report, based on a compilation of five years of legislative directives, is another example of a performance measure report.

This report summarizes legislation or legislative budget directives governing the production of this report. We describe the source of measurement sets used by DSHS and HCA. We provide measure results over a two to three year time period. The agencies discuss recent efforts to implement value-based purchasing in managed care contracts, including identifying value-based measures currently or soon to be in use.

Individuals Receiving Medicaid Services in the State of Washington

The number of Apple Health covered lives decreased to 1,817,674 from June 2016 to July 2017. The federally-funded Children's Health Insurance Program (CHIP)[1] population was 48,914; the state-funded children's population was 19,410. The total Apple Health, CHIP, and state-funded population was 1,885,998. The new adult population was 595,736 (a decrease of 4,857 from the last reporting period). The largest percentage of Apple Health clients are under 19 years old.

Service Coordination Organization Measures

This report identifies measures used to monitor performance of Area Agencies on Aging (AAAs), Behavioral Health Organizations (BHOs), and Managed Care Organizations (MCOs) under contract with HCA and DSHS. While these contracts always included requirements for performance measures, state legislation created a term for these entities—Service Coordination Organizations (SCOs)[2]—and new requirements for performance measures. SCOs refer to contracts with the same organizations above.

The measure sets resulted from Engrossed Substitute House Bill 1519 and Second Substitute Senate Bill 5732, which required common SCO performance measures. This legislation required DBHR, HCS, and HCA to identify or develop performance measures to include in contracts with SCOs beginning July 2015. DSHS and HCA contracts affected by the legislation were the newly formed BHOs (resulting from ESSB 6052), MCOs, and AAAs. Each of these contracts require SCO measures.

Our 2014 legislative report provided operational and technical details on SCO measure selection, including selection principles (intended to include Apple Health individuals across the lifespan). These measures have evolved over time. Department of Social and Health Services-Research and Data Analysis (DSHS-RDA), responsible for calculating and reporting the measures, prioritized the list for measure development. Measures began to be calculated in 2015. Presently, 14 measures are calculated by DSHS-RDA for SCOs.

Following the 2016 implementation of BHOs statewide and Fully Integrated Managed Care (FIMC)[3] in Clark and Skamania counties (Southwest Washington), DSHS and HCA continued to include the SCO measures in Medicaid MCO contracts.

---

[1] CHIP is a federal program that provides funding for children enrolled in Apple Health. Washington law requires health care coverage for children in households up to 250 percent federal poverty level (FPL); the state uses CHIP funding to cover additional children from 250 to 312 percent FPL.

[2] Service Coordination Organizations, as defined in ESHB 1519, are entities that contract with the state to provide, directly or through subcontracts, a comprehensive delivery system of medical, behavioral, long-term care, or social support services.

[3] Fully Integrated Managed Care (FIMC) initiated by the Washington Legislature integrates physical and behavioral health (mental health and substance use disorder) services under one managed care contract. By 2020, FIMC will be operational throughout the state of Washington.

Home and Community Services (HCS), a division of the DSHS Aging and Long-Term Support Administration (ALTSA), contributed in the development of the SCO measure set. ALTSA staff participated in the legislatively-created steering committee tasked with identifying SCO performance measures. HCS and the AAAs worked together on performance measure contract language. The contract process took into account the goal of shared performance measures and the AAA's need to consider the measures in their service delivery and planning (as defined in "Home and Community Services Division Contracts with Area Agencies on Aging, Service Coordination Organization Measure Results" beginning on page 17).

The measures listed in Table 1 are the current, active SCO measures. DSHS-RDA publically reports these measures at www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid. The measures in grey on Table 1 are not calculated by DSHS-RDA, but are available to agencies through other means. For example, HCA MCOs report the access to preventive/ambulatory health services rate annually. Other measures are unique to the program. For example, the mental health service (treatment) penetration (narrow) measure was developed for BHOs-only and is not required for MCO reporting.

Table 1: Service Coordination Organization Performance Measures by SCO Type

Service Coordination Organization Performance Measures	Area Agencies on Aging	Behavioral Health Organizations	Managed Care Organizations
Adults' Access to Preventive/Ambulatory Health Services	X	X	
Arrest Rate	X	X	X
Emergency Department (ED) Utilization per 1000 Coverage Months	X	X	X
Employment Rate	X	X	X
Engagement in Alcohol and Other Drug Dependence Treatment Penetration	X	X	X
Home and Community-Based Services and Nursing Facility Utilization	X	X	X
Homelessness (Broad)	X	X	X
Homelessness (Narrow)	X	X	X
Initiation of Alcohol and Other Drug Dependence Treatment	X	X	X
Mental Health Service (Treatment) Penetration (Broad)	X	X	X
Mental Health Service (Treatment) Penetration (Narrow)	X	X	
Plan All-Cause Readmission Rate	X	X	
Substance Use Disorder Service (Treatment) Penetration	X	X	X
Thirty (30) Day Psychiatric Hospital Readmission Rate	X	X	X

Note: The measures in grey are not calculated by DSHS-RDA.

Behavioral Health Organization Measures

The 2017 contracts with the BHOs contain three performance measures which DBHR intends to continue in the BHO contracts through 2018 and 2019:

- 30-day psychiatric readmission rate
- Substance Use Disorder (SUD) treatment initiation and engagement rates-including both youth and adult treatment initiation and treatment engagement rates.
- Behavioral Health Access Monitoring (BHAM)-a Results Washington[4] measure capturing the monthly count of youth and adults who receive mental health or substance use disorder treatment; this includes both Medicaid and non-Medicaid services.

Two measures, the mental health treatment penetration rate and substance use disorder treatment penetration rate, are not required in BHO contracts. However, they are tracked by DSHS-RDA. The BHAM measure captures the same type of information (the rate at which people access the public behavioral health system); however, the BHOs can replicate and track for themselves the BHAM measure. This makes the measure more actionable for the BHOs.

DSHS-RDA's Integrated Client Database inform the mental health and substance use disorder treatment penetration rate measures by identifying individuals with mental health and/or substance use disorder treatment needs. BHOs do not have access to this information and cannot identify and respond to trends in a timely basis. To align performance measures across initiatives, DBHR will use the newly created BHAM measure. Results Washington will also use this measure as to capture the totality of BHO activity.

DBHR planned to add SCO performance measures addressing employment and housing to the BHO contracts in 2018, however this has been reconsidered due to the decision that the BHOs will not administer the Demonstration[5] funding for supportive housing and employment services. The BHOs are expected to encourage their contracted behavioral health agencies to address housing and employment needs. Housing and employment measures will continue to be monitored and reported publically, as they currently are for BHOs, MCOs, and the AAAs.

Beginning in April 2016, HCA and the DSHS began the process of integrating behavioral health and physical health services under one contract. In collaboration with DSHS-RDA, HCA began to calculate these same measures for integrated managed care contracts.

[4] Results Washington is a Governor-directed initiative that requires Washington State agencies to measure and report regularly on their progress on the Governor's five goals. State agencies are accountable for making improvements and delivering results for Washington citizens on these measures.
[5] The Demonstration is an 1115 Medicaid waiver granted to the HCA. The Demonstration is implementing a number of initiatives and programs to improve the health of Washington citizens, including one to help individuals' access housing and wraparound supports, and develop independent living skills to remain housed.

Behavioral Health Organization Value-Based Purchasing Performance Measures

While BHO contracts include performance measures, they are not attached to payment. BHO performance is managed through contract monitoring activities. Multiple considerations were taken into account when deciding not to include incentive payments for performance in BHO contracts. These include:

- SCO performance measures require a 21-month cycle for performance to occur; BHOs must report performance and DSHS-RDA analyzes and calculates the measures. From the end of the review period, it takes 9 months for a final report to be published. The first opportunity to use this process for incentive payments under the current BHO contracts is during the FY 2019 contract cycle.
- Federal regulations for Medicaid managed care incentive payments state they "must be for a fixed period of time and performance is measured during the rating period under the contract in which the incentive is applied." This requires the BHO's performance to take place, be measured, and the incentive be paid within the contract period.
- BHOs will phase out by January 2020. The Southwest Regional Service Area has no BHO, and North Central BHO will sunset at the end of 2017. An additional five BHOs have submitted letters of intent to move to full integration in January 2019, and other BHOs will decide by the time this report is issued their phase-out timelines.
- Using incentive funding so late in the BHO life cycle may not be logical given the insufficient time for the BHOs to use the funding.

A major challenge to implementing financially-based performance measures for BHOs is the expectation that BHOs will phase out by January 2020. This makes performance incentives for BHOs a short term strategy. HCA has required MCOs to report both physical and behavioral health measures in contract for some years. As the transition from BHOs occurs, we anticipate adding more behavioral health measures into the FIMC contract and into value-based purchasing.

Statewide Common Measures and Healthcare Effectiveness Data and Information Set (HEDIS®) Measures

The measures in the Statewide Common Measure Set (SCMS) are defined by the legislatively-created (per ESHB 2572) statewide Performance Measure Coordinating Committee (PMCC)[6]. The PMCC, with the support of ad hoc technical workgroups, provided a starter set of measures in 2014. The measures have evolved over the last three years; the measures are intended to change over time as the science of measurement and state priorities advance.

[6] The Performance Measures Coordinating Committee (PMCC) is a statewide performance measurement committee appointed by the Governor to oversee creation of the Statewide Common Measure Set. Technical workgroups comprised of health care clinicians helped define the initial set of measures.

Thirty-six of 56 SCMS measures are included in the 2018 AHMC contract. Twenty SCMS measures are excluded from AHMC contracts. Measures are excluded for the following reasons:

- Measures require using a single data source (the Department of Health Immunization Information System). Two measures, immunizations for influenza and pneumococcal vaccinations for older adults, use data contained in the Immunization Information System to calculate these measures.
- The measures require a survey source, calculated at the statewide and regional level of analysis. Two surveys meet these requirements, both conducted by the Department of Health. These are the Behavioral Health Risk Factor Surveillance System (BRFFS) survey and Pregnancy Risk Assessment Monitoring System (PRAMS) survey.
- The measure specifications do not require MCOs to produce the measures. For example, a subset of measures are required to be calculated by Washington's hospitals. Measure examples are the chronic asthma, older adult admissions, and falls with injury measures.
- The measure specifications are finance-oriented. One of the finance measures is the annual state purchased health care spending growth relative to State GDP. The HCA Finance Division calculates this measure.

Along with the SCMS measures, HCA requires MCOs to calculate and report the full set of HEDIS measures. Apple Health MCOs are required to be accredited by the National Committee for Quality Assurance (NCQA). As such, they are required to annually report the full set of HEDIS measures to the NCQA. HCA also requires MCOs to report these same measures to the agency.

Many SCMS measures originate from HEDIS. A few are state-developed measures, e.g., DSHS-RDA: substance use disorder service (treatment) penetration and mental health service (treatment) penetration measures.

In 2017, HCA formed a committee structure to guide the agency's Chief Medical Officer (CMO) in the selection of clinical performance measures. The interagency, Quality Measurement, Monitoring and Improvement (QMMI) Committee was established to:

- Manage the many measures required by state and federal legislative action and accreditation bodies;
- Align measures between Apple Health and the PEB (Public Employee Benefits) program and between value-based contracts, as much as feasible; and
- Define and develop consistent methods for measures selected for value-based purchasing.

Formed by the HCA Executive Leadership Team in 2017, the committees guided by a Clinical Quality Council (CQC) select measures to include in Apple Health and PEB managed care contracts for annual MCO reporting. The CMO is guided by research and analytical expertise from a clinical data team and an operations workgroup, the clinical implementation team. The CQC reviews committee guidance and makes recommendations to the CMO.

QMMI committee participants include HCA, DBHR, ALTSA, and Department of Health staff with expertise in prevention; treatment and management of behavioral health conditions; and the needs of Washington citizens requiring long-term care services and supports. These participants enrich discussion and decision-making regarding the selection of performance measures used to assess the quality of services and care for our most vulnerable clients.

The table below provides a master list of all approved measures by the HCA's Chief Medical Officer and CQC. Most, but not all measures, will be reported by Apple Health Managed Care (AHMC) contractors. Some of the measures below relate to services carved out of the AHMC contract. The AHMC contractors are not responsible for admissions to psychiatric hospitals. Thus, they will not be required to report on the 30-day psychiatric inpatient readmission measure.

As a result of the transition from AHMC to FIMC, the state has been challenged with how to handle performance measure reporting between the transition periods, 2016 through 2020. After discussion with regulators and NCQA HEDIS experts, the state required MCO contractors to report performance measures through the AHMC contract, regardless of the population served (AHMC and/or FIMC members). This action was the least administratively burdensome for the MCOs as the agency transitioned away from AHMC and to fully integrated care. Through the contract, MCOs sample across the entire client population to calculate and report how well the organizations met statewide performance measures.

During the transition period, the state will evaluate FIMC contractors on a number of FIMC measures. Examples of these measures include:

- Home and Community-Based Services and Nursing Facility Utilization
- Emergency Department (ED) Utilization per 1000 Coverage Months
- Ambulatory Care: Emergency Department Visits per 1,000 Member Months

The first two measures were developed by DSHS-RDA and will be calculated and reported by DSHS-RDA on behalf of the FIMC MCOs. These measures will be calculated at the regional level of analysis. The last measures, ambulatory care: emergency department visits per 1,000 member months will be calculated by the MCOs by region.

The DSHS-RDA-developed ED measure more fully examines ED utilization patterns, including the impact of the transition to fully integrated health care services. This measure is especially sensitive to change in individuals impacted by serious mental health conditions. It measures ED utilization for individuals with mental health diagnoses and collects ED data, regardless of the number of ED visits in a single day. The HEDIS measure does not account for ED use in those individuals with mental health diagnoses and counts only one ED visit per day (regardless of the number of ED visits in a 24-hour period).

Table 2 lists the clinical performance measures for the 2018 AHMC contracts. SCMS measures sanctioned by the Performance Measures Coordinating Committee are noted with a 'Y,' as well as the measure steward or manager, such as the NCQA-HEDIS, DSHS-RDA, etc.

Table 2: Clinical Performance Measures, 2018 Apple Health Contracts

2018 Clinical Performance Measures for Apple Health Contracts	Measure Steward	Statewide Common Measure Set Measures
Adherence to Antipsychotic Medication for Individuals with Schizophrenia	NCQA-HEDIS	
Adolescent Immunization Status (Immunizations for Adolescents)	NCQA-HEDIS	Y
Adolescent Well-Child Care Visit	NCQA-HEDIS	
Adult Access to Preventive/Ambulatory Health Services	NCQA-HEDIS	Y
Adult Body Mass Index (BMI) Assessment	NCQA-HEDIS	Y
Alcohol and Drug Treatment Engagement**	DSHS-RDA	
Ambulatory Care: Emergency Department Visits per 1,000	NCQA-HEDIS	Y
Annual Monitoring for Patients on Persistent Medications (ACE/ARB component)	NCQA-HEDIS	Y
Antibiotic Utilization	NCQA-HEDIS	
Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA-HEDIS	Y
Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA-HEDIS	Y
Appropriate Testing for Children with Pharyngitis	NCQA-HEDIS	Y
Appropriate Treatment for Children with Upper Respiratory Infection	NCQA-HEDIS	
Asthma Medication Ratio	NCQA-HEDIS	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	NCQA-HEDIS	Y
Breast Cancer Screening	NCQA-HEDIS	Y
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NCQA-HEDIS	
Cervical Cancer Screening	NCQA-HEDIS	Y
Childhood Immunization Status (Combo 10)	NCQA-HEDIS	Y
Children and Adolescents' Access to Primary Care Practitioners	NCQA-HEDIS	Y
Chlamydia Screening in Women	NCQA-HEDIS	Y
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	NCQA-HEDIS	Y
Comprehensive Diabetes Care: HbA1C Control (<8.0%)	NCQA-HEDIS	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA-HEDIS	Y
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA-HEDIS	Y
Comprehensive Diabetes Care: Eye Exam	NCQA-HEDIS	Y
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm)	NCQA-HEDIS	Y
Controlling High Blood Pressure	NCQA-HEDIS	Y
Diabetes Monitoring for People with Diabetes and Schizophrenia	NCQA-HEDIS	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	NCQA-HEDIS	
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	NCQA-HEDIS	
Follow-up Care for Children Prescribed ADHD Medication	NCQA-HEDIS	Y
Follow-Up After ED Visit for Mental Illness	NCQA-HEDIS	
Follow-Up After ED Visit for Alcohol and other Drug Dependence	NCQA-HEDIS	
Frequency of Ongoing Prenatal Care	NCQA-HEDIS	

2018 Clinical Performance Measures for Apple Health Contracts	Measure Steward	Statewide Common Measure Set Measures
Frequency of Selected Procedures	NCQA-HEDIS	
Lead Screening in Children	NCQA-HEDIS	
Long-Term Services and Support	NCQA-HEDIS	
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA-CAHPS	Y
Medication Management for People with Asthma	NCQA-HEDIS	Y
Mental Health Utilization	NCQA-HEDIS	
Mental Health Service (Treatment) Penetration	DSHS-RDA	Y
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA-HEDIS	
Non-Recommended Cervical Cancer Screening in Adolescent Females	NCQA-HEDIS	
NTSV C-Section (Cesarean Birth)	The Joint Commission	Y
Oral Health: Primary Caries: Prevention Offered by Primary Care	HCA	Y
Persistence of Beta Blocker Treatment after Heart Attack	NCQA-HEDIS	
Pharmacotherapy Management of COPD Exacerbation	NCQA-HEDIS	
Plan All Cause Readmission	NCQA-HEDIS	
Prenatal and Postpartum Care	NCQA-HEDIS	
Proportion of Enrollees receiving LTSS**	DSHS-RDA	
Statin Therapy for Patients with Cardiovascular Disease	NCQA-HEDIS	Y
Statin Therapy for Patients with Diabetes	NCQA-HEDIS	
Substance Use Disorder Treatment (Service) Penetration	DSHS-RDA	Y
30 day Psychiatric Inpatient Readmissions	DSHS-RDA	Y
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA-HEDIS	
Use of Imaging Studies for Low Back Pain	NCQA-HEDIS	Y
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NCQA-HEDIS	
Use of Opioids at High Dosage	NCQA-HEDIS	
Use of Opioids from Multiple Providers	NCQA-HEDIS	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA-HEDIS	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA-HEDIS	Y
Well Child Visits in the First 15 Months of Life	NCQA HEDIS	Y
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA-HEDIS	Y

Managed Care Organization Value-Based Purchasing Performance Measures

In 2016 HCA adopted a Value-Based Roadmap, a key strategy under Healthier Washington. HCA adopted a goal that 90 percent of HCA provider payments under state-financed health care programs, Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program, would be linked to quality and value by 2021.

Paying for value is key to achieving the Triple Aim[7] and—most importantly—ensuring that systems contribute to the health of the whole person. Meeting this goal requires the agency to shift reimbursement and delivery system strategies away from a system that rewards volume of service to one that rewards quality and outcomes. Washington HCA set on a path to be the "first mover" in this change effort.

The HCA embarked on an aggressive effort to implement value-based purchasing (VBP). The HCA led this effort starting with the Accountable Care Program (or UMP+) as a PEBB health plan in 2016, adding value-based purchasing language to the AHMC contract in 2017.

In 2017, the QMMI program recommended a list of SCMS and SCO measures for use in value-based purchasing. The program selected measures based on the needs and risks of the populations served. For example, discussion with the DSHS-Behavioral Health Administration and DSHS-Children's Administration, led to a more informed selection of measures for the Apple Health Foster Care contract.

Table 3 lists the value-based purchasing measures selected for all Apple Health contracts. We started using the AHMC value-based measures in 2017, with the remaining measures added to 2018 contracts. Each contract describes how HCA rewards MCO performance; and includes requirements for the MCOs to ensure clinics also receive incentives for achieving performance.

[7] The Triple Aim, developed by the National Institute of Medicine, refers to the goal of improving the U.S. health care system by the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

Table 3: Value-Based Purchasing Clinical Performance Measures, Apple Health Contracts

Value-Based Purchasing Clinical Performance Measures for Apple Health Contracts	Apple Health	Fully Integrated Managed Care	Apple Health Foster Care	Statewide Common Measure Set (CMS)/ Service Coordination Organization (SCO)
Antidepressant Medication Management: Effective Acute Phase Treatment	X	X		SCMS
Antidepressant Medication Management: Effective Continuation Phase Treatment	X	X		SCMS
Childhood Immunization Status (Combo 10)	X	X		SCMS
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	X	X		SCMS
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm)	X	X		SCMS
Controlling High Blood Pressure	X	X		SCMS
Medication Management for People with Asthma: Medication Compliance 75% (Ages 5-11)	X	X	X	SCMS
Medication Management for People with Asthma: Medication Compliance 75% (Ages 12-18)	X	X	X	SCMS
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	X	X	X	SCMS/SCO
Substance Use Treatment (Service) Penetration		X		SCMS/SCO
Substance Use Disorder Initiation		X		SCO
Substance Use Disorder Engagement		X		SCO
Mental Health Treatment (Service) Penetration		X		SCMS/SCO
Adolescent Well-Care Visits			X	SCMS/SCO
Follow-Up Care for Children Prescribed ADHD Medication: Initiation			X	SCMS
Follow-Up Care for Children Prescribed ADHD Medication: Continuation			X	SCMS
Lead Screening in Children			X	N/A

An agency goal is to maintain the same value-based measures over multiple years. Between-year performance assessment is required under the reimbursement model. The model requires measure stability so we can assess performance changes over time. For more information about the VBP reimbursement methods, see Appendix A.

Performance Measure Results

Behavioral Health Organization Measure Results

The DSHS-RDA has produced SCO measures on behalf of DSHS and HCA over a multi-year period. Results are reported for three years and can be found at https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0. DSHS-RDA calculates measures by coverage population, such as disabled adults or new adults.

The SCO measures were developed to focus the health care delivery system on shared clinical outcomes. Measures reported here depend on collaborative work across service delivery systems. For example, an Area Agency on Aging alone cannot be responsible for decreases in avoidable

emergency room use, but they can play a role in achieving this outcome by monitoring clients with high use of emergency room use. High emergency room use might be addressed through changes in a client's care plan or through primary care provider intervention. An adult's access to preventive or ambulatory care services doesn't just rely on the work of managed care organizations, but also on the other service providers—including mental health treatment providers—delivering care to the individual. Together, all providers across the health care delivery system share accountability in improving these measures.

Table 4 and Table 5 provide results of the SCO measures calculated at a statewide level of analysis for Apple Health enrollees with mental health services needs and for individuals with substance use disorder service needs. Individuals with mental health and substance use disorder treatment needs (who may or may not be receiving treatment services) are attributed to BHOs. Measure results are reported separately for each grouping. Those with co-occurring disorders are included in both the "mental health" and "substance use disorder" tables.

Table 4: Statewide Measure Results, Mental Health; Medicaid Enrollees

Behavioral Health Organization–Medicaid Enrollees with Mental Health Service Needs, Statewide Measure Results	CY 2014 1/14-12/14	CY 2015 1/15-12/15	CY 2016 1/16-12/16
Adults' Access to Preventive/Ambulatory Health Services	95.0%	92.0%	91.1%
Substance Use Disorder Treatment Penetration	30.3%	27.9%	30.5%
Initiation of Alcohol and Other Drug Dependence Treatment	68.3%	72.8%	71.8%
Engagement in Alcohol and Other Drug Dependence Treatment	55.2%	61.2%	60.9%
Mental Health Treatment Penetration (Narrow Definition-% who needed a service through RSN/BHO)	26.4%	23.6%	23.3%
Mental Health Treatment Penetration (Broad Definition-% who received service through RSN/BHO, Medicaid and Medicare paid services for dual-eligibles)	47.0%	44.1%	44.2%
Plan All Cause 30-Day Readmission	18.4%	17.6%	17.3%
Psychiatric Inpatient 30-Day Readmission	13.4%	13.1%	12.2%
Medicaid–Percent Homeless (Narrow Definition–Excludes 'homeless with housing', ACES living arrangement code)	5.2%	5.7%	6.0%
Percent Homeless (Broad Definition–Includes 'homeless with housing' ACES living arrangement code)	12.8%	13.5%	14.0%
Percent Employed	33.8%	38.9%	39.8%
Percent Arrested	7.4%	7.7%	8.1%
Emergency Department Utilization per 1,000 Coverage Months	121.2	113.2	107.5

Table 5: Statewide Measure Results, Substance Use Disorder, Medicaid Enrollees

Behavioral Health Organization – Medicaid Enrollees with Substance Use Disorder Service Needs, Statewide Measure Results	CY 2014 1/14-12/14	CY 2015 1/15-12/15	CY 2016 1/16-12/16
Adults' Access to Preventive/Ambulatory Health Services	90.4%	85.3%	84.3%
Substance Use Disorder Treatment Penetration	30.6%	27.4%	28.9%
Initiation of Alcohol and Other Drug Dependence Treatment	76.43%	79.4%	76.5%
Engagement in Alcohol and Other Drug Dependence Treatment	63.5%	68.1%	65.5%
Mental Health Treatment Penetration (Narrow Definition-% who needed a service through RSN/BHO)	39.7%	35.2%	33.9%
Mental Health Treatment Penetration (Broad Definition-% who received service through RSN/BHO, Medicaid and Medicare paid services for dual-eligibles)	57.6%	53.1%	51.2%
Plan All Cause 30-Day Readmission	21.5%	19.8%	20.0%
Psychiatric Inpatient 30-Day Readmission	14.4%	14.4%	13.4%
Medicaid–Percent Homeless (Narrow Definition–Excludes 'homeless with housing', ACES living arrangement code)	12.0%	12.4%	12.9%
Percent Homeless (Broad Definition–Includes 'homeless with housing' ACES living arrangement code)	26.41%	26.5%	26.8%
Percent Employed	33.1%	38.42%	37.5%
Percent Arrested	20.3%	19.9%	19.42%
Emergency Department Utilization per 1,000 Coverage Months	184.4	168.7	156.2

Discussion

The SCO measures are relatively new and are being stabilized as measure calculations and stakeholder feedback inform the refinement of the measures. The SCO results generally show consistency over time with the exception of these measures: adult access to preventive/ambulatory health services, mental health treatment penetration (narrow and broad measures), percent employed, and emergency department utilization per 1,000 coverage months. It should be noted that the "narrow" mental health penetration rate includes only those who received services covered by the BHOs (and the Regional Support Networks [RSNs] before April 2016), while the "broad" mental health penetration rate is inclusive of those who received mental health services provided by the BHOs/RSNs, the MCOs, and under Medicare for people with dual Medicaid and Medicare coverage.

Changes in these measures over time are primarily a result of the impact of Medicaid Expansion under the Affordable Care Act on the composition of the adult Medicaid caseload. When we stratify by major coverage group, these measures are relatively stable for the Disabled population that has experienced the most stable case mix over the reporting period. That said, there is evidence of a modest downward drift in the "narrow" (RSN/BHO) mental health service penetration rate.

Reduction in mental health treatment use could have multiple root causes. State regulatory changes may have influenced provider networks resulting from the state's plan to integrate health care services in Washington. Employees worried about having a job due to changes in insurance

contracts may have sought employment elsewhere during this time. Hiring may have been reduced because of uncertainty in maintenance of historical referral patterns; this in turn could influence access to care and services.

Increases in the percent employed is likely due to Medicaid expansion which increased the number of employed individuals eligible to receive Medicaid coverage. Last, the reduction in ED utilization could reflect a number of initiatives to address elevated ED utilization levels due to the opioid epidemic in the state.

The state implemented integrated managed care in April 2016. A recent DSHS-RDA preliminary evaluation of the Southwest Washington FIMC program showed positive results for those served. Ten clinical performance measures, including adult access to preventive/ambulatory health care services, showed significant improvement, while 8 measures showed no significant difference between the FIMC region and the balance of the state. One measure, ED utilization per 1,000 member months, was negative, showing statistically smaller decrease compared to the rest of the state. While initial FIMC evaluation results are generally positive, behavioral health measures are being closely monitored given the potential disruption for the member in their ability to access care; and in provider availability due to changes in how the state purchases behavioral health services.

The observations above are shared with caution. Many of these performance measures are new and being stabilized. The FIMC is a new program; enough time has not lapsed to draw conclusions regarding program impacts. Instability in the health care system brought about by increased client volumes, and changes in how care is purchased may have influenced the changes observed here. Additional data points and analysis are necessary to evaluate the basis for these changes.

Home and Community Services Division Contracts with Area Agencies on Aging, Service Coordination Organization Measure Results

AAA measures are calculated and reported at both the regional service area and statewide level of analysis. The results here are reported at the statewide level of analysis and include only measures currently required in AAA contracts. Both Medicaid and dual-eligible (Medicare-Medicaid eligible) clients are included in the measures reported in the Table 6.

Table 6: Statewide Measure Results; Aging and Long-Term Support Administration

Aging and Long-Term Support-Statewide Measure Results	CY 2014 1/14-12/14	CY 2015 1/15-12/15	CY2016 1/16-12/16
Adults' Access to Preventative/Ambulatory Care Health Care Services	97.7%	97.7%	97.8%
HCBS and Nursing Facility Utilization Balance	83.4%	84.3%	85.2%
Mental Health Treatment Penetration (Broad Definition-% who received service through RSN/BHO, Medicaid and Medicare paid services for dual-eligibles)	37.6%	38.2%	39.1%
Substance Use Disorder Treatment Penetration	19.7%	17.8%	17.5%
Emergency Department Visits per 1,000 Coverage Months	90.0	95.6	103.3
Plan All Cause 30-Day Readmission	17.2%	18.2%	17.7%
Percent Homeless (Broad Definition)	0.5%	0.7%	0.7%

Discussion

Changes in these measures over time result from the impact of Medicaid Expansion under the Affordable Care Act on the composition of the adult Apple Health caseload. When we stratify by major coverage group, these measures are relatively stable for the Disabled population; this group experienced the most stable case mix over the reporting period.

Health Care Authority Service Coordination Organization Measure Results

Table 7 describes the results of SCO performance measures for all Apple Health MCOs (regardless of contract arrangement) at the statewide level of analysis. Details at the regional level of analysis can be found at https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0.

Table 7: Statewide Measure Results; Managed Care Organization

Managed Care Organization-Statewide Measure Results	CY 2014 1/14-12/14	CY 2015 1/15-12/15	CY 2016 1/16-12/16
Substance Use Disorder Treatment Penetration	29.4%	26.5%	28.5%
Initiation of Alcohol and Other Drug Dependence Treatment	71.3%	76.5%	74.7%
Engagement in Alcohol and Other Drug Dependence Treatment	58.3%	65.7%	63.9%
Mental Health Treatment Penetration (Broad Definition-% who received service through RSN/BHO, Medicaid and Medicare paid services for dual-eligibles)	49.6%	45.1%	45.4%
Psychiatric Inpatient 30-Day Readmission	15.6%	14.4%	13.5%
Percent Homeless (Narrow Definition–Excludes 'homeless with housing', ACES living arrangement code)	4.4%	4.9%	5.1%
Medicaid–Percent Homeless (Broad Definition–Includes 'homeless with housing' ACES living arrangement code)	10.9%	11.9%	12.0%
Percent Employed	50.8%	52.0%	51.5%
Medicaid–Percent Arrested	5.8%	6.4%	6.6%

Discussion

As discussed previously, changes in mental health service penetration rates over time are the result of the impact of Medicaid Expansion under the Affordable Care Act on the composition of the adult Apple Health caseload. When we stratify by major coverage group, this measures is stable for both the Disabled and the non-Expansion, non-Disabled adult populations; these two populations experienced relatively stable case mixes over the reporting period.

Managed Care Organization Measure Results

Apple Health MCOs have been required to report performance measures annually since the mid-1990s. HCA adopted the HEDIS measurement set, produced by the National Committee for Quality Assurance, during that time. The federal law, Balanced Budget Act of 1997, P.L. 105-33 (implemented in the early 2000s), required annual reporting of performance measures by MCOs. The state Medicaid program annually reports performance measure.

Appendix B lists the Apple Health performance measures reported over a three-year period. MCOs annually report these measures and calculate at a statewide level of analysis (the statewide mean). There are some positive trends observed in the statewide Apple Health measures. Appendix B lists 41 measures reported by Apple Health MCOs, of which 25 had three years of data from which to compare performance. Eighteen of 25 measures showed improvement between these years.

Nine measures selected for value-based purchasing are highlighted in this report and described below. The CMO and CQC selected these measures for AHMC and FIMC value-based contracts. We present these measures by MCO and show two years of performance in reporting years 2016 and 2017. These results precede implementation of value-based payments. The measures are compared to the National Committee for Quality Assurance Quality Compass mean and 90th percentile for all

Medicaid health plans. Quality Compass is a source of benchmark data by which to compare Medicaid MCO performance. Apple Health's measurement goal for MCOs is to achieve at least the Quality Compass 90th percentile.

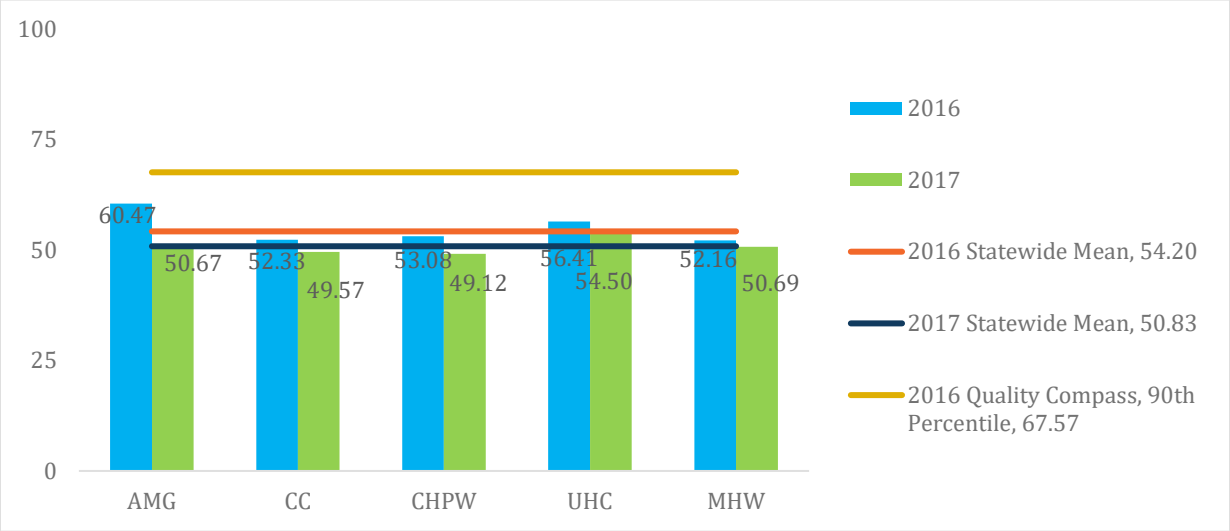
We show MCO performance on these measures:

- Antidepressant Medication Management: Effective Acute Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment
- Childhood Immunization Status (Combo 10)
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm)
- Controlling High Blood Pressure
- Medication Management for People with Asthma: Medication Compliance 75% (Ages 5-11)
- Medication Management for People with Asthma: Medication Compliance 75% (Ages 12-18)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

Antidepressant Medication Management: Effective Acute Phase Treatment

This measure examines the proportion of enrollees 18 years and older who were treated with antidepressant medications, had a diagnosis of major depression, and who remained on antidepressant medication treatment for at least 12 weeks. The percentages ranged from a low of 49.12% for Community Health Plan of Washington (CHPW) to a high of 54.50% for United Health Care (UHC). Figure 1 shows that our state's average dropped from 54.20% to 50.83% in 2017. Plans would need to achieve at least 67.57% on the measure to meet the national Medicaid benchmark, the 90th percentile produced by Quality Compass.

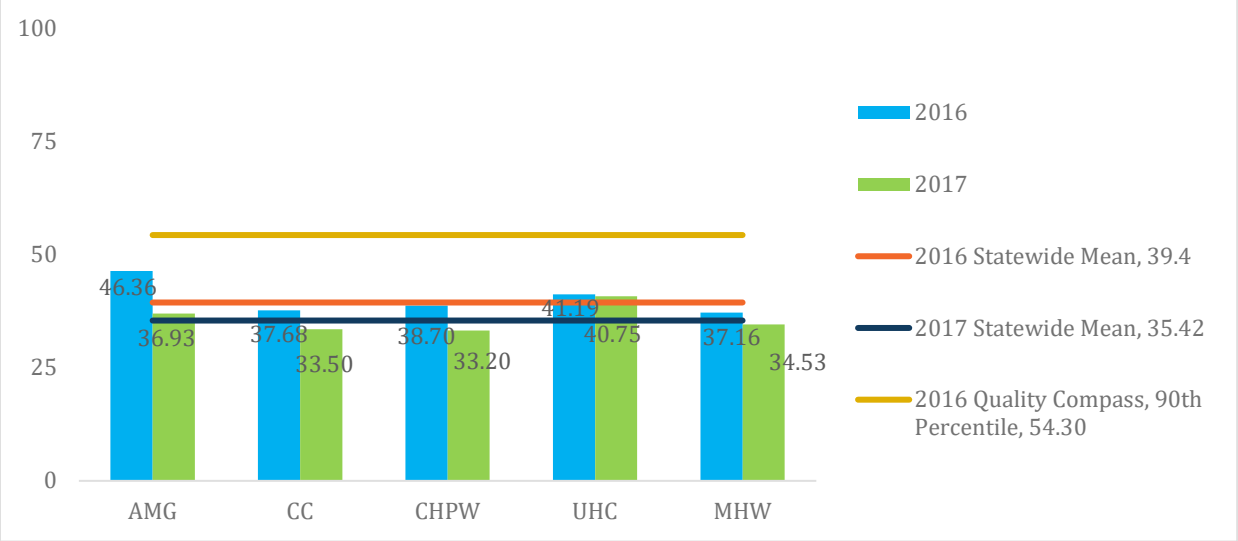
Figure 1: Antidepressant Medication Management; Effective Acute Phase Treatment, 2016-2017



Antidepressant Medication Management: Effective Continuation Phase Treatment

The continuation phase measure examines how many enrollees with depression remained on an antidepressant for at least 6 months. The 2017 statewide average fell from the 2016 performance; 39.44% to 35.42%. Four of five MCOs saw statistically significant reductions in performance between the two years.

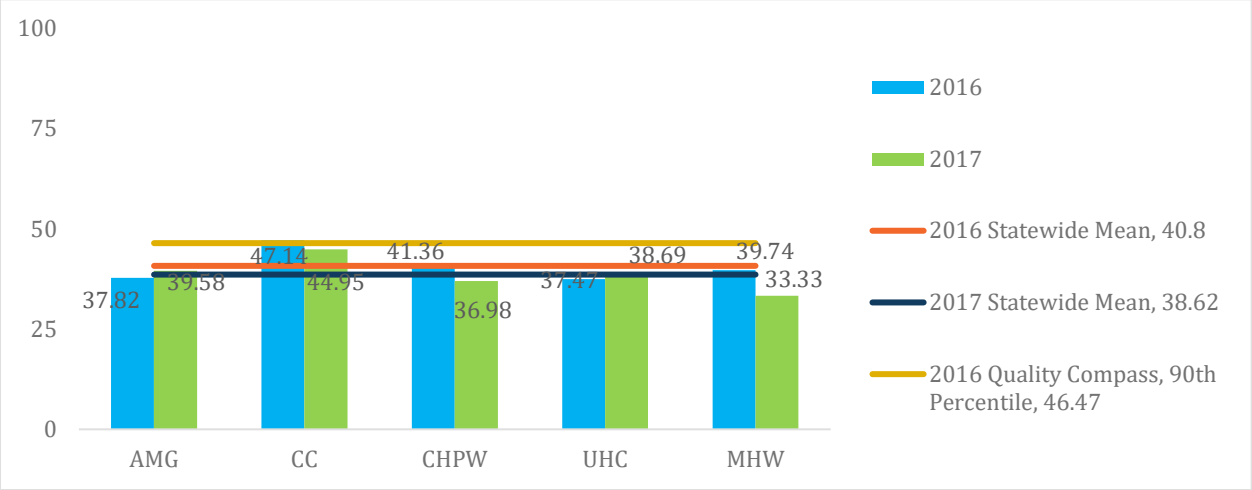
Figure 2: Antidepressant Medication Management: Effective Continuation Phase Treatment, 2016-2017



Childhood Immunization Status (Combo 10)

The 2017 statewide average for this measure was 38.62%. The measure examines the percent of two-year-olds who had all recommended immunizations. Two MCOs saw improved performance from 2016 to 2017. These were Amerigroup (AMG) and United Health Care (UHC). CHPW, Coordinated Care (CC) and Molina Healthcare of Washington (MHW) had lower performance. Plans would have to achieve a rate of 46.47% to meet the Quality Compass 90th percentile benchmark.

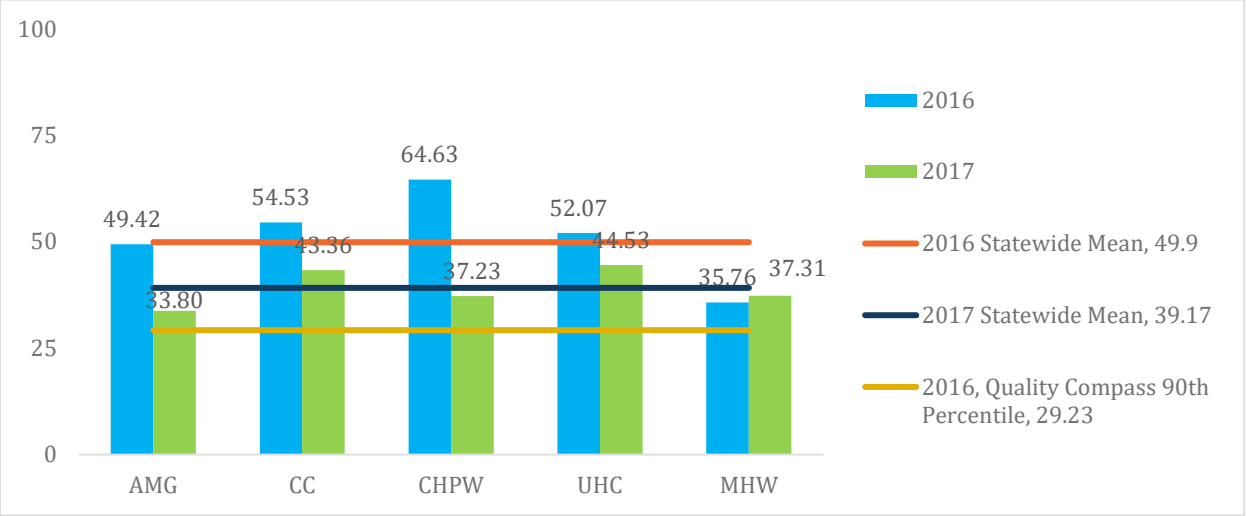
Figure 3: Childhood Immunization Status (Combo 10), 2016-2017



Comprehensive Diabetes Care-Hemoglobin A1C Poor Control (>9.0%)

The 2017 MCO performance improved from the previous reporting year to 39.17%. For this measure, a lower score is better; a low Hemoglobin A1c shows a person is better managing their diabetes. Figure 4 shows performance for each MCO over a two year period. Four of the MCOs (AMG, CC, CHPW, and UHC) saw significant improvement in performance; MHW had lower performance between 2016 and 2017.

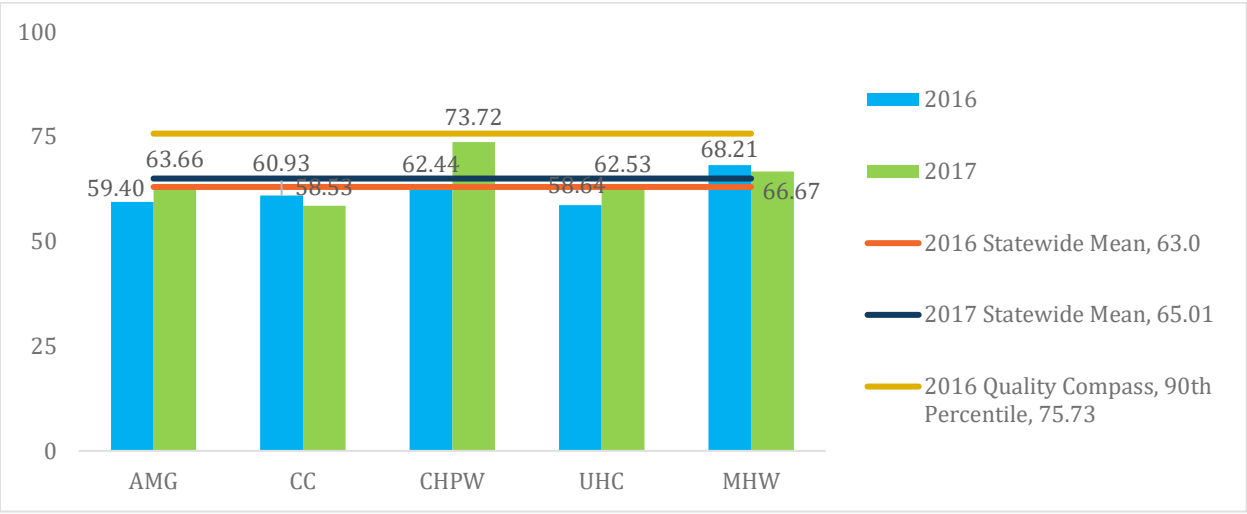
Figure 4. Comprehensive Diabetes Care; Hemoglobin A1C Poor Control (>9.0%), 2016-2017



Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)

This measure improved from 2016 to 2017 with 65% of the population demonstrating blood pressure control. Figure 5 shows that AMG, CHPW, and UHC's performance improved between 2016 and 2017; CC and MHW had reductions in performance. The plans would need to have achieved 75.73% to meet the Quality Compass benchmark.

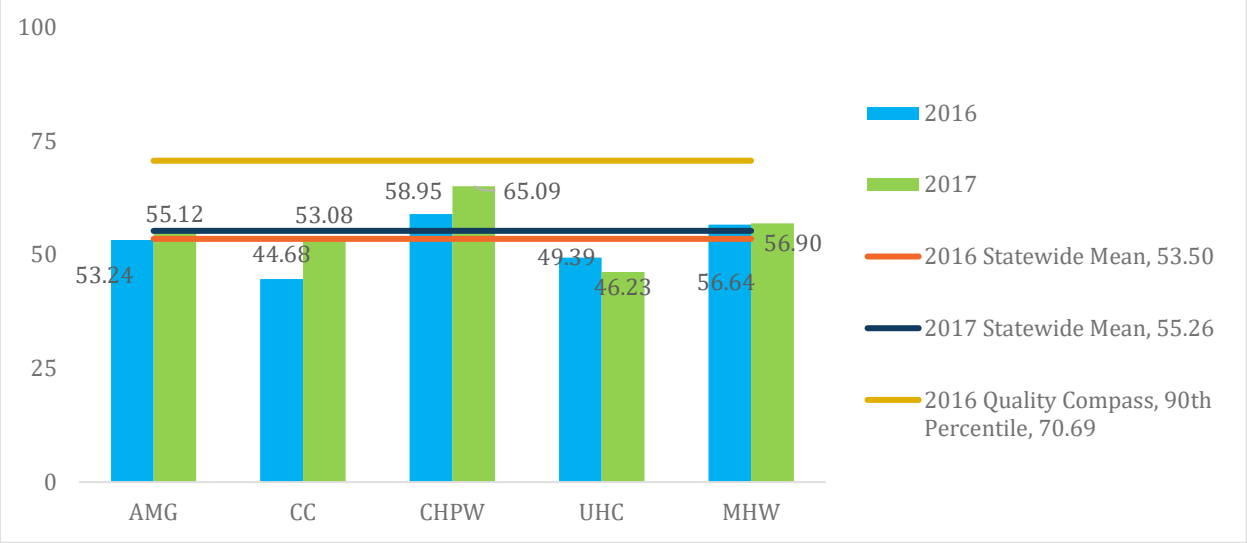
Figure 5. Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg), 2016-2017



Controlling High Blood Pressure

On average in 2016, 53.5% of enrollees statewide had controlled blood pressure below 140/90 mm Hg. The average for 2017 improved to 55.26. Figure 6 shows improved performance among all MCOs—with the exception of UHC which showed lower performance in 2017. Plans would need to achieve 70.69% to meet the Quality Compass benchmark.

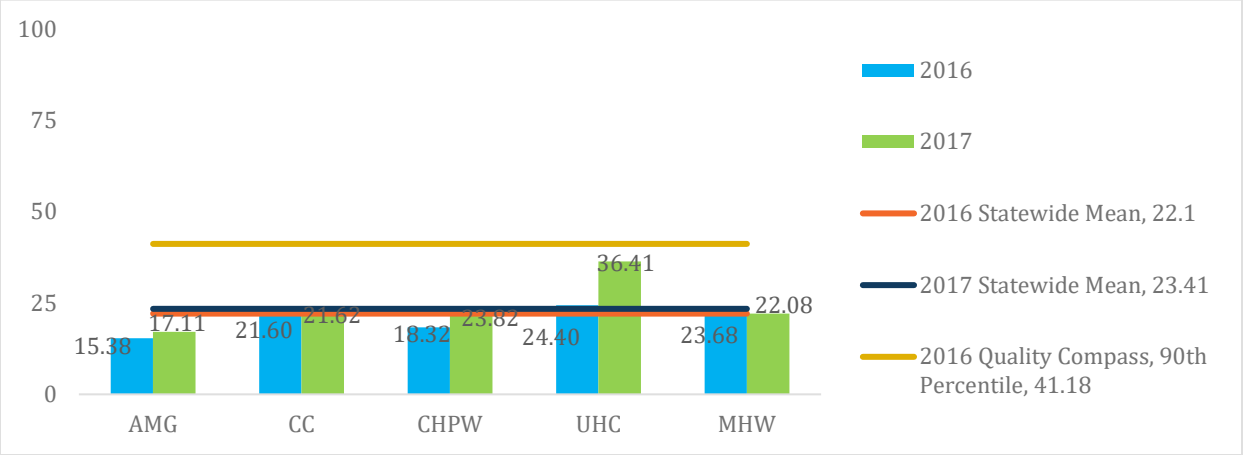
Figure 6. Controlling High Blood Pressure, 2016-2017



Medication Management-People with Asthma: Medication Compliance 75% (5-11 years)

This measure examines the percentage of enrollees, ages 5-64, with persistent asthma who had appropriate medication dispensed to them and who remained on the medication during the treatment period. This measure looks at children, ages 5-11, who remained on an asthma controller medication for at least 75% of the time. Figure 7 shows all MCO performance in a two year period. All MCOs showed improvement in performance over the two year period.

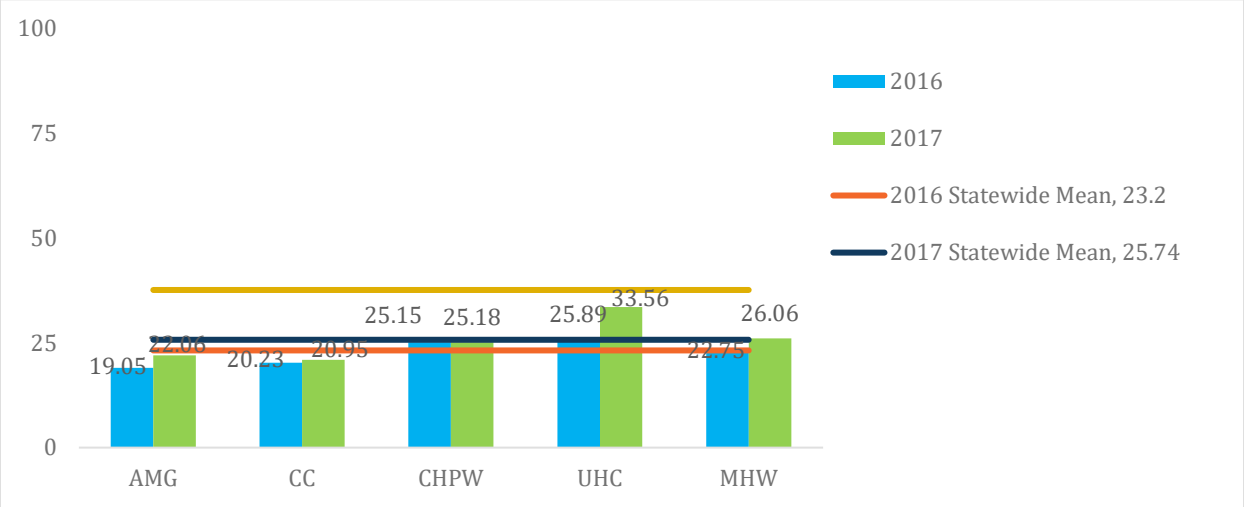
Figure 7: Medication Management-People with Asthma: Medication Compliance-75% (5-11 years), 2016-2017



Medication Management-People with Asthma: Medication Compliance 75% (12-18 years)

This measure, the same as above, looks at how many 12- to 18-year-old enrollees remained on an asthma controller 75% of the time. The statewide average improved between 2016 and 2017 from 23.2 to 25.74% All MCOs saw improvement in performance between 2016 and 2017. To achieve the 90% percentile through Quality Compass, the plan statewide average would need to reach 37.63%.

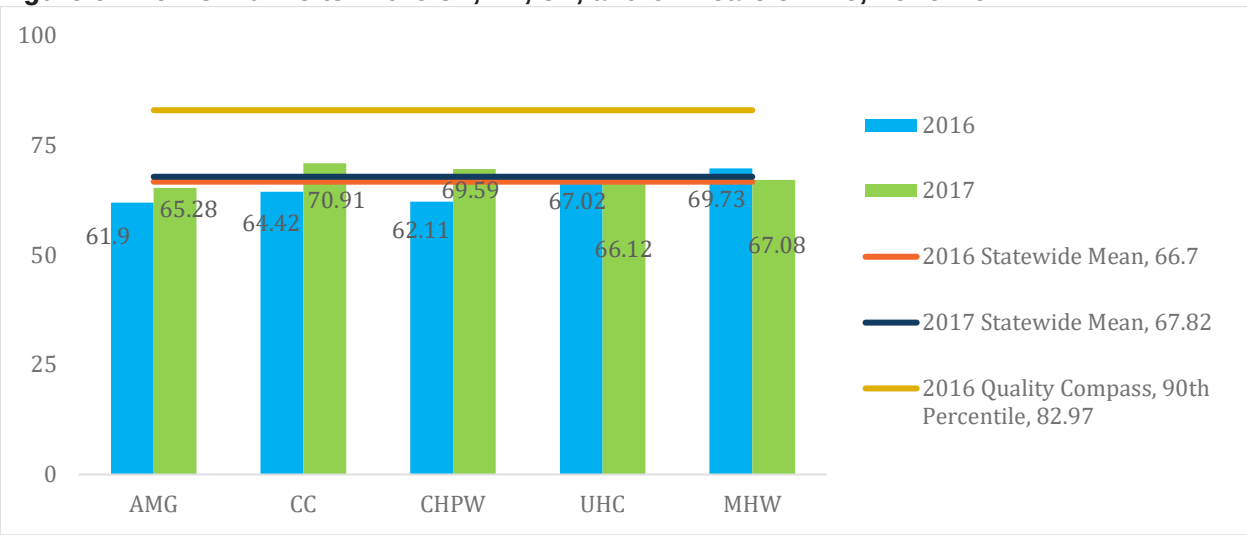
Figure 8. Medication Management-People with Asthma: Medication Compliance-75% (12-18 years), 2016-2017



Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

The 2017 rate for well-child care visits in this age group was 67.82%. In Figure 9, three of the MCOs show between-years improved performance: AMG, CC, and CHPW. Both MHW and UHC saw slight performance reductions. The plans would need to have achieved 82.97% on this measure to meet the Quality Compass 90th percentile benchmark.

Figure 9. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, 2016-2017



Other Measures and Reports on Clinical Performance

HCA, DSHS, or agency contractors create other reports which include performance measures, including two legislatively-requested reports:

- Child Health Services: Provider Performance, http://hca.wa.gov/assets/program/eshb-2128-child-health-svcs.pdf (responsive to Engrossed Substitute House Bill 2128, Laws of 2009; produced every other year); and
- Medicaid Managed Care Preventive Services and Vaccinations, http://hca.wa.gov/assets/program/2eshb-2376-med-prev-vacc_0.pdf (responsive to Second Engrossed Substitute House Bill 2376, Laws of 2016; produced annually).

Along with the above two reports, DSHS and HCA contract with an External Quality Review Organization (EQRO), Qualis Health, to produce annual reports containing performance measures. The reports include the Performance Measure Comparative Analysis report and an External Quality Review Annual report. These reports must comply with federal regulations, 42 CFR 438.364. These technical reports summarize findings on access and quality of care. Find current reports at https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports.

We caution the reader in comparing the results in the many performance measure reports cited, including the data presented in this report. Measures for these reports may use data from different sources or time frames, or track different subject populations (e.g., all Medicaid enrollees, in both managed care and fee-for-service, instead of only Medicaid managed care enrollees).

Initial Health Screen and Assessment of Managed Care Enrollees

HCA requires the MCOs to conduct a brief Initial Health Screen (IHS) for all new enrollees within sixty calendar days of enrollment. The MCOs are expected to make at least three reasonable attempts on different days and times of day to contact an enrollee to complete the IHS and document these attempts.

The IHS evaluates the enrollee's physical, behavioral, and oral health status; health services history, including receipt of preventive care services; and current medications. The IHS should also identify an enrollee's special needs. The screener evaluates the need for care coordination—or the need for clinical and non-clinical services—including referrals to specialists and community resources.

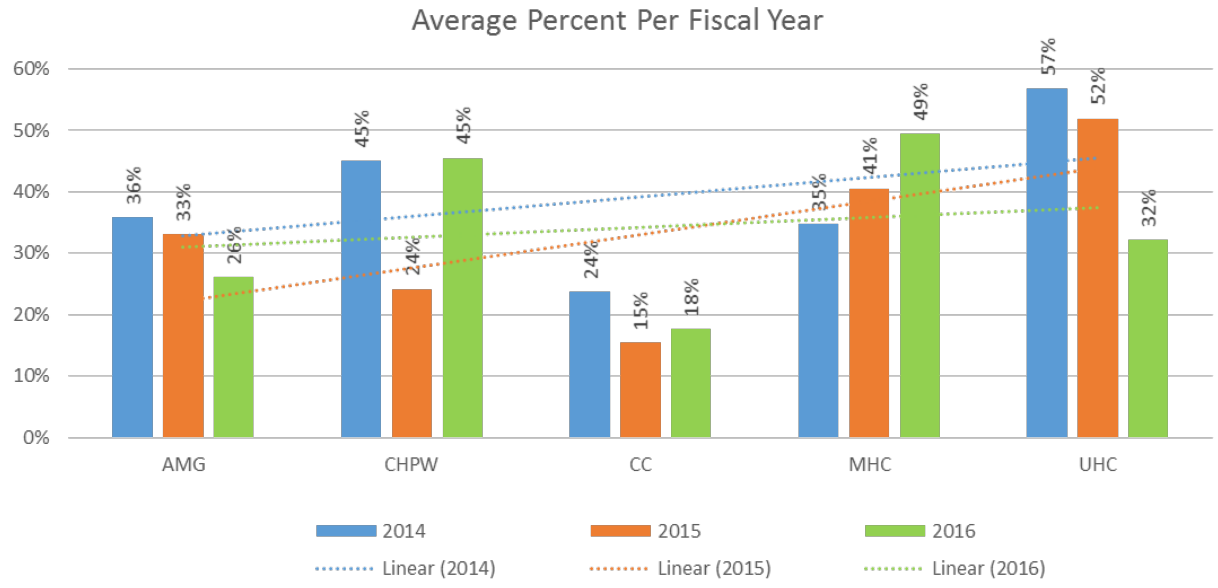
As a result of the screening, the MCO works with the enrollee's primary care provider and care coordinator to ensure the enrollee receives follow-up services reflecting the IHS findings. Follow-up services may include consultations with mental health and/or substance use disorder providers or referrals to community-based social services. The screener develops a care coordination plan for any enrollee identified with special health care needs.

This plan will address:

- Enrollee self-management goals.
- Short- and long-term treatment goals—and any barriers to meeting goals.
- Barriers to achieving self-management goals and how these were addressed.
- Follow-up treatment and communication with the enrollee.
- Clinical and non-clinical services accessed by the enrollee or recommended by the primary care provider or care manager.
- Referrals and, as appropriate, funding of community-based self-help programs, such as the Chronic Disease Self-Management Education program. The contractor may choose to fund such programs.
- Integration and coordination of clinical and non-clinical services, including follow-up to ensure the enrollee accesses these services.
- Comprehensive medication therapy management services.
- Changes, as needed, to address the enrollee's emerging needs.
- Progress (or reason for lack of progress) on self-management goals.
- Communication with primary and specialty care providers, including mental health and substance use disorder providers.
- Clear description of actions the enrollee's care manager shall take to support the enrollee in meeting their goals.

The following chart shows the Initial Health Screen results for each health plan during the last three state fiscal years, 2015–2017. Trends are portrayed using linear lines, plotted to show MCO trends over a three fiscal year period of time. Performance on this measure dipped in 2016-2017.

Figure 10: Initial Health Screening by Plan, 2015-2017



Note: Trends are portrayed using linear lines, plotted to show MCO performance over time for each health plan.

Service Coordination Organization and Managed Care Performance Measure Report
December 1, 2017

Conclusions and Recommendations

Since the original 2013 legislative directive, DSHS and HCA have partnered with DSHS-RDA, BHOs, AAAs, Apple Health MCOs, and the agency's contracted External Quality Review Organization to calculate and report the measures in this report. This report summarizes measures used by both DSHS and HCA to evaluate and monitor contractors required to calculate and report performance measures. Results of many of the performance measures are provided over a two- to three-year period. Measures specifically required in value-based contracting were noted, where relevant.

This report provided an update on the publically-reported BHO performance, the SCO performance measures, and the implementation status of these measures in BHO contracts. This report also identified the risks related to attaching these measures to performance incentives given the current context of the BHOs' dissolution by January of 2020.

We used historical HCA reporting systems to identify performance measures required of SCOs (i.e., AAAs, BHOs, and MCOs), including those measures selected for Apple Health VBP contracts. As discussed in the report, the QMMI program was developed to gain a better handle on the myriad measurement initiatives with the intent of streamlining efforts around performance measurement.

Regarding measurements, results showed varying performance. Health screens showed a drop in performance. Corrective actions are in place with Apple Health managed care organizations to improve performance on this measure. There were some genuinely positive trends, such as improvement in diabetes and blood pressure control in Apple Health value-based purchasing measures between 2016 and 2017. Appendix A listed 41 additional measures reported by Apple Health, of which 25 had three years of data from which to compare performance. Eighteen of 25 measures showed improvement between these years.

Changes in the SCO measures over time are primarily a result of the impact of Medicaid Expansion under the Affordable Care Act on the composition of the adult Apple Health caseload. When stratified by major coverage group, these measures are relatively stable for the Disabled population that has experienced the most stable case mix over the reporting period. There is evidence of a modest downward drift in the "narrow" (RSN/BHO) mental health service penetration rate which bears watching as the state integrates health care services.

The aims of Healthier Washington—to ensure better health and care for Washington's residents and communities, and to keep health care costs manageable—are more critical than ever. Significant progress has been made in achieving these aims. The state's commitment and investments were instrumental in positioning Washington for success in securing the Demonstration grant. The additional resources afforded to the state supported by executive and legislative action holds great promise for synergizing the work of state government to improve the quality of care our clients receive. The additional federal resources will ensure that Washington State remains a leader in health system transformation and achieves the triple aim of better health, better care, at a lower cost.

Appendix A: Value-Based Reimbursement Methods for Health Care Authority Managed Care Contracts

Beginning January 2017, payments to Apple Health MCOs were modified. Payments to MCOs are now based on their ability to deliver high quality care and keep clients healthy—rather than payment for specific tests or services alone. One percent of each MCO's monthly premium is withheld. MCOs receive the withhold amount if they meet specific, quality milestones based on performance on a set of performance measures.

These payment changes are part of HCA's strategy to implement value-based purchasing. HCA has established a goal that 90 percent of its provider payments under state-financed health care will be linked to quality and value by 2021.

The agency adopted a Quality Improvement (QI) model which measures how the MCOs improve and reach specific quality targets. The model rewards health plans for clinical quality improvement. The following scores are calculated and used to compute a QI score:

- Weight–the degree of influence each measure has on the overall QI score–each measure used to calculate a QI score is weighted;
- Mean Score–the average percentage for each measure informed by various national data sources; and
- Target score–the performance that the MCO should achieve on each measure, also informed by various national data sources.

The QI score is based on a weighted average of a set of quality measures. The QI score is blended between the MCO improvement performance and movement toward achieving a target score. When an MCO is further from the target score, the calculation weighs improvement more than quality. As the MCO approaches the target for an individual score, the calculation weighs quality more on improvement to reward strong performance. This dynamic weighting ensures the MCO has an incentive to perform well, regardless of where their score is relative to the target. The individual QI scores are then combined with their weights into the overall QI score.

MCOs can earn back up to 75 percent of the premium withhold based on their overall QI score. The remaining 25 percent premium withhold is earned back after MCOs provide evidence of passing qualifying, value-based provider incentive payments to subcontracted providers.

For more information about how the QIS is calculated:

- https://www.hca.wa.gov/assets/program/QIS-MCO-fact-sheet.pdf; and
- https://www.hca.wa.gov/search/site/quality%20improvement%20score?section=%2A.

Appendix B: Apple Health Managed Care Organization Clinical Performance Measure Results

Apple Health Managed Care Organization-Statewide Results	Reporting Year 2015 Measurement Year 1/14–12/14	Reporting Year 2016 Measurement Year 1/15–12/15	Reporting Year 2017 Measurement Year 1/16–12/16
Adult Access to Preventive/Ambulatory Health Services	80.4%	74.8%	74.2%
Adult BMI Assessment	82.2%	85%	90.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile	36.7%	45.8%	58.0%
Counseling for Nutrition	51.1%	57.4%	58.7%
Counseling for Physical Activity	45.1%	53.5%	53.2%
Immunization for Adolescents (Combo 1)	73.7%	74.2%	76.6%
Lead Screening in Children	NR	NR	20.3%
Breast Cancer Screening	54.4%	52.3%	53.5%
Cervical Cancer Screening	50.4%	52.8%	55.8%
Chlamydia Screening in Women (Total)	51.2	54.8	54.4%
Appropriate Testing for Children with Pharyngitis	64.7%	68.1%	73.9%
Use of Spirometry Testing in Assessment and Diagnosis of COPD	NR	NR	23.7%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	75.8	74.6%	72.3%
Bronchodilator	87%	85%	83.6%
Asthma Medication Ratio (Total)	NR	50.8%	50.8%
Persistence of Beta Blocker Treatment after a Heart Attack	NR	NR	79.4%
Statin Therapy for Patients with Cardiovascular Disease			
Received Statin Therapy (Total)	NR	NR	80.1%
Statin Adherence (Total)	NR	NR	61.2%
Comprehensive Diabetes Care: Hemoglobin A1c Testing	90.4%	88.3%	89.6%
Comprehensive Diabetes Care: Retinal Eye Exam	54.8%	55.5%	59.1%
Comprehensive Diabetes Care: Medical Attention for Nephropathy	83.4%	88.9%	90.1%
Statin Therapy for Patients with Diabetes			
Received Statin Therapy	NR	NR	64.3%
Statin Adherence 80%	NR	NR	60.4%
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	NR	NR	82.2%
Follow-up Care for Children Prescribed ADHD Medication			
Initiation Phase	37.7%	38.7%	43.1%
Continuation and Maintenance Phase	39.1%	48.2%	53.5%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medication	85.9%	85.6%	85%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.6%	67.1%	61.8%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	NR	NR	31.1%

Apple Health Managed Care Organization-Statewide Results	Reporting Year 2015	Reporting Year 2016	Reporting Year 2017
	Measurement Year 1/14–12/14	Measurement Year 1/15–12/15	Measurement Year 1/16–12/16
Annual Monitoring for Patients on Persistent Medications	NR	NR	86.7%
ACE Inhibitors or ARBs (Total)	NR	NR	86.8%
Non-Recommended Cervical Cancer Screening Adolescent Females	NR	NR	0.9%
Appropriate Treatment for Children with URI	92.6%	93.5%	93.7%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	29.3%	30.3%	36.1%
Use of Multiple, Concurrent Antipsychotics in Children and Adolescents (Total)	NR	NR	3.1%
Timeliness of Prenatal Care	73.7%	68.2%	77.9%
Postpartum Care	51.6%	52.2%	58.8%
Use of First Line Psychosocial Care for Children/Adolescents on Antipsychotics (Total)	NR	NR	20.3%
Well-Child Visits in First 15 Months of Life (6+visits)	56.8%	60.3%	66.3%
Adolescent Well-Care Visits	42.6%	43.3%	45.8%

Notes:
NR means the measure was not reported. When the measure is reported, the measure was activated the previous year. One year lapses before a measure is publically reported.

Measures highlighted in grey reflect the title of measures which have sub-measures. For example, the pharmacotherapy managed for individuals with COPD exacerbation measure include two sub-measures; the rate of individuals on a systemic corticosteroid and the rate of individuals receiving a bronchodilator. Both rates reflect the standard of care for individuals with the diagnosis of COPD.

Appendix C:

Washington State Medicaid Managed Care Quality Strategy

October 2017

Medicaid Programs Operations and Integrity
P. O. Box 45530
Olympia, WA 98504
Phone: (360) 725-2053
Fax: (360) 586-9551
www.hca.wa.gov

Division of Behavioral Health and Recovery
P.O. Box 45330
Olympia, WA 98504-5330
Phone: (360) 725-1400
Fax: (360) 725-2280
www.dshs.wa.gov/bha/division-behavioral-health-and-recovery

Table of Contents

Introduction

The Washington State Health Care Authority (HCA) purchases health care for more than two million Washingtonians through Apple Health (Medicaid) and the Public Employees Benefits programs. HCA works with its partners to help ensure enrollees and members have access to better care at a lower cost. In partnership with many contractors and community partners, HCA provides high quality health care through innovative health policies and purchasing strategies with an overarching goal of creating a healthier Washington.

The Washington Department of Social and Health Services (DSHS), Behavioral Health Administration's Division of Behavioral Health and Recovery (DBHR) provides behavioral health care for more than 200,000 Washington residents. DBHR works with the Health Care Authority, as well as other agencies, DSHS administrations and divisions, to coordinate the delivery of care to low-income and/or Medicaid-enrolled individuals with mental health and/or substance use disorder treatment needs.

Implementation of the Affordable Care Act in 2014 and two key federal grants awarded to Washington strengthen and support many of the Health Care Authority's recent efforts to leverage its purchasing power to drive health transformation across Washington State and improve the quality of health care services and the health of Apple Health Fee-for-Service (FFS) and managed care enrollees. In 2015, the Health Care Authority was awarded a Center for Medicare and Medicaid State Innovation Model grant, followed by a five-year, $1.5 billion Centers for Medicare and Medicaid Section 1115 Medicaid Waiver in 2017 (hereafter, Demonstration).

Titled *Healthier Washington*, the agency has leveraged changes resulting from the Affordable Care Act, the grant and Demonstration and set ambitious health transformation goals to achieve better health, better care and smarter spending:

- Build healthier communities through a collaborative, regional approach, Accountable Communities of Health;
- Integrate how we meet physical and behavioral health needs so that health care focuses on the whole person; and
- Improve how we pay for services by rewarding quality over quantity, by moving 90 percent of state financed health care into value-based care models, as defined by the CMS LAN Framework (2c-4b).

Through Healthier Washington and agency realignment activities to support value-based purchasing, HCA and DSHS have achieved the following results and successes focused on improving quality of care and services that Washington health care consumers receive.

- HCA created a new division led by the Chief Medical Officer (CMO) entitled Clinical Quality and Care Transformation (CQCT) to set and standardize clinical policies and care redesign approaches based on evidence for state purchased program, Medicaid and PEB.

- Designated nine Accountable Communities of Health responsible for conducting a regional health needs assessment and convening partners to identify regional health priorities for community-based, health improvement efforts. This includes a strong focus on whole person care and the recognition of clinical-community linkages.
- Implemented a Practice Transformation Support HUB to assist and support physical and behavioral health clinical practices toward integrated health care, support progress toward value-based payment and quality care, and improve population health.
- Implemented several innovations to behavioral health system design, based on a legislative Adult Behavioral Health System Task Force report and a series of key Washington legislation:
    - Behavioral Health Organizations, providing administrative oversight of both mental health and substance use disorder services in nine regions of the state;
    - Fully integrated physical and behavioral health services in Southwest Washington in April 2016, followed by North Central Washington slated for January 2018; and
    - A coordinated strategy with Washington Tribal leaders to facilitate changes required as a result of behavioral health care changes.
- Adopted a set of cross-system performance measures, entitled Service Coordination Organization (SCO) measures as a result of two pieces of legislation designated for use in Behavioral Health Organization (BHO), Managed Care Organization (MCO), and Area Agencies on Aging (AAA) contracts.
- Adopted a Statewide Common Measure Set (SCMS); evidence-based, Clinical Performance Measures (CPMs) recommended by clinicians participating in a legislatively mandated Performance Measure Coordinating Committee.
- Created the Health Home program, afforded through Section 2703 of the Affordable Care Act. The program was implemented in collaboration with DSHS, Aging and Long Term Support Administration and the Centers for Medicare and Medicaid. Health Home delivers a set of services to support chronically ill and complex clients. The program seeks to improve a client's self-management of health care conditions and better manage the progression of chronic disease. Initially delivered in 37 of 39 counties, the program expanded statewide in 2017.
- Established an interagency Quality Measurement, Monitoring and Improvement (QMMI) Committee, creating a Clinical Quality Council governed by the HCA Chief Medical Officer which guides the selection and implementation of performance measures in Managed Care Organization (MCO) and MCO value-based contracting arrangements.
- Invested in agency analytics, interoperability and measurement to:
    - Support analytical and measurement efforts required of the Accountable Communities of Health;
    - Develop measurement dashboards for use by agency staff and stakeholders; and
    - Guide the analytical needs of QMMI, including the selection of performance measures and analytical methods to assess the quality of care Washington residents receive through Apple Health.

- Created its own home-grown Quality Improvement Model for state-financed value-based contracts, to reward quality improvement and attainment of targets based on national benchmarks.
- Implemented numerous value-based contracts, or added language to existing MCO contracts to reward contractors for improvement in quality of care and services, that are risk-based contracts where providers and MCOs are held accountable for costs and quality (based on a subset of measures from the Statewide Common Measure Set in the Quality Improvement Model). New value-based contracts also include care transformation requirements.
- Published a HCA Value-based Roadmap in June 2016, articulating HCA's vision and principles for new value-based models of care for Medicaid and state employees.
- Under the Demonstration, published a Project Toolkit, to guide ACHs in planning and carrying out delivery system reform projects. The Toolkit provides guidance in the following areas: financial sustainability through value-based payment, promoting health workforce that supports coordinated care, leveraging health information technology to advance population health management, implementing bi-directional integration and care coordination, and addressing opioid use.

These combined efforts are intended to achieve the Triple Aim[8]: improve health, lower health care costs, and improve the experience of care. The state has taken multiple steps to align clinical measures and quality initiatives across all state-financed programs (Medicaid and public employees) by creating the Accountable Communities of Health, Practice Transformation HUB, and risk-based contracts—all to standardize clinical care based on evidence and reduce provider burden across the Washington health care system.

As mentioned in the above description of successes and results our state has achieved, it is important to note that the Governor and Legislature intend to combine the purchase and administration of behavioral healthcare into managed care systems by 2020. Regions have begun transitioning from Behavioral Health Organizations to Managed Care Organizations' managing behavioral health services through the Fully Integrated Managed Care (FIMC) contracts. Additionally, plans will transition staff from the DBHR to the Department of Health and the Health Care Authority in 2018, pending legislative action. With these planned changes, HCA and DBHR quality structures will be in further alignment.

[8] The Triple Aim, developed by the National Institute of Medicine, refers to the goal of improving the U.S. health care system by the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations and reducing per capita costs of health care.

Background

Two agencies sponsor and monitor the Washington Medicaid Managed Care Quality Strategy:

- Washington Health Care Authority (HCA), Medicaid Program Operations and Integrity (MPOI) Division, Compliance Review and Analytics (CRA) section (hereafter, MPOI); and
- Department of Social and Health Services (DSHS), Behavioral Health Administration (BHA), Division of Behavioral Health and Recovery (hereafter, DBHR).

MPOI and DBHR developed a combined Quality Strategy summarizing a systematic approach to plan, measure, assess, and improve health care services to Apple Health enrollees. The strategy describes the methods MPOI and DBHR use to measure and enforce material terms of Managed Care Organization (MCO), Pre-Paid Inpatient Health Plan (PIHP), and Primary Care Case Management (PCCM) contracts. The Quality Strategy aligns with MPOI and DBHR quality activities and agency goals and Federal managed care requirements.

Six HCA divisions and their staff administer health care coverage for low-income adults, families, pregnant women, children, the elderly, and persons with disabilities. Apple Health covers nearly 50 percent of all Washington children and more than 50 percent of all births in Washington.

Nearly 1.8 million Washingtonians currently receive health care through Apple Health managed care and fee-for-service arrangements and more than 80 percent are enrolled in managed care. Along with physical health care benefits, managed care plans are responsible for mental health services for less complex mental health conditions.

The lead HCA division for the implementation and oversight of Apple Health managed care contracts, MPOI secures managed care contracts through a competitive procurement process.

There are four managed care contracts in place:

- Apple Health Managed Care (AHMC): This program serves adults, families and CHIP-eligible children in Washington. The program provides medical benefits and low complexity mental health services to enrollees. There are five managed care organizations serving families in 34 of 39 Washington counties.
- Apple Health Foster Care (AHFC): Serves children receiving foster care services, including families of adoptive children. Youth aging out of the foster care system can also receive services through this program, alternate managed care plans or Medicaid FFS. One managed care plan serves these individuals.
- Fully Integrated Managed Care (FIMC): Initiated by the Washington legislature, this program integrates physical and behavioral health (mental health and substance use disorder services) under one contract. By 2020, FIMC will be operational throughout the state and take the place of the AHMC program.

- Primary Care Case Management (PCCM): This program is offered to American Indians and Alaska Natives within the state of Washington. Tribal clinics receive a small per member per month payment for care management; services are paid through the Medicaid fee-for-service system.

The DSHS Behavioral Health Administration purchases and administers Medicaid behavioral health services for children and adults through managed care contracts with Prepaid Inpatient Health Plans (PIHPs) known as Behavioral Health Organizations (BHOs). There are nine BHOs, whose regions align with the HCA and DSHS-designated regional service areas. Eight of the BHOs were formed by county governments and one, Pierce County, utilizes a private, for-profit healthcare organization. These PIHPs are responsible for:

- Purchasing inpatient mental health treatment for all Medicaid-enrolled adults and children.
- Purchasing and administering outpatient mental health treatment for Medicaid-enrolled children and adults who meet the medical necessity criteria known as the access to care standards[9]. Outpatient mental health treatment is provided by community behavioral health agencies (BHAs). Medicaid-enrolled children and adults who do **not** meet access to care standards receive their mental health treatment through the HCA-contracted MCOs.
- Purchasing and administering all publically-funded substance use disorder services statewide with the exception of the Southwest Washington Regional Service Area and beginning in 2018, the North Central region. In these regions, Medicaid-funded mental health, substance use disorder, and physical health care services are provided via contracts between the HCA, two MCOs, and one administrative service organization.

The state provides inpatient treatment for behavioral illness through community hospitals statewide and two adult state-run hospitals: Eastern State Hospital in Medical Lake and Western State Hospital in Lakewood. The state also owns and operates one psychiatric hospital for children, the Child Study and Treatment Center (CSTC) in Lakewood. The hospitals are reserved for the most seriously ill or those sent by state courts for evaluation or treatment and have a combined capacity to serve 1,100 patients.

[9] The statewide access to care standards describe the minimum standards and criteria for clinical eligibility for behavioral health services for the Behavioral Health Organization delivery system. Apple Health enrollees are eligible for all outpatient and residential levels of care and clinical services based on medical necessity and access to care standards. See https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/ACS_201602.0.pdf for more information.

History of Washington's Medicaid Managed Care Programs

Managed Care Organizations (MCOs)

Medicaid managed care has a long history in Washington. Beginning in the early 1980's, DSHS purchased physical health care services and contracted with two MCOs in parts of the state in which clients could voluntarily enroll. Based upon the successes of that voluntary effort and the need to improve access to care for Medicaid clients, mandatory managed care started in one county and, with continued success, later expanded statewide. HCA now contracts with five MCOs through three Apple Health contracts. Apple Health is a mandatory program but enrollment is voluntary in one county, either because there is only one MCO or because the contracted MCOs does not have sufficient capacity to serve all enrollees.

In 2014, the Legislature required HCA to integrate physical and behavioral health (mental health and substance use disorder services) throughout the state. MPOI started this program in Southwest Washington in April 2016 and will add a second region, North Central in January 2018. In 2018, a competitive procurement will be conducted to purchase integrated care in the remaining seven Washington regions. By the end of 2020, all counties will be converted to regional, integrated contracts. Health care benefits, including physical and behavioral health care will be provided through this contract arrangement.

Prepaid Inpatient Health Plans (PIHPs)

Increased heath care costs led the DBHR to transition from block grant and fee-for-service payment models to managed care strategies. This transition occurred in four phases.

1. March 1990: the Regional Support Networks (RSNs) were formed. These networks were made up of one or more Washington counties. DBHR purchased services from the RSNs, who then contracted with mental health agencies that directly provided behavioral health services.
2. 1993: The state began outpatient managed mental health care services for people covered by Medicaid under a 1915(b) federal waiver. Washington began purchasing outpatient services through capitated payments to the RSNs. RSNs began operating as Prepaid Health Plans (PHPs) by assuming financial risk to provide all medically necessary outpatient community mental health rehabilitation services to people in their geographic region.
3. October 1997: DBHR included community psychiatric hospital services within the managed care contracts with PIHPs.
4. 2014: Senate Bill 6312 in 2014, required DSHS to change how it purchases and administers public mental health and substance use disorder services under managed care. Beginning April 2016, regionally-operated BHOs purchase substance use disorder and mental health services. These single, local entities assume responsibility and financial risk for providing behavioral health services previously overseen by the counties and RSNs.

Managed Care Goals and Objectives

Health Care Authority

Interagency Quality Measurement Monitoring and Improvement (QMMI) Committee

In 2017, the CQCT Division formed a committee structure to guide the agency's Chief Medical Officer in the selection of valid, reliable, evidence-based CPMs in Apple Health and Public Health Benefit program for reporting purposes or tied to payment and value. The Chief Medical Officer is advised by research and analytical expertise from a clinical data team and an operations workgroup, the clinical implementation team. A Clinical Quality Council reviews team guidance and makes recommendations to the CMO.

MCOs are required to annually report CPMs to the HCA. The CPMs are independently audited to ensure accuracy in calculation of the measures.

QMMI committees include partner agency staff with expertise in prevention, the treatment and management of behavioral health conditions, and the needs of Washington citizens requiring long-term services and supports. The Washington State Department of Health, Department of Social and Health Services: Division of Behavioral Health and Recovery and Aging and Long-Term Support Administration enrich discussion and decision-making regarding the selection of CPMs used to assess the quality of services and care for our most vulnerable clients.

As a result of partner efforts, the agency created a list of measures for statewide reporting in both Apple Health and PEB contracts. QMMI participants also selected a list of SCMS and SCO measures for use in value-based purchasing arrangements. Many of these same measures are also found in the National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set (HEDIS®) measure set.

Measures are selected based on the needs and risks of the populations served. For example, discussion with the DSHS-Behavioral Health Administration and DSHS-Children's Administration, the latter responsible for managing the foster care system in Washington, led to a more informed selection of measures for the Apple Health Foster Care contract.

Clinical Quality Metrics and Performance Targets for Value-Based Purchasing

QMMI teams selected measures for reporting by the MCOs, as well as measures for inclusion in HCA contracts containing value-based purchasing contract language. With few exceptions, three key pieces of Washington state legislation resulted in the measures found in the table below. The legislation directed HCA and DSHS to develop a list of SCMS and SCO measures.

The source of these measures include those identified by the state Performance Measures Coordinating Committee or SCMS measures, or from a committee that guided the development of SCO measures. These measures will be effective in all Apple Health managed care contracts January 2018 and are tied to a withhold amount.

Table 1: Value-Based Purchasing Clinical Performance Measures by Plan Type

Value-Based Purchasing Clinical Performance Measures	Apple Health Managed Care	Fully Integrated Managed Care	Apple Health Foster Care	Statewide Common Measure Set (SCMS)/ Service Coordination Organization (SCO) Measures
Antidepressant Medication Management: Effective Acute Phase Treatment	X	X		SCMS
Antidepressant Medication Management: Effective Continuation Phase Treatment	X	X		SCMS
Childhood Immunization Status (Combo 10)	X	X		SCMS
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	X	X		SCMS
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm)	X	X		SCMS
Controlling High Blood Pressure	X	X		SCMS
Medication Management for People with Asthma: Medication Compliance 75% (Ages 5-11)	X	X	X	SCMS
Medication Management for People with Asthma: Medication Compliance 75% (Ages 12-18)	X	X	X	SCMS
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	X	X	X	SCMS/SCO
Substance Use Treatment (Service) Penetration		X		SCMS/SCO
Substance Use Disorder Initiation		X		SCO
Substance Use Disorder Engagement		X		SCO
Mental Health Treatment (Service) Penetration		X		SCMS/SCO
Adolescent Well-Care Visits			X	SCMS/SCO
Follow-Up Care for Children Prescribed ADHD Medication: Initiation			X	SCMS
Follow-Up Care for Children Prescribed ADHD Medication: Continuation			X	SCMS
Lead Screening in Children			X	N/A

Rewards for Quality Improvement in Clinical Performance Measures

Beginning January 2017, payments to Apple Health MCOs were modified to link payment to cost and quality performance of MCOs and their provider networks. Payments to MCOs are now based on their ability to deliver high quality care and keep clients healthy, rather than payment for specific tests or services alone.

These payment changes are part of HCA's strategy to implement value-based purchasing. Value-based purchasing language contained in the MCO contracts is intended to advance the state's Quality Strategy and agency goal of improving how the agency pays for services, rewarding quality over quantity (42 C.F.R. § 438.6(c)(ii)(C)).

One percent of each MCO's monthly premium is withheld as allowed under federal CFR (42 C.F.R. § 438.6(c)(i)). A percentage of the one percent is linked to MCO performance on a select set of quality measures (see above), in the Quality Improvement Model. MCOs can earn back up to 75 percent of the premium withhold based on their overall QI score. The remaining 25 percent premium withhold is earned back after MCOs provide evidence of passing qualifying, value-based provider incentive payments to subcontracted providers. HCA's Quality Improvement (QI) model measures how the MCOs improve and reach specific quality targets. The model rewards health plans for clinical quality improvement. The following scores are calculated and used to compute a QI score:

- Weight–the degree of influence each measure has on the overall QI score – each measure used to calculate a QI score is weighted
- Mean Score–the average percentage for each measure informed by various national data sources
- Target score–the performance that the MCO should achieve on each measure, also informed by various national data sources.

The QI score is based on a weighted average of a set of quality measures. The QI score is blended between the MCO improvement performance and movement toward achieving a target score. When an MCO is further from the target score, the calculation weights improvement more than quality. As the MCO approaches the target for an individual score, the calculation weighs quality more on improvement to reward strong performance. This dynamic weighting ensures the MCO has incentive to perform well, regardless of where their score is relative to the target. The individual QI scores are then combined with their weights into the overall QI score.

For more information about how the QIS is calculated:
https://www.hca.wa.gov/assets/program/QIS-MCO-fact-sheet.pdf; and
https://www.hca.wa.gov/search/site/quality%20improvement%20score?section=%2A.

Goals for Continuous Quality Improvement

HCA's Healthier Washington initiative guides the agency in its efforts to improve care to Apple Health enrollees. As mentioned in the beginning of this document, the Goals of Healthier Washington include:

- Building healthier communities through a collaborative regional approach,
- Integrating physical and behavioral healthcare to focus on the whole person, and
- Improving how the agency pays for services by rewarding quality over quantity.

To achieve the above goals, the agency played a vital role in supporting the development of the Accountable Communities of Health (ACH). This effort was largely resourced by the State Innovation Model Round Two Test Grant. The ACHs coordinate and oversee regional projects aimed at improving care for the entire community, including Apple Health clients.

The HCA began its journey to integrate health care services in 2015 with release of a competitive procurement selecting two MCO contractors to deliver care in the newly formed, Southwest Washington purchasing region. Beginning with the implementation of the Accountable Care contract in the PEB program, the agency implemented its first value-based contract in 2016. In January 2017, value-based purchasing language was added to the AHMC contract. By 2018, value-based purchasing language will be contained in the remaining AHFC and FIMC contracts.

Program Objectives

The following objectives have been identified for the Apple Health managed care program. Through these objectives and their alignment with Healthier Washington, the agency intends to realize the goals of the Triple Aim: better health, better health care services, at a lower cost. The objectives are for the benefit of all Apple Health enrollees.

- Strengthen the HCA quality infrastructure to ensure deliberative, coordinated and high quality decisions regarding quality measurement and improvement activities.
- Align measurement across managed care purchasing arrangements.
- Align value-based purchasing measures where feasible, while also reflecting the unique needs and risks of the population served.
- Increase the percentage of managed care enrollees with diabetes receiving optimal care as evidenced by measureable improvement in diabetes CPMs.
- Increase the percentage of managed care enrollees with the diagnosis of hypertension receiving optimal hypertension management as evidenced by measureable improvement in a hypertension clinical performance measure so as to prevent long-term sequelae from this condition such as heart attack or stroke.
- Ensure children receive adequate preventive care through measureable improvement in the quality and utilization of EPSDT services, including childhood immunizations.
- Continue to collect race and ethnicity data, as well as age, gender and special needs information in order to develop meaningful objectives for improving preventive and chronic care and reduce disparities in enrollee outcomes.
- Decrease disparities in health care processes or outcomes between Medicaid and commercial populations.
- Identify and reduce disparities in access and outcomes for individuals with serious behavioral health conditions.
- Improve care coordination for individuals with complex behavioral and physical health needs through continued support and implementation of the Health Home and MCO/PIHP-based care management services.

- Improve transitions of care between health care entities and across settings and systems of health care services to promote optimal health of the Apple Health enrollee. Collect and monitor CPMs that assess coordination of care and the impact of care transitions.
- Reduce high opioid prescribing patterns by measuring and monitoring opioid utilization and implementing prescribing guidelines for the management of acute and chronic pain.
- Improve maternal and child outcomes by decreasing unnecessary C-sections and inductions. Monitor obstetric outcomes with special attention to primary C-section, vaginal birth after C-section (VBAC) and nulliparous, term singleton vertex (NTSV) C-section rates.
- Increase the use of shared decision-making into clinical practice, including the use of patient decision aids to help enrollees make informed decisions regarding their health care.
- Maximize opportunities for Apple Health enrollees to receive effective and successful treatment for substance used disorders including expanding the utilization of medication assisted treatment.

These objectives are intended to ensure individuals receive evidence-based health care services, preventive care and optimal management of chronic conditions. The objectives include actions to improve health care delivery systems, such as the deployment of shared decision-making tools and use of patient decision aids in clinic settings. Through Health Home, care coordination is designed to ensure the enrollee is central in the development of a patient-centered health improvement plan and which supports transitions of care, optimizing health while reducing unnecessary care such as re-hospitalizations.

Prepaid Inpatient Health Plan Goals and Objectives

Department of Social and Health Services

With the 2013 passage of Second Substitute Senate Bill 5732 and Engrossed House Bill 1519, the Washington Legislature directed the Department of Social and Health Services and the Health Care Authority to develop a comprehensive strategy to improve the adult behavioral healthcare system. Legislative goals were to better integrate physical and behavioral healthcare; improve long term supports and services; and improve outcomes for Medicaid-enrolled clients. This effort identified goals shared across DSHS and HCA to improve access, quality, appropriateness, and outcomes of services.

In 2017, HCA contracted with MCOs and DBHR contracted with BHOs and included the following SCO performance measures identified in the Washington legislation: SB 5732 and HB 1519:

- Prevent readmission for psychiatric hospitalizations within 30 days of discharge (30-day Psychiatric Readmission Rate measure)

- Increase the number of individuals with substance use disorders who initiate and engage in substance use disorder treatment (Substance Use Disorder Treatment Initiation and Engagement-*Washington Circle* adaptation, performance measures)

In addition to these performance measures, DBHR is intensely monitoring key performance indicators in order to ensure the timeliness and quality of the behavioral health services being delivered under the new BHOs. Substance use disorder treatment is of particular importance as neither the BHOs, nor their predecessor, the Regional Support Networks, have administered substance use disorder treatment. The following metrics are included on the BHO Operations Dashboard, and will be reviewed by the BHO Contract Monitors and DBHR leadership.

Access to Services

- SUD: Unduplicated Persons Served
- Clients receiving residential Substance Use Disorder treatment services
- Alcohol/Drug Treatment Penetration

Timeliness and Service Quality

- SUD: Number of Admissions to Treatment
- SUD: Average Days from First Contact to Treatment Admission
- SUD: Median Days from First Contact to Treatment Admission
- Outpatient Substance Use Disorder treatment retention: Adults
- Outpatient Substance Use Disorder treatment retention: Youth
- SUD: Treatment Initiation
- SUD: Treatment Engagement

Operations

- Ratio of Denials to Assessments
- Number of Administrative Hearings
- Number of Grievances
- Corrective Action Plan Status

Development and Review of the Quality Strategy

The Quality Strategy establishes the methods for ensuring MCOs/PIHPs/PCCMs meet contractual and regulatory obligations and objectives for the improvement of health care quality and timeliness and access to health care services. The Quality Strategy is guided by the missions of both HCA and DSHS.

The HCA's mission is to provide high quality health care through innovative health policies and purchasing strategies. The HCA works with partners to help ensure Washington citizens have

access to better health and better care at lower cost. DBHR's mission is to transform lives by supporting sustainable recovery, independence and wellness.

Quality staff in MPOI and DBHR are responsible for developing a draft Quality Strategy. The Quality Strategy is then reviewed and approved by the respective: HCA-MPOI Division Director, BHA-Division Director, HCA-Chief Medical Officer and HCA-Director and DSHS-Secretary. After approval, the Quality Strategy is submitted to sponsors, HCA and BHA's Executive Committees (EC), and the national Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid. Sponsors review the draft and initial approval is obtained from HCA and DSHS' ECs.

Beneficiaries and other stakeholders are notified that the strategy is available for public comment on the HCA and DSHS-BHA websites. Both the Medical Care Advisory Committee (Washington's Title XIX Committee) and Tribal representatives are notified in advance of the state's intent to modify the strategy. Both groups receive a copy of the draft strategy for comment. Recommendations received through public comment or the above committees are taken into consideration and used in revisions to the strategy.

After a 15-day public comment period, the MPOI and the DBHR make any needed changes, sponsors approve the strategy, and it is submitted for final CMS approval. Once approved by CMS, the state's Quality Strategy is made available on both the HCA and DSHS websites.

The timeframe for updating the strategy is every three years. The strategy is also updated when there is a material change or when there is a significant change in a managed care product; for example, a governor mandate or legislative change that would trigger public comment, or a change in the quality strategy accountability or critical process. Significant changes to the strategy require CMS approval and adoption by ECs.

The DSHS Behavioral Health Administration has been engaged in a process to develop an administration-wide Quality Management System and it is anticipated that DBHR will utilize this Strategy on an interim basis until staff are merged within DOH and HCA. The process for developing the new Quality Management System will include DBHR and other divisions within BHA as well as system partners, in addition to others. As this System is created, DBHR will update and align the strategy, as needed.

HCA and DSHS-DBHR both have long-term strategic plans. Goals, objectives, strategies and measures are defined in the strategic plans which are reviewed and updated on a biennial basis. As part of the development of the BHA Quality Management System, DBHR will update its Strategic Plan.

Monitoring and Compliance

MPOI and DBHR quality staff are responsible for monitoring the overall effectiveness of the Quality Strategy and produces an annual evaluation. The evaluation includes information about:

- Progress and status of performance goals and objectives;
- Trends in clinical and service quality performance measures;
- Trends in performance improvement projects;
- Corrective actions and sanctions;
- Progress and status of the impact of performance based contracting; and
- Overall structure and process of the Quality Strategy.

Monitoring activities are ongoing, others are annual as described below. Findings are communicated within the quality infrastructure and via written reports.

Ongoing Monitoring

HCA-MPOI and DSHS-DBHR monitor compliance directly or by contract through ongoing desk reviews of policies and procedures, including grievances, fraud and abuse, credentialing, and claims payment and encounter reporting. Staff assess enrollee materials for content and reading level, communication of enrollee rights and responsibilities, and compliance with privacy and confidentiality policies. MPOI and DBHR use standardized guidelines and checklists to ensure consistency in the monitoring review process.

MCOs, PIHPs and PCCMs are required to correct deficiencies and MPOI and DBHR track corrective actions to ensure compliance.

Annual Review

MPOI and DBHR conduct contract monitoring compliance through two separate mechanisms. The DBHR contracts with an External Quality Review Organization (EQRO) to conduct annual monitoring activities, while MPOI uses agency staff. An EQRO is an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354.

MPOI's contract monitoring is based upon the 42 C.F.R. § 438.358(b)(3), Activities Related to External Quality Review. The monitoring review process uses standards, methods, and data collection tools from the DHHS monitoring protocols (42 C.F.R. § 438.352). Additional standards and monitoring guidelines such as those promulgated by the National Committee for Quality Assurance (NCQA) and HCA and BHA-defined standards and guidelines used to assess Contractor compliance with regulatory requirements and standards for the quality outcomes and timeliness of, and access to, services provided by MCO and PIHP contractors. When necessary, HCA and DBHR impose corrective actions and appropriate sanctions for standards not in compliance.

MPOI–Annual review performed by TEAMonitor

For MPOI, the annual contract monitoring process is overseen by *TEAMonitor*, a multidisciplinary team of staff responsible for formally monitoring MCOs. TEAMonitor is responsible for:

- Development of an annual, on-site contract monitoring schedule;
- Collection of MCO material (for the desk audit portion of a monitoring review);
- Development and maintenance of a secure website for document collection;
- Development of standardized MCO interview questions and observation protocols;
- Methods of evaluation, including development of standardized monitoring tools, guidelines, checklists, and scoring tools; and
- Assignment of expert reviewers to assess MCO's compliance with standards.

Following completion of a monitoring review, a contract monitoring compliance report is sent to each MCO. Final reports are available to the public. Corrective actions are tracked by contract managers and the monitoring team. The MPOI Medicaid Compliance Review and Analytics section use the results from the monitoring review to inform analytical activities and future contract: monitoring, construction and procurement.

Standards reviewed on-site may vary from year-to-year based on analysis of individual MCOs (which may generate a targeted review), new contract requirements, statewide issues, or a particular focus area. For example, MPOI staff reviewed Patient Review and Coordination case files to ensure MCOs were implementing contractual requirements correctly.

Contract managers annually review MCO provider subcontract templates and delegation agreements. This ensures all elements required in the MCO contract affected by the delegation are included in subcontracts and agreements.

Some of Washington's Tribal health care clinics are designated as Primary Care Case Management (PCCM) entities. The clinics are subject to federal regulatory requirements that apply to PCCMs. Not all federal regulations referenced in the Quality Strategy are relevant to PCCM-designated Tribal clinics. To monitor Tribal clinics, MPOI staff request material for PCCM contracts. MPOI monitors PCCMs for grievances, utilization, and enrollment/disenrollment.

DBHR–Annual review performed by EQRO

For DBHR PIHP contracts, the EQRO conducts annual monitoring of Performance Measures, Performance Improvement Projects and a subset of the Quality Assessment and Performance Improvement standards for managed care. Encounter Data Validation and an Information System Capability Assessment are conducted every year.

Additional areas are reviewed according to a three year cycle and per CMS protocols. At the beginning of each EQR contract cycle, DBHR quality staff meets with the EQR staff to define the focus of the review. DBHR staff provides guidance and direction to EQR staff on PIHP history and contract expectations and collaborates with EQR staff in reviewing and rating the PIPs and

providing feedback to the PIHPs. Further, DBHR purchases technical assistance from the EQRO to support improvement in areas identified through the review process as requiring additional interventions.

Table 2: Projected External Quality Review (EQR) Pre-Paid Inpatient Health Plan (PIHP) Review, by Year

Projected EQR PIHP Review by Year			
Activity	**2017**	**2018**	**2019***
Information System Capability Assessment (ISCA)	• Full ISCA • ISCA with DBHR	• Follow up ISCA	• *Follow up ISCA as it pertains to transition year to FIMC* • *Full ISCA for State*
Encounter Data Validation (EDV) Special Focused Studies	• Mental Health and SUD EDV • SUD Golden Thread • Care Coordination MH and SUD	• Mental Health and SUD EDV • Special focused studies TBD	• *As appropriate for transition year to FIMC*
Enrollee Rights & Protections	• Follow up CAPs from previous year	• Full Enrollee Rights & Protections	• *Follow up as appropriate for transition year to FIMC*
Special Focused Studies	• Children (WISe[10]) • BHO Integration	• Children (WISe)	• *As appropriate for transition year to FIMC*
Grievances and Appeals	• Follow up CAPs from previous year	• Real-time Mental Health and SUD • Children (WISe)	• *As appropriate for transition year to FIMC*
Performance Improvement Projects (PIPs)	• SUD • Children • Clinical or Nonclinical	• Same as 2017	• *As appropriate for transition year to FIMC*
Quality Assessment and Performance Improvement (QAPI)	• Full QAPI	• Follow up QAPI	• *Full QAPI as it pertains to transition year to FIMC*
Certification and Program Integrity (CPI)	• Follow up CAPs from previous year	• Full CPI	• *Follow up as appropriate to transition year to FIMC*

*Note: 2019 is a transition year to Fully Integrated Managed Care (FIMC). EQR will be tailored to meet the needs of this transformation.

[10] The Wraparound with Intensive Services (WISe) program model is designed to provide comprehensive services and supports, providing intensive mental health services in home and community settings to Medicaid eligible children and youth.

Annual Reports

The following reports are generated as part of MPOI's and DBHR's overall evaluation of MCOs/PIHPs:

- Behavioral Health Organization report-The EQRO prepares annual reports which are provided to the DBHR PIHP contract monitors for follow up on any suggestions for improvement or findings requiring corrective action plans. This information is reviewed by the DBHR Quality Improvement Committee to identify any system-wide issues that need to be addressed universally instead of with the individual BHOs.
- Contract Monitoring Compliance report – The report contains a score summary; both the specific criteria needed to comply with Federal regulations and state MCO and PIHP contracting requirements; documents reviewed; year-specific findings; recommendations; and a corrective action plan (CAP) for areas that have deficiencies identified.
- Corrective Action Plans (CAPs)-Required from the MCOs and PIHPs when deficiencies are identified. CAPs are due from MCO's and PIHPs thirty (30) days after the receipt of the contract monitoring compliance report.
- CAP responses-CAPs are reviewed by contract or program managers and quality monitoring staff and either accepted or not accepted. The response includes whether a CAP is accepted or not accepted and what the MCO and PIHP needs to do to come into compliance, if not accepted. All corrective actions are reviewed in the next annual contract monitoring visit for follow-up.

Findings and recommendations from the MCO/PIHP annual reports are found in the EQR Annual Technical Report (42 C.F.R. § 438.258). Recommendations for improving quality of services furnished, along with appropriate comparative information about all MCOs and PIHPs, are documented in the technical report. MPOI/DBHR use recommendations contained in the Quality Strategy to inform contract construction, quality improvement, and performance measure requirements. The technical report also contains an assessment of each MCO's and PIHP's action to address problems and effect changes previously identified by the state or as recommended by the EQRO.

External Quality Review

In addition to the MPOI and DBHR evaluation of the Quality Strategy and monitoring reviews, MPOI and DBHR contract with an External Quality Review Organization (EQRO) to review and evaluate the Quality Strategy in order to provide an outside perspective on its effectiveness and comparability to best practice Quality Strategies in other states.

Federal managed care regulations require each Medicaid agency or its agent that is not an MCO or PIHP to perform annual, external quality review of MCO/PIHP required Performance Improvement Projects (PIP) and Clinical Performance Measures (CPMs) and conduct a review of compliance with standards within a three-year period. MPOI and DBHR staff and contracted EQR staff validate the

MCO/PIHP conducted PIPs. MPOI and DBHR contract with a qualified EQRO to conduct annual, external validation of state-required CPMs (42 C.F.R. § 438.358). PCCMs are not subject to EQRO review.

HCA and DBHR may use information obtained from a Medicare or private accreditation review of an MCO to avoid duplication if all of the conditions in 42 C.F.R. § 438.360 are met. HCA and DBHR may also exempt an MCO or PIHP from EQR if the following conditions are met:

- The MCO or PIHP has a current Medicare contract under part C of title XVIII or under section 1876 of the Social Security Act (the Act), and a current Medicaid contract under section 1903(m) of the Act.
- The two contracts cover all or part of the same geographic area within the state.
- The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO or PIHP has been subject to EQR under this part, and found to be performing acceptably with respect to the quality, timeliness and access to health care services it provides to Medicaid recipients (42 C.F.R. § 438.362).

MPOI and DBHR is responsible for ensuring the EQRO has sufficient information to perform an annual EQR for each MCO and PIHP (42 C.F.R. § 438.350). To that end, the managed care contracts requires MCOs and PIHPs to allow a qualified EQRO, contracted by HCA and DBHR, to perform an annual, external independent review as described in 42 C.F.R. § 438.358.

MPOI and DBHR's contract with the EQRO, as outlined by federal regulations, includes the analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that an MCO, PIHP, or its contractors furnish to Medicaid recipients. The information is used by the EQRO to assess MCO and PIHP compliance with Balanced Budget Act requirements.

MPOI and DBHR provides copies of EQR information, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees, recipient advocacy groups and members of the general public. Reports produced by the EQR are placed on the HCA and DBHR websites.

The EQRO prepares annual reports which are provided to the DBHR PIHP contract monitors to follow-up on any suggestions for improvement or findings requiring corrective action plans. This information is also reviewed by the DBHR Quality Improvement Committee to identify any system-wide issues that need to be addressed globally at the statewide-level instead of with individual PIHPs.

State Standards

The Quality Strategy is organized to reflect the standards outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. Subpart D is divided into three sections: Access, Structure/Operations, and Measurement/Improvement Standards. The sections provides an explanation of each standard, MCO, PIHP, PCCM and state duties, oversight activities, and any additional review and evaluation reports, other than those generated by TEAMonitor or the EQRO.

Access to Care Standards

438.206 Availability of services, including emergency and post-stabilization services

MCO and PIHP Duties

In a managed care delivery system, the MCOs and PIHPs (through their state contracts), agree to provide all services to enrollees, whereas PCCMs provide a medical home. Medical and behavioral health advice is available 24-hours a day, seven days a week from licensed health care professionals for MCO and PIHP enrollees.

Through contract, MCOs and PIHPs agree to provide care sufficient to meet the needs of enrollees. This includes physician services, inpatient and outpatient hospital services, behavioral health services, therapies, pharmacy, and home care services. MCO enrollees are encouraged to choose a primary care provider (PCP) to manage the care client's receive. If the enrollee does not select a PCP the MCO assigns a PCP or clinic within reasonable proximity to the enrollees' home, no later than fifteen (15) working days after coverage begins. To ensure each MCO enrollee has an ongoing source of primary care, the PCP is responsible for provision, supervision, and coordination of health care to meet enrollee needs.

MCOs are required to maintain and monitor an appropriate provider network (42 C.F.R. § 438.206(b)(i)). To fulfill this expectation, MCOs quarterly provide documentation of their provider network including six critical provider types and all contracted specialty providers. The report includes information regarding the Contractor's maintenance, monitoring, and analysis of the network. State staff review provider network information for completeness and accuracy. HCA provides technical assistance, removes providers no longer contracted with the MCOs and examines the effect that changes in the provider network have on the network's compliance with the requirements.

MCO contractors are required to conduct quarterly quality assurance reviews on 25 percent of the combined network of primary care, pediatric primary care, and obstetrical providers. MCOs verify contact information, open/closed panel status, including whether the provider is currently accepting Apple Health clients, and any current or anticipated limitation on the number of Apple Health patients the provider sees.

MCOs may contract with family planning providers. Enrollees may receive family planning services outside the MCO network. Enrollees have the right to self-refer to participating and non-participating family planning clinics paid through separate arrangements within the state (42 C.F.R. § 438.206(b)(2)(7)).

Each MCO and PIHP must participate in the state's efforts to promote delivery of services in a culturally competent manner to all enrollees. This includes those with limited English proficiency; diverse cultural and ethnic backgrounds; disabilities; and regardless of gender, sexual orientation or gender identity. They must ensure that network providers give physical access, reasonable accommodations and accessible equipment for Apple Health enrollees with physical or mental disabilities (42 C.F.R. § 438.206(c)(2)(3)).

For PIHPs, a request for behavioral health services may be made through a telephone call, walk-in or written request from an enrollee or those defined as family. PIHPs must maintain documentation, including the reason for all service requests even if no service occurs.

For PIHP services, enrollees are provided a choice of participating Mental Health Care Providers (MHCP) and/or Chemical Dependency Professional/Chemical Dependency Professional Trainee (CDP/CDPT) according to WAC 388-865-0345. If the enrollee does not make a choice, the contractor assigns a MHCP/CDP/CDPT provider no later than 14 working days following the request for behavioral health services. The contractor must also inform the enrollee that he or she may change MHCPs/CDP/CDPT providers upon request. The assigned provider is responsible for creating an individualized service plan for behavioral health rehabilitation services.

An enrollee may access urgent and emergent medically necessary behavioral health services (e.g., crisis behavioral health services, stabilization behavioral health services) without full completion of an intake evaluation or other screening and assessment processes. The PIHP must document the reason for any delays. This includes documentation when the enrollee declines an intake appointment within the first 14 calendar days following a request for services or declines a routine appointment offered within a 28 day timeframe. The contractor must monitor the frequency of routine appointments that occur after 28 days for patterns and apply corrective action where needed.

All State Plan[11] services not covered by the MCO contract or for PCCM enrollees can be accessed through Medicaid FFS. American Indian/Alaska Native (AI/AN) enrollees may request Tribal clinic

[11] A State Plan is an agreement between the state and the Federal government describing how the state administers its Medicaid and CHIP programs. It provides assurance that the state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan identifies groups of covered individuals, services provided, and methods for provider reimbursement and administrative activities provided by the state. Changes in the state plan require amendments submitted to the Federal government for approval.

services either within or outside a PCCM-designated Tribal clinic if one is near them or they may choose a PCP through an MCO.

MCOs are required to identify individuals with special health care needs within 90 days of enrollment and then quarterly report on them. To identify individuals, the MCO reviews administrative data, such as including PRISM data and risk scores, diagnoses of chronic conditions, evidence of high risk pregnancy, client classifications such as foster care, SSI or Title V designation, social complexity characteristics (evidence of a history of homelessness, language barriers, substance use disorder, chronic behavioral health conditions, domestic violence or arrests) or through enrollee responses to Contractor Initial Health Screen or other interviews or surveys.

Medicaid Benefits (MCO, PIHP, AND PCCM)

The MCO, PIHP and PCCM contracts require:

- Transitional health care services by a primary care provider for clinical assessment and care planning within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program (42 C.F.R. § 438.62(b)(1))–MCO, PIHP;
- Transitional healthcare services by a home care nurse or home care registered counselor within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan (42 C.F.R. § 438.62(b)(1))–MCO, PIHP;
- Preventive care (i.e., non-symptomatic) within 30 days of the request–MCO;
- Routine primary care (i.e., non-urgent, symptomatic) within 10 days of the request-MCO;
- Routine services appointment from request to visit within 28 calendar days of the request–PIHP;
- Routine intake evaluation or assessment appointment within 10 business days of the request —unless an intake evaluation or assessment has been provided in the previous 12 months that established medical necessity and the provider agrees to use the previous intake evaluation or assessment as the basis for the authorization decision-PIHP;
- Urgent care available within 48 hours-MCO; PIHP-within 24 hours;
- Emergency care (including post-stabilization services), available that day–MCO;
- Emergency care within 2 hours of a request for behavioral health services from any source-PIHP;
- Authorization of services–PIHP, MCO;
- Emergency drug supply–MCO;
- Medically necessary behavioral health services (emergent behavioral health care)-PIHP;
- After-hour services (24 hours a day, seven days a week when medically necessary)-MCO, PIHP;
- Direct access to a woman's health specialist for women's routine and preventative services (42 C.F.R. § 438.206 (b)(2))–MCO;

- Second opinion from a qualified health care professional within the network or arrange for one outside the network at no cost to the enrollee (42 C.F.R. § 438.206(b)(3))–PIHP, MCO;
- Medically necessary services[12] obtained outside the network if, and for as long as, they cannot be obtained within the network (42 C.F.R. § 438.206 (b)(4)), and payment coordination with out-of-network providers to ensure cost to the enrollee is no more than it would be if the services were provided within the network (42 C.F.R. § 438.206(b)(5))–MCO, PIHP;
- Network provider hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid FFS, if the provider serves only Medicaid enrollees (42 C.F.R. § 438.206(c)(1))–MCO, PIHP;
- Delivery of culturally competent services to enrollees with limited English proficiency and diverse cultural and ethnic backgrounds (42 C.F.R. § 438.206(c)(2))–MCO, PIHP; and
- Interpreter services available free of charge to enrollees–MCO, PIHP, and PCCM.

The MCO contract specifies the amount, duration and scope of services offered. Appendix A, describes the services covered under the managed care contracts. The PIHP and MCO may establish utilization controls provided that medically necessary services are not denied. Medical necessity is defined in contract and in the Washington State Administrative Code (WAC). Service authorizations require physician approval for medical necessity denials.

Any services or benefits provided under the State Plan that are not covered under the contracts must be identified in the MCO's certificate of coverage (COC). The MCO must provide information to enrollees on how to access State Plan services not covered by the MCO contract. Under its contract with the state, the MCO may provide the same or equivalent services, or at its own expense, may exceed the state limits provided through the FFS delivery system. The MCO may also provide alternative services. All PCCM services are covered under the Medicaid FFS program.

Oversight Activities

In addition to the DBHR EQRO review process and MPOI TEAMonitor review process, MPOI and DBHR may receive enrollee complaints/grievances regarding requests to pay for medically necessary services either in or out-of-network. These complaints are brought to the attention of the

[12] The definition of medically necessary services in the managed care contracts are: services which are reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee requesting the service. Course of treatment may include mere observation or, where appropriate, no treatment. For BHO enrollees, the individual must be determined to have a behavioral illness covered by Washington State for public behavioral health services. The individual's impairment(s) and corresponding need(s) must be the result of a behavioral illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a behavioral illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

DBHR-MPOI contract managers or program managers for investigation and correction. These cases receive follow-up until resolution.

MPOI and DBHR monitor patterns of complaints (received orally, telephonically or in writing) to determine if there are specific concerns regarding access to services, access to women's health care providers, second opinions, or complaints about cost for services in or out-of-network. Issues, including trends are referred to the MCO, PIHP or PCCM for correction to resolution. Both DBHR and MPOI monitor critical incidents, follow-up with MCO/BHO to identify the root cause of the incidences and any preventive measures that could have been taken, trends, and system-wide approaches to addressing them.

Reports and Evaluation

Periodically, the EQRO assesses each PIHP/MCO's compliance with this standard and summarizes their findings in a report to MPOI and DBHR. The EQRO also makes recommendations for improving the quality of health care services.

438.207 Assurance of adequate capacity and services

MCO and PIHP Duties

Through contracts with the state, the MCOs or PIHPs, confirms they have the capacity to provide all health care services to publicly-funded enrollees and that those services are sufficient to meet the health care needs of enrollees and that there is sufficient capacity to meet community standards.

MCOs and PIHPs must submit provider network information when they first contract with the state, annually, and whenever there a significant change 42 C.F.R. § 438.206 above or 42 C.F.R. § 438.207(c). Reportable changes include updated payment methods or provider network or service area. For example, the 2015 procurement of the FIMC program resulted in a re-examination of the contractor network.

To ensure adequate primary care capacity, MCOs may contract with a wide variety of qualified practitioners, including pediatricians, family practitioners, general practitioners, internists, advanced registered nurse practitioners, and physician assistants (under the supervision of a physician). MCOs contract with specialty providers to meet the needs of the population. Specialty providers include the services of obstetricians/gynecologists, midwives, orthopedists, etc.

PIHPs are required to maintain sufficient capacity, including the number, mix and geographic distribution of Behavioral Health Agencies, Mental Health Care Providers (MHCPs) and Chemical Dependency Professionals (CDPs/CDPTs) needed to meet the needs of the anticipated number of enrollees in the service area. Specialty providers may include services provided by child behavioral health specialists, developmental disability specialists, and geriatric behavioral health specialists.

MCOs and PIHPs are required to have an appropriate range of preventive, primary care, and specialty services for the populations they serve. They are required to maintain and monitor their

network of appropriate providers (42 C.F.R. § 438.206(a))-Availability of services and 42 C.F.R. §§ 438.68, 438.206(c)(1). They must consider:

- Anticipated enrollment-MCO, PIHP;
- Expected utilization of services based on enrollee characteristics (cultural, ethnic, racial, linguistic and health care needs)–MCO, PIHP;
- Numbers and types of network providers required to furnish contract services–MCO, PIHP;
- Number of network providers who are not accepting new patients–MCO,PIHP; and
- Geographic location of providers and enrollees (distance, travel time, means of transportation, enrollees normally use, and physical access for enrollees with disabilities)–MCO, PIHP.

HCA and DBHR require MCOs and PIHPs to pay out-of-network providers for required services that the MCO or PIHP is not able to provide within its own provider network. Out of network services must be provided at no additional cost to the enrollee.

In addition, if HCA or DSHS terminates a subcontractor from participation in any HCA/DSHS program, the subcontractor is excluded from participation in state-contracted managed care programs. The MCO or PIHP must terminate subcontracts of excluded providers immediately when the MCO or PIHP becomes aware of such exclusion or when the MCO/PIHP receives notice from HCA/DSHS, whichever is earlier (WAC 388-502-0030).

Upon notification of a Termination of a Core Provider HCA:

- Sends an e-mail notice to all MCOs with a courtesy copy to the HCA Division Director, HCA program staff, and the Medical Assistance Customer Service Center (MACSC) supervisor; and
- Tracks and retains all required MCO responses.

BHOs must comply with contractual terms to address the changes in the provider network, including terminating or adding a subcontractor and closing a subcontractor site.

For MCOs, all provider terminations must be reported, including the number of individuals who are affected by such terminations. There are provisions in contract that cover continuity of care in the event of a provider termination. In the case of a "significant change" (material modification) the MCO must notify the state as soon as the change. Affected enrollees must be notified by the MCO in writing and given the opportunity to change PCPs from among the remaining choices or to disenroll and change to another MCO.

For continuity of care, PIHPs encourage their subcontractors to assign enrollees to clinicians who are anticipated to provide services to the enrollee throughout the authorization period.

The managed care contract with MCOs requires that the MCO maintain an adequate number of hospitals, nursing facilities, health care professionals, and allied and paramedical personnel

distributed across sufficient service sites for all covered services. The MCO and PIHP provider networks must meet MPOI/DBHR requirements for distance or travel time, adequate resources, timely access, and reasonable appointment times. The contract with PIHPs also requires the PIHPs to maintain an adequate number of behavioral health care providers for the provision of all covered services.

Oversight Activities

In addition to the DBHR EQRO review and the MPOI TEAMonitor review processes, MPOI and DBHR review the MCO's/PIHP's proposed provider network for completeness at the time of initial entry of an MCO/PIHP into a region. MCOs and PIHPs must have service area approval before MPOI/DBHR sign a contract.

The MCOs and PIHPs are required to assess network adequacy at least annually, using internal data on appointment times, grievances, location of members in relationship to providers, etc. The MCO and PIHP are expected to address any deficits identified in the analysis and to report to the state on their assessment (42 C.F.R. § 438.207(c)(2)).

Reporting and Evaluation

Every three years, the EQRO evaluates and reports on each PIHP's efforts to ensure and maintain an adequate delivery network.

MPOI submits an assurance of compliance to CMS that the MCO or PIHP meets the state's requirements for availability of services. The submission includes documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO or PIHP related to its provider network (438.207(d)). The analysis report is provided to CMS annually at the time of contract renewal.

438.208 Coordination and continuity of care

MCO, PIHP, and PCCM Duties

All contracts require care coordination. In the process of coordinating care, each enrollee's privacy must be protected according to the privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E, to the extent that they are applicable. The MCO must create procedures to ensure an enrollee has primary care and to share information, including the results of its identification and assessment of enrollees with special health care needs (42 C.F.R. 438.208(b)(1)). All enrollees with special health care needs are allowed direct access to specialists for needed care, or to use a specialist as a PCP (42 C.F.R. § 438.208(c)(4)).

The MCO or PIHP must ensure services are coordinated between settings of care. This includes appropriate discharge planning from hospital or institutional settings; with the services the enrollee receives from any other MCO or PIHP; and with the services the enrollee receives in FFS Medicaid. Care coordination also includes coordination with the services the enrollee receives from community and social support providers (42 C.F.R. § 438.208(b)(2)).

MPOI identifies two levels of care coordination services within the managed care contract. The first level of care coordination is provided to individuals with lesser needs, but still meeting the criteria described above or a second level, those meeting Health Home criteria.

Health Homes described in Section 2703 of the Affordable Care Act, allows the states to deliver a care coordination/care management function to individuals identified as having at least one chronic health care condition and at risk for a second chronic condition. Along with the chronic condition diagnostic criteria, Washington uses a Predictive Risk Intelligence System (acronym, PRISM) to identify individuals who are estimated to have 50% or higher costs in the succeeding 12 months based on the patient's disease profile and pharmacy utilization. These clients are referred by the MCO to community-based programs for comprehensive care coordination/care management.

Along with Health Home services, MCOs are required to perform care coordination for individuals with special health care needs. MCOs conduct an Initial Health Screen (HIS) and look at diagnostic criteria and risk scores to identify these individuals. All new enrollees are screened within 90 days of the effective date of enrollment. Multiple outreach contacts are made, if the MCO is not able to reach the member in the initial contact (42 C.F.R. § 438.208(c)(1)).

The Initial Health Screen must contain behavioral, developmental and physical health questions and if the screen is positive, an Initial Health Assessment is conducted to determine what ongoing services the enrollee needs. These needs may include clinical and non-clinical services and referrals to specialists and community resources (42 C.F.R. § 438.208(b)(3)). For these enrollees, MCOs are required to develop, document and maintain an individualized treatment plan (42 C.F.R. § 438.208(c)(2)).

MCOs must offer additional services to their special health care needs clients, including long term services and supports. These individuals are generally identified through the Initial Health Screen or through Health Home care coordinators.

MCOs are also required to have individualized treatment plans for their special health care needs clients. The client and any specialists providing care to the client must be involved in creating the treatment plan. The treatment plan must be developed by a person trained in person-centered care planning. (42 C.F.R. § 438.208(c)(3)(ii)).

The treatment plan must address integration and coordination of clinical and non-clinical disciplines and services. The plan must be modified as needed to address the emerging needs of the enrollee and at least every 12 months, or when the enrollees circumstances or needs change significantly (42 C.F.R. § 438.208(c)(3)(iv)). Additionally, the treatment plan may be informed by services provided by the state. For example, an MCO may use the Second Opinion Network, a network of University of Washington Psychiatrists for medication consultation. These consults are used when psychotropic medications or medication regimens for children under 18 exceed those established by the agency Pharmacy Management team.

If the MCO requires PCP approval of the treatment plan, it must be provided in a timely manner appropriate to the enrollee's health condition. The PCP is responsible for the provision, supervision, and coordination of health care to meet enrollee needs. MCOs are required to provide support services to assist PCPs in providing coordination such as support for care transitions of enrollees. The MCO must also ensure PCPs coordinate with community-based and state services, such as First Steps' Maternity Support Services and Infant Case Management, transportation services, and long-term services and supports.

MCOs are contractually required to ensure that medically necessary care for enrollees in an active course of treatment for a chronic or acute medical condition is not interrupted. MCOs must preserve provider relationships where possible and reasonable, or transition the enrollee as expeditiously as the medical condition requires. For example, new enrollees are allowed to fill prescriptions written until the first of the following occurs:

- The enrollee's prescription expires.
- A participating provider examines the enrollee to evaluate the continued need for the prescription. If the enrollee refuses an evaluation by a participating provider the Contractor may refuse to fill the prescription.

To facilitate transitions of care, the state makes its transition of care policy publicly available to enrollees and potential enrollees, including how to access continued services upon transition (42 C.F.R. § 438.62(b)(3)). MCOs are required to allow enrollees to receive care from non-participating providers with whom an enrollee has documented, established relationships. The MCO must make a good faith effort to subcontract with the non-participating provider and if a transition is necessary, shall facilitate collaboration between the non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.

PIHPs are responsible for providing care management functions, including oversight of care coordination. The PIHP's care management system must include a review of the Individual Service Plan (ISP) to ensure requirements of WAC 388-877-0620 are met. The ISP review must be completed in accordance with WAC timelines found in WAC 388-877A and WAC 388-877B and includes a review of goals which have been met, discontinued or need to be continued/or added; evidence that the enrollee is a participant in the development of the treatment plan; and input from other health, education, social service and justice agencies, as appropriate.

The ISP is reviewed to determine the need for re-authorization of services. This includes an evaluation of the effectiveness of service provided during the benefit approval period, recommendations for changes in methods or intensity of services, and an assessment as to whether the enrollee meets service discharge criteria. For continuity of care, the PIHP encourages its subcontractors to assign enrollees to clinicians who are anticipated to provide services to the enrollee throughout the authorization period. Services such as rehabilitation case management must ensure timely and appropriate treatment, including continuity of behavioral health care and care coordination.

The MCO and PIHP contracts requires the delivery of culturally competent care and care coordination. Both contracts include definitions for cultural competent care with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care or CLAS Standards required in the MCO contract. Cultural considerations, including cultural strengths and community/family support are an integral source of information in developing a care management plan and facilitating care coordination activities.

PCCM providers refer enrollees to other providers when appropriate and help with management and coordination of the enrollee's health care.

Oversight Activities

As part of the TEAMonitor review process, a sample of MCO care coordination case files are selected for review. Care coordination case files are evaluated against a standardized checklist. The checklist content results from federal requirements, NCQA Standards, and contract language and includes indicators for identification of enrollees with special needs, assessment, treatment plan, and direct access to specialists.

In addition to the EQR PIHP reviews, which periodically focus on the quality of the treatment planning process and coordination of care with the primary care provider and other agencies, PIHPs also conduct annual audits of their subcontractor's clinical records. These audits are conducted on a monthly or quarterly basis and include assessment of coordination of care with the enrollee's primary care provider and with ancillary agencies such as Corrections/Justice, Guardian/Advocate, Hospital, Housing, School/Education, Social Services or Vocational Rehabilitation.

438.210 Coverage and authorization of services

MCOs/PIHPs are required to have written policies and procedures in place according to 42 C.F.R. § 438.210, state rules, and the contract, and must have mechanisms in effect to ensure consistent application of review/assessment criteria for authorization decisions. Subcontractors with delegated authority for authorization of services must comply with the MCO's/PIHP's policies and procedures regarding authorization of services and are monitored annually by the MCOs/PIHPs to ensure compliance with regulation and policy.

PIHP Duties

PIHPs use state defined *Access to Care Standards* as the eligibility criteria for authorization of routine mental health services. The PIHPs utilize the American Society of Addiction Medicine criteria for authorization and placement into appropriate substance use disorder treatment. PIHPs are responsible to maintain level of care guidelines. The PIHP level of care guidelines must include criteria to determine:

- The level of services to be provided based on the presenting care needs of the enrollee;
- Authorization of inpatient care at a community hospital and extensions to community hospital episodes of care; and

- When an enrollee is ready for discharge from outpatient community behavioral health services.

The PIHP is responsible to ensure benefits are provided according to the PIHP level of care guidelines and are not arbitrarily denied or reduced (e.g., the amount, duration, or scope of a required service) based solely upon the diagnosis, type of behavioral illness or the enrollee's behavioral health condition. The PIHP is responsible for providing a written notice of adverse benefit determination, when there is a denial, reduction, termination or suspension based on the PIHP guidelines. The PIHP level of care guidelines are provided to DBHR upon request and may be changed if determined necessary by the DBHR.

When other DSHS service systems are involved or need to be involved, a child-family team is convened to ensure coordination of cross system treatment needs.

The PIHP is required to have Care Managers available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve hours of the initial request. Only a psychiatrist or doctoral level clinical psychologist may deny a request for psychiatric inpatient care. If the authorization is denied, a notice of adverse benefit determination is provided to the enrollee or their legal representative.

MCO Duties

The MCO contract specifies the amount, duration, and scope of services offered. MCOs generally use nationally promulgated utilization management guidelines or decision-making criteria for managing service authorization and appeal requests. All MCOs may establish utilization controls, including utilization review criteria for authorization decisions provided that medically necessary services are not denied.

For the purposes of utilization control, the services supporting individuals with ongoing or chronic conditions or who require long-term care services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning (42 C.F.R. §§ 42 438.210(4), 441.20)).

MCOs are required to use the evidence-based, Health Technology Assessment program decisions endorsed by HCA for the Apple Health population and, upon HCA's request provide documentation demonstrating compliance with these decisions. The HTA program uses scientific evidence to determine if health services are safe and effective. For more information: https://www.hca.wa.gov/about-hca/health-technology-assessment.

Appendix A describes the services covered under managed care. These services must be provided in the same amount, duration, and scope as those furnished to beneficiaries under FFS Medicaid and for enrollees under the age of 21 (subpart B, Part 441);(42 C.F.R. § 440.230).

Medical necessity is defined in contract and in WAC and the MCO contracts contain that definition. The current definition is comprehensive, covering prevention, diagnosis, treatment, and maintenance of functional capacity.

Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical or behavioral health condition or disease, and must not be denied solely because of diagnosis, type of illness, or condition (42 C.F.R. § 438.210(b)(3)). Service authorization requests may be made by an enrollee for the provision of any service (42 C.F.R. § 431.201).

The MCO must notify the enrollee in writing and the enrollee's provider of the outcome of a service review. If the notice is not in the enrollee's favor, a notice of adverse benefit determination must be provided the member, requesting provider. The notice must meet the requirements of 42 C.F.R. § 438.404. This notification includes information about how to file an appeal and how to file an administrative hearing with HCA or DSHS if the appeal process does not result in a decision favorable to the enrollee.

For standard authorizations, determinations are to be made within five (5) business days of the receipt of necessary information, but may not exceed fourteen (14) calendar days following receipt of the request for services. For standard authorization decisions, notification of the decision shall be made to the attending physician, ordering provider, facility and enrollee within the timeframe allowed for standard authorizations, but not exceeding 28 calendar days from the request for authorization of the service.

Beyond the fourteen (14) calendar-day period, a possible extension of up to fourteen (14) additional calendar days (equal to a total of twenty-eight (28) calendar days) is allowed under the following circumstances:

- The enrollee, or the provider, requests extension; or
- The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest. If the Contractor extends that timeframe, it must give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

For cases in which the enrollee's medical provider indicates, or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, the MCO must provide a process for expedited authorization or denial of services, and provide notice as expeditiously as the enrollee's health condition requires, and no later than three (3) calendar days after receipt of the request for service. The MCO may extend the time period by up to fourteen (14) calendar days if the enrollee requests the extension; or the MCO justifies and comments on a need for additional information and how the extension is in the enrollee's interest.

Notice for outpatient drug authorization decisions are described in section 1927(d)(5)(A) of the Act. All authorization for prescriptions or over the counter drugs must be made no later than the following business day after receipt of the request for services, unless additional information is required. If the provider does not respond to the MCOs request for additional information within 3 business days of the request the MCO must made a decision based on the information on hand.

Oversight Activities

PIHP

The EQRO conducts an on-site review of the grievance and appeal system every other year which includes an assessment of the PIHP's grievance system to assure compliance with 42 C.F.R. § 438.400. As part of the review, the EQRO examines the PIHP's process for notification of an adverse benefit determination including the language and format requirements, and the content and timing requirements for notice of adverse benefit determinations, authorization decisions, expedited authorization decisions and resolution of appeals.

The EQRO also reviews to ensure the PIHP does not delegate to providers or subcontractors the adjudication of final appeals and that the PIHP has a process to monitor performance of the grievance system as well as a corrective action plan to respond to any findings. In addition to the EQR, PIHPs submit on a quarterly basis reports that provide aggregate data of grievances, notices of adverse benefit determinations, and appeals. DBHR's Grievance Committee utilizes these reports to review and track trends.

MCO

MCOs submit records on a quarterly basis of each notice of adverse benefit determination (through the grievance, adverse benefit determination, and appeal [GAA] process) as part of its GAA reports. The state reviews Notices of Adverse Benefit determinations and tracks trends in denial, termination and reduction of services.

TEAMonitor conducts an on-site MCO review, examining MCO coverage and authorization policies and procedures, protocols and a sample of adverse benefit determinations, grievances, and appeals annually. The sample case files are reviewed using a checklist developed by state staff and comprised of standards described in federal and state regulations and contracts.

Structure and Operational Standards

438.214 Provider selection, credentialing and recredentialing

Each MCO/PIHP must have a provider network and implement written policies and procedures for the selection and retention of providers. Policies and procedures follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO/PIHP (42 C.F.R. §438.214(b)).

The MCO/PIHP must not discriminate against providers who serve high risk populations or specialize in conditions that require costly treatment (42 C.F.R. §438.214(c). The MCO/PIHP may

not employ or contract with providers excluded from the participation in Federal health care programs under either section 1128 or section 1128A of the Act (42 C.F.R. 438.214(d). This process is described in 42 C.F.R. § 438.207, Assurance of adequate capacity and services.

PIHP Duties

Each PIHP must have written policies that require monitoring of provider credentials. PIHPs can only contract with BHAs that are licensed and/or certified by DSHS. Behavioral Health Clubhouses do not have to be licensed, but must meet credentialing requirements put in place by the state.

PIHPs and their subcontractors are required to conduct a criminal history background check through the Washington State Patrol for employees and volunteers of the Contractor who may have unsupervised access to: children, people with developmental disabilities or vulnerable adults.

MCO Duties

HCA requires that all MCOs have a credentialing and recredentialing system that aligns with NCQA standards and measures. This system includes the elements described below.

Credentialing policies–the organization must have a rigorous process to select and evaluate practitioners. Credentialing procedures include a process for:

- Making credentialing and recredentialing decisions;
- Managing credentialing files that meet the MCO's established criteria;
- Delegating credentialing and recredentialing;
- Ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner;
- Notifying practitioners if information obtained during the MCO's credentialing process varies substantially from the information they provided to the MCO;
- Ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision;
- Ensuring the MCO Medical Director or other designated physician's direct responsibility and participation in the credentialing program;
- Ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law;
- Identifying the type of practitioners that are to be credentialed and recredentialed; and
- Ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty designation.

The MCO must have evidence of a Credentialing Committee including a schedule of regular meetings and minutes documenting the meeting schedule. The committee and associated documentation must include:

- Verification of sources used;
- Criteria for credentialing and recredentialing;
- Initial credentialing verification;
- Application and attestation;
- Initial sanction information;
- Practitioner office site quality;
- Recredentialing verification;
- Recredentialing cycle length;
- Ongoing monitoring;
- Notification to authorities and practitioner appeal rights;
- Assessment of organizational providers; and
- Delegation of credentialing
- Oversight Activities

MCOs

HCA uses both state-developed and NCQA Standards for the monitoring of its MCOs. Among the documents reviewed include the MCO's credentialing policies and procedures, credentialing committee minutes, the initial credentialing verification process, sanction information and credentialing site visits, the recredentialing process, monitoring process and activities, and the MCO's oversight of any entity delegated for credentialing.

Samples of executed provider agreements and practitioner credentialing files, and cross-checks with the National Practitioner Data Bank for sanctions and state licensure limitations are reviewed for compliance. MCOs are notified of any known sanction against a provider resulting from action by a state or federal agency. HCA requires confirmation from the MCOs of receipt of the communication.

PIHPs

The EQRO conducts monitoring of PIHPs to assure compliance with 42 C.F.R. §§ 438.214 and 438.12. This includes assurances that that primary source verification and OIG exclusions and required background checks are performed on all employees providing direct services to enrollees.

438.10 Information requirements

State Duties

Enrollee information must meet the requirements of 42 C.F.R. § 438.10, Information requirements. Each MCO, PIHP and PCCM must provide all required information to enrollees and potential enrollees in a manner and form that may be easily understood and is readily accessible by enrollees

and potential enrollees (42 C.F.R. § 438.10(c)). Washington HCA and DSHS maintain websites that contain information on the Medicaid program illustrated in the links below.

The entry point for eligibility for Medicaid and state programs is generally determined by the Washington Healthcare Exchange (hereafter, Exchange). Application and eligibility for Modified Adjusted Gross Income (MAGI) Apple Health programs is completed through the Exchange. An electronic link from the Washington HCA website directs current or potential Apple Health enrollees to the Exchange website. Citizens who choose not to go on-line directly can apply for health care coverage by phoning the Healthplanfinder Customer Support Center, completing a paper application or going in person to local resources that can apply for health care coverage. For more information: https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/apply-or-renew-coverage.

American Indians and Alaska Natives have a range of options for health care and health care coverage through Washington Apple Health. An AI/AN can enroll in an Apple Health managed care plan or receive Apple Health coverage without a managed care plan. The HCA website directs AI/ANs to the Washington Healthplanfinder for purchase of private health insurance, as appropriate and provides an exemption from the federal mandate to have health care coverage. Information afforded to AI/ANs can be found on the following website: https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/american-indianalaska-native.

Washingtonians are encouraged to visit a local Department of Social and Health Services office to apply for Aged, Blind or Disabled Coverage. For Long-term Services and Supports, citizens are encouraged to visit a Home and Community Services office. These applicants can apply on-line through *Washington Connections* or by completing a paper application. Those individuals eligible for managed care can select/change their plan by going to the HCA web portal, or calling the HCA toll free line. Recipients who do not select their manage care plan are auto assigned by HCA.

Managed care information is located on the agency website https://www.hca.wa.gov/billers-providers/programs-and-services/managed-care as required by 42 C.F.R. § 438.10(c)(3). Enrollees or potential enrollees can find links to contracted Apple Health managed care plans and the phone numbers to health plan call centers. Members can link to the Washington Apple Health enrollee handbook, available in the eight most prevalent non-English languages (42 C.F.R. 438.10(g)). The handbook contains all information required in CFR.

Enrollees in a medical program covered by managed care, receive enrollment and MCO/PCCM selection material. Enrollees or potential enrollees have access to clinical performance measure results to aid the member in selection of an MCO. This information is provided to potential or renewing members in the enrollee handbook and through the Exchange Medicaid application process.

PIHP clients eligible for Medicaid are assigned to the BHO in their geographic area. In the Approval Letter for Medicaid, PIHP enrollees receive information that explains the behavioral health system, information on how to access behavioral health benefits in their BHO network area and information on how to choose and contact providers within their BHO network area.

The state provides information at the time each potential enrollee becomes eligible to enroll in a Medicaid program or is first enrolled or required to enroll in a mandatory Medicaid program. The following information must be provided within a timeframe that allows the potential enrollee to use the information to choose among available MCOs and PCCMs:

- The basic features of managed care–PIHP, MCO, PCCM;
- Populations free to enroll voluntarily, such as American Indian or Alaska Natives–PCCM;
- Responsibility for coordination of care–PIHP, MCO, and PCCM;
- Summary information specific to each MCO or PCCM operating in the potential enrollee's service area which includes benefits covered, service area, names, locations, phone numbers, any non-English language spoken by providers, and providers not accepting new patients–PIHP, MCO, PCCM; and
- Benefits available under the State Plan but are not covered under the MCO contract including how and where enrollees may obtain those benefits, and how transportation is provided–MCO, PCCM.

At least annually, the state notifies MCO/PIHP enrollees about their rights and protections and information on grievance and administrative hearing procedures. Annually, and upon request, each enrollee receives the MCOs/PIHPs service areas, benefits covered under the contract, and names, locations and phone numbers of MCOs, PIHPs and the contracted community behavioral health agencies available in their community. Each enrollee receives a written notice of any change in the MCO or PIHP provider that the state defines as significant. Many of these materials are available on the HCA website.

MCO, PIHP and PCCM Duties

MCO/PIHP enrollees receive information regarding covered services and how to access those services through the DSHS/HCA enrollee handbooks https://www.hca.wa.gov/assets/free-or-low-cost/22-1298.pdf.

MCOs/PIHPs are required to make benefit information available in eight languages and to translate any MCO/PIHP specific information. This ensures that information regarding MCO/PIHP services is

available to enrollees with limited English proficiency. These documents are updated on a regular basis. MCO/PIHPs requirements for enrollee information include:

- Sixth grade reading level for all enrollee materials;
- Use of a font size no smaller than 12 point;
- Alternative format and language requirements and through the provision of auxiliary aids and services in a manner that takes into account those with LEP and those individuals with disabilities (42 C.F.R. § 438.10);
- Service areas covered by each MCO (42 C.F.R. 438.10(e));
- Information on grievances, appeals, adverse benefit determinations, and administrative hearings definitions and processes;
- Enrollee handbooks providing enrollees of their right to disenroll, communicated at least annually – MCOs only (42 C.F.R. § 438.10(f));
- Provider Directory made available in paper form upon request and electronic form (42 C.F.R. § 438.10(h));
- Information on the MCO/PIHP/PCCM formulary – MCOs only (42 C.F.R. § 438.10(i));
- Benefit coverage, and how to obtain care (42 C.F.R. § 438.10(e));
- Advance directives; and
- Written notice of termination of a contracted provider within 15 calendar days after receipt or issuance of the termination notice of a provider.

The MCO, PIHP and PCCM must identify the prevalent non-English languages spoken within its service area and make written information available in those languages. The MCO, PIHP and PCCM must make oral interpretation services available in any language and provide information on how to access interpreter services. Information must be available in alternative formats that take into account the enrollee's special needs, including those who are visually impaired or have limited reading proficiency, and how to access these formats.

MCOs must submit all enrollee material to HCA for review and approval. The PCCMs submit marketing material for approval. The material is reviewed using a checklist composed of contract and Federal requirements. Deficiencies found in the documents are returned to the MCO for correction and tracked for compliance through the TEAMonitor process. The same procedures are true with PCCM for any marketing material.

There is no marketing material for PIHP Medicaid enrollees. Enrollees are automatically enrolled in PIHPs. The state develops the enrollee Medicaid Behavioral Health Benefit Booklet which is offered to all Medicaid enrollees upon approval for Medicaid benefits, at intake, available online at DBHR's website, or by requesting a booklet be mailed through postal services.

Oversight Activities

PIHP member materials are reviewed on an annual basis. BHOs are required to report any changes in BHO or provider status within 14 days so the Behavioral Health Benefits Booklet can be kept current. For MCOs, member materials and marketing are two areas the state reviews on an on-going basis, in addition to the annual TEAMonitor review.

MCOs and PCCMs submit all potential enrollee communications, member information, and enrollee marketing material to HCA for approval before it is finalized and sent to enrollees or potential enrollees. A standardized checklist is used to ensure the material meets all requirements of 42 C.F.R. § 438.10(c). MCOs must specifically respond to a series of questions regarding enrollee material, such as readability, etc.

The EQRO reviews the state's and PIHPs' enrollee handbooks and other enrollee information to affirm that they comply with federal and contractual requirements.

438.224 Confidentiality

MCO, PIHP and PCCM Duties

Confidentiality requirements in the contracts govern disclosure of medical records and other health information that individually identifies an enrollee in accordance with the privacy requirements of 45 C.F.R. § parts 160 and 164, subparts A and E of the Health Insurance Portability and Accountability Act (HIPAA) regulations and 42 C.F.R. § 438.224.

MCOs, PIHPs and PCCMs provide information about confidentiality requirements to enrollees in the member handbook. Health care providers receive such communication in the provider handbook.

MCOs, PIHPs and PCCMs ensure PHI security by: encrypting electronic confidential information during transport; physically securing and tracking media containing confidential information during transport; limiting access to staff that have an authorized business requirement to view the Confidential Information; using access lists, unique user ID and hardened password authentication to protect Confidential Information; physically securing any computers, documents or other media containing the confidential information; and encrypting all confidential information that is stored on portable devices including but not limited to laptop computers and flash memory devices. Contractors must require the same standards of confidentiality of all of its subcontractors.

Additional rules and regulations concerning confidentiality apply to substance use disorder treatment services, and these are stricter than confidentiality rules for medical care. A release of information signed by the client is required under 42 C.F.R. § Part 2. Information may be shared only with the client's written consent and as permitted by law. The law does not permit the re-disclosure of identifiable confidential information without patient consent, only de-identified/aggregate data.

PCCMs answer questions annually about their confidentiality procedures on the self-assessment.

Oversight Activities

MPOI/DBHR or the EQRO reviews and approves all MCO/PIHP confidentiality policies and procedures. MCO implementation of approved Confidentiality policy and procedures are also evaluated as part of TEAMonitor. The confidentiality content of enrollee handbooks and other member information material is reviewed annually.

The PCCM checklist is reviewed for compliance.

438. 226 Enrollment and disenrollment

State Duties

Washingtonians apply for or renew their Apple Health coverage through the Washington Exchange website. MAGI recipients can select or change their managed care plan through the Exchange, by going to the HCA web portal, or calling the HCA toll free line. Recipients who do not select their managed care plan are auto-assigned by HCA. HCA assigns clients who do not select a plan.

Long-term services and support information is currently available through the PRISM system. The information can be accessed by MCO care managers or Health Home care coordinators delivering care management services to high risk members who may be more likely to use or need LTSS (42 C.F.R. § 437.208(c)). This information may also be collected as part of the MCO-conducted Initial Health Screen completed on new members.

As part of their application for coverage, individuals choose their MCO or PCCM. Information on an applicant certified for coverage is sent to the member's selected MCO through a HIPPA-compliant 834, Benefit Enrollment and Maintenance Format (45 C.F.R. § 162.103). A member's eligibility for MCO services is backdated to the beginning of the current month.

Apple Health enrollees may change MCOs (or join a PCCM, if eligible) monthly, regardless of reason. Enrollees who move to other counties are kept in the same plan, if available, or given new enrollment materials with their choices.

An exception is made when an enrollee is placed in the HCA Patient Review and Coordination (PRC) program. Enrollees placed in PRC are restricted from changing their enrolled contractor for a minimum of twelve months after placement in the PRC program by HCA or the MCO unless the enrollee moves to a residence outside the MCO's service areas. If HCA limits the ability of an enrollee to change their enrolled MCO, family members may still change enrollment.

The MCO and PCCM contracts specify how and why an enrollee may be disenrolled for cause. Enrollees may request disenrollment either orally or in writing to the state. Enrollees denied disenrollment for cause or plan change may request an appeal of the decision through a state hearing. Denials of disenrollment requests will be based on the reasons cited in the request information.

In addition to exceptions approved by HCA on a case-by-case basis, enrollees may be disenrolled from mandatory programs for the following reasons:

- A medical need that requires continuation of an established treatment plan;
- The Medicaid client is American Indian or Alaskan Native;
- The Medicaid client is homeless; and
- A child has a special health care need.

A determination for disenrollment must be made no later than the first day of the second month following the month in which the enrollee requests disenrollment or the request is considered approved. When approved by state staff, the enrollee is transferred to Medicaid fee-for-service benefits. Automatic reenrollment to the same MCO is provided if the disenrollment period is for a period of 2 months or less.

PIHP enrollees through a 1915(b) waiver are assigned to one Behavioral Health Organization for all managed care behavioral health services. Enrollees may choose their provider through the Behavioral Health Organization provider network. FIMC enrollees are allowed to select the MCO delivering fully integrated health care services.

MCOs inform enrollees about the enrollment and disenrollment process in the MCO handbook. MCOs are precluded by contract from requesting that an enrollee be disenrolled except if the enrollee becomes ineligible for Medicaid, moves out of the service area, or engages in disruptive behavior as specified in 42 C.F.R. § 422.74. MCOs must refer any requests for disenrollment to the state.

All PIHP enrollees receive a handbook that describes how to access behavioral health services in their region. Anyone seeking behavioral health services must be provided an intake evaluation to determine their eligibility for services.

Oversight Activities

On an annual basis, the MCO provides a list of disenrollment requests that were made by the MCO. These requests are reviewed during the monitoring process to ensure MCO contractual and procedural requirements for disenrollment requests, including HCA decisions, were correctly handled. State staff also monitors disenrollments through complaints, disenrollment statistics, client surveys, and communications with MCOs and state enrollment staff.

State staff also monitors disenrollments through complaints, disenrollment statistics, client surveys, and communications with MCOs and state enrollment staff.

438.228 and Subpart F Grievance systems

State Duties

MCO/PIHP contract standards include:

- Enrollee right to file a grievance at any time; or an appeal of an adverse benefit determination within 60 calendar days from adverse determination notice to file an appeal.
- Enrollee right to receive assistance (including: Ombuds services [PIHP, only], interpreter services, TTY/TTD, and toll-free numbers), and contribute to and participate in appeal hearings.
- Specified timeframes for enrollee appeals and MCO/PIHP response (42 C.F.R. §§ 431.211, 431.213, 431.214, 438.210(d)(1)(ii)(2), 438.408(b)(c), 438.424).
- Specified timeframes for state administrative hearings review and response (42 C.F.R. §§ 431.206(b), 431.244, 438.408(f), 438.424).
- Requirement that individuals making clinical decisions regarding appeals must have appropriate clinical expertise and not be involved in previous levels of review or a subordinate of any such individual.
- Easily understood enrollee communication, giving clear explanation of the adverse benefit determination and reasons, circumstances for and how to request expedited resolution, right to continue benefits pending appeal resolution, how to request it, circumstances under which enrollees may be required to pay, and written notice of resolution and completion date.
- Requirement to process each adverse benefit determination, grievance and appeal within established standards and expedited timeframes.
- Requirement (MCO contract only) for external, independent review at the enrollee's option and which must not be required before or used as a deterrent to proceeding to an administrative hearing; the review must be independent of the state and MCO, offered without cost to the enrollee, and must not extend timeframes specified in CFR and contract and not disrupt continuation of benefits (42 C.F.R. § 438.402(c)(1)(i)(B)).
- Enrollee right to request a HCA/DBHR administrative hearing after exhausting the MCO/PIHP appeal system.
- Requirement to treat enrollee oral inquires seeking to appeal an adverse benefit determination as appeals and confirm in writing, unless the enrollee or provider requests an expedited resolution of the appeal.
- Enrollee opportunity to present evidence and testimony and make legal and factual arguments in person and in writing.
- Requirement to provide the enrollee and his or her representative, free of charge, and with sufficient advance notice of the resolution timeframe for appeals, the enrollee's case file including all medical records associated with the determination, any new or additional evidence in connection with the appeal of the adverse benefit determination.
- Requirement to include the enrollee and the enrollee's representative or estate as parties to the appeal.

MCO, PIHP Duties

A grievance system provides an opportunity for managed care enrollees to express dissatisfaction with medical or behavioral health services provided. The MCO/PIHP and MPOI/DBHR grievance and appeal process ensures that enrollees and providers have input into the health care decision-making process. MCOs/PIHPs are required to have an overall grievance system that includes a grievance and appeal process, and access to the state's administrative hearing system.

The MCO/PIHP must acknowledge each grievance and appeal. The MCO/PIHP assists enrollees, as needed, in their oral or written grievance and appeals. The appeal process provides that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and that there is an opportunity to present evidence in person, as well as in writing. A provider may file a grievance or an appeal for the enrollee, with the enrollee's written permission. MCO/PIHP offers one level of appeal before the Enrollee has the right to an administrative hearing.

The enrollee may receive services while an appeal or a state administrative hearing are pending. The enrollee may be responsible for services if the state administrative hearing decision is adverse to the enrollee as described in contract. In processing an appeal, the MCO/PIHP must meet all continuation of benefits requirements (42 C.F.R. § 438.420).

The MCO/PIHP sends a written notice of an adverse benefit determination to the provider and the enrollee when it denies, terminates, suspends or reduces a service or denies payment, in whole or in part, of a service. A notice of adverse benefit determination is also required if the MCO or PIHP fails to provide services in a timely matter or act within the timeframes in 438.408 (b)(1)(2). An MCO must provide an enrollee living in a rural area with only one MCO a notice if services outside the network are denied. All notices must meet the timeframes and review processes specified in 42 C.F.R. §§ 431.211, 431.213, 431.214 and 438.210(d).

The notice must state the adverse benefit determination the MCO/PIHP made or intends to make; the type of service or claim that is being denied, terminated, suspended or reduced; the reason for the adverse benefit determination including the citation of the rules used to make the decision, the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination; how to file an expedited appeal; and the enrollee's right to request an appeal including information on how to request a state administrative hearing; and the right to have benefits continue pending resolution of the appeal and the conditions under which the enrollee may be required to pay the costs of services.

The MCO/PIHP resolves each grievance and appeal, and provides notice, as expeditiously as the enrollee's health condition requires, but no later than the federal BBA or state timeframes, as specified in the contract. The notice explains the enrollee's right to appeal the adverse benefit determination and information explaining how to do so. The MCO/PIHP must continue to provide previously authorized benefits when an enrollee appeals the termination, suspension, or reduction

of those benefits and the timelines and other conditions for continuation are met, as specified in the contract.

An enrollee may file a State administrative hearing after receiving notice under 42 C.F.R. § 438.408. If the MCO/PIHP fails to adhere to the notice and timing requirements the enrollee is deemed to have exhausted the MCO's appeal process. At this time, the enrollee may file for a State fair hearing. The MCO/PIHP must be a party to the State fair hearing and comply with hearing decisions promptly and expeditiously.

The MCO/PIHP are required to maintain grievance and appeal records documented according to the contract and specifications in 42 C.F.R. § 438.416 and provides notification to the state, as specified in the contract. MCOs/PIHPs are required to analyze the records to identify trends and areas for quality improvement at least annually.

Oversight Activities

DBHR EQR and MPOI staff review PIHP/MCO policies and procedures for compliance with grievance and appeal regulatory requirements. DBHR EQR and HCA staff review PIHP/MCO client materials, such as notice of adverse benefit determination and appeal resolution letters to ensure all applicable regulations are conveyed correctly and in an understandable manner. Sample cases of MCO/PIHP adverse benefit determinations, grievances, and appeals are reviewed examining medical necessity, timeliness, and the appropriateness of actions taken. Listed below are the standards that are reviewed for compliance:

The adverse benefit determination standards are:

- A professional review with appropriate clinical expertise of medical necessity actions;
- Adverse benefit determinations processed within decision time standards;
- Content of written materials and confirmation that materials are written in easily understood language and provide the enrollee their appeal rights;
- Instructions on how to obtain the clinical review criteria for decision-making; and
- Clinical information appropriate to support the action.

The grievance standards are:

- Adequacy of grievance documentation;
- Timeliness of grievance resolution such as evidence of resolution no later than ninety calendar days from receipt of the grievance;
- Evidence that the MCO/PIHP investigated the grievance, and notified the member of the grievance resolution, including appeal rights if applicable.

The appeal standards are:

- Documentation of the appeal;
- Investigation of the appeal, i.e., consideration of all additional information provided by the member or requesting practitioner and assessment of additional information that was not considered when the MCO/PIHP first made its decision;
- The reviewer for the appeal differs than the individual who made the initial determination and the reviewer is appropriately credentialed; and
- Notification of the enrollee's right to appear in person, representation at the appeal hearing or the ability to communicate with the appeal panel.

MCOs/PIHPs are required to submit a corrective action plan to HCA/DBHR for any area out of compliance with federal or state regulation. Systemic problems identified through the review process, such as understandability of the adverse benefit determination (or denial) letter content are remedied through technical assistance or the development of a common set of letter templates provided by HCA/DBHR for use by the MCO/PIHPs.

438.230 Subcontracts relationships and delegation

State Duties

The MCO/PIHP/PCCM maintains ultimate responsibility for adhering to and fully complying with all terms and conditions of its contract with the state. If any MCO/PIHP/PCCM activity or obligation under its contract with the state are delegated to a subcontractor:

- The delegated activities or obligations and reporting responsibilities are specified in the written agreement;
- The subcontractor agrees to perform the delegated activities and reporting responsibilities with the MCO/PIHP/PCCM entity's contract obligations; and
- The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the MCO/PIHP/PCCM entity determines that the subcontractor has not performed satisfactorily.

The subcontractor must agree to comply with all applicable Medicaid laws, regulations, including applicable regulatory guidance and contract provisions. The subcontractor must also agree to a State, CMS, HHS Inspector General or Comptroller General audit, evaluation and inspection of books, records, contracts, computer or other electronic systems of the subcontractor that pertain to any aspect of services and activities performed or determination of the amounts payable under the MCO/PIHP's contract with the state.

The subcontractor must make available, for purposes of an audit, evaluation or inspection its premises, physical facilities, equipment books, records, contracts, computer or other electronic systems related to its Medicaid enrollees. The right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the

state, CMS, or the HHS Inspector General determines that there is reasonable possibility of fraud or similar risk, the state, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Contract language developed by MPOI/DBHR requires the MCO/PIHP to evaluate the prospective subcontractor's ability to perform the activities prior to delegation. The MCO/PIHP must have a written agreement with the delegate that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the delegate's performance is inadequate. At least annually, the MCO/PIHP must monitor the delegates' performance. If the MCO/PIHP identifies deficiencies or areas for improvement, the delegate must take corrective action.

Special Provisions for Indian Health Care Provider and American Indian/Alaska Native Enrollees

Contracts with MCO/PIHP/PCCMs must contain special provisions for Indian Health Care Provider (IHCP) and AI/AN enrollees. An IHCP may submit a written request to the MCO/PIHP/PCCM contractor indicating the IHCP's intent to enter into a subcontract with the contractor. The contractor must negotiate in good faith with the IHCP. Such contractors must include Special Terms and Conditions set forth in the IHCP Addendum to be developed in consultation with the IHCPs and Tribes and based on the Model Indian Addendum for IHCPs. To the extent that any provision set forth in the subcontract between the Contractor and the IHCP conflicts with the provisions set forth in the IHCP Addendum, the provisions of the IHCP Addendum prevail.

Subcontracts may include additional Special Terms and Conditions that are approved by the IHCP and the contractor. Each party must provide the HCA Tribal Liaison with a complete copy of such Additional Special Terms and Conditions, in the format specified by the HCA, and a written statement that both parties have agreed to such Additional Special Terms and Conditions. Subcontracts with IHCPs must be consistent with the laws and regulations that are applicable to the IHCP.

The contractor must work with each IHCP to prevent the contractor's business operations from placing requirements on the IHCP that are not consistent with applicable law or any of the special terms and conditions in the subcontract between the contractor and the IHCP. The contractor may seek technical assistance from the Health Care Authority Tribal Liaison to understand the legal protections applicable to IHCPs and AI/AN Medicaid recipients.

In the event that (a) the contractor and the IHCP fail to reach an agreement on a subcontract within ninety (90) calendar days from the date of the IHCP's written request (as described in Subsection 15.1.1) and (b) the IHCP submits a written request to Health Care Authority for a consultation with the contractor, the Contractor and the IHCP shall meet in person with Health Care Authority within thirty (30) calendar days from the date of the IHCP's written consultation request in an effort to resolve differences and come to an agreement. Executive leadership of the contractor must attend this meeting in person and be permitted to have legal counsel present.

If an AI/AN Enrollee indicates to the contractor that he or she wishes to have an IHCP as his or her PCP, the contractor must treat the IHCP as an in-network PCP under the contract for such Enrollee regardless of whether or not such IHCP has entered into a subcontract with the contractor.

In response to Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the contractor is required to allow AI/ANs free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to AI/AN enrollees at a rate equal to the rate negotiated between the contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.

MCO/PIHP Duties

Sub-contractual relationships and delegation standards must meet the conditions of 42 C.F.R. § 438.20. The MCO/PIHP may choose to delegate certain health care functions (e.g., utilization management, pharmacy benefits management, credentialing) to another for efficiency or convenience, but the MCO/PIHP retains the responsibility and accountability for the function(s). The MCO/PIHP is required to evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor performance is inadequate.

Oversight Activities

MPOI/DBHR EQRO or contract management staff reviews PIHP and MCO contractor subcontracts and delegation agreements for compliance with standards. The review ensures that all subcontract elements required in the MCO/PIHP contracts and regulations are included in subcontracts and delegation agreements. If the standard is not met, the MCO/PIHP is required to correct missing or incorrect information.

During HCA/DBHR's contract compliance audit of MCOs and PIHPs, different types of fully executed subcontracts are reviewed. If the subcontract language does not meet established requirements, the MCO/PIHP is required to submit a corrective action plan. Amendments to the subcontracts are usually required to address problems identified through the review process. Examples of the subcontract and delegation agreement requirements examined in the subcontract and delegation agreement review include:

- Solvency;
- Procedures and specific criteria for termination of the contract;
- Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor;
- A ninety (90) day termination notice provision; and
- A specific termination provision for termination with short notice when a provider is excluded from participation in the Medicaid program.

Quality Measurement and Improvement Standards

438.236 Practice guidelines

State Duties

DBHR/HCA developed contract language requiring MCOs/PIHPs to meet the CFR requirements for practice guidelines. Practice guidelines must consider the needs of the MCO/PIHP enrollees, be adopted in consultation with contracting health care professionals.

MCO/PIHP Duties

HCA/DBHR requires MCOs/PIHPs to adopt and use clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances and promote prevention and early detection of illness/disease. The language concerning clinical practice guidelines is contained in the managed care contracts. Practice guidelines must meet the following contractual requirements:

- Consider enrollee needs, and in consultation with contracted health care professionals, adopt clinical practice guidelines based on valid and reliable clinical evidence;
- Distribute to all affected providers within 60 days of adoption or revision, and to enrollees upon request;
- Annually measure performance against the guidelines and periodically review and update the guidelines periodically to reflect new medical research and recommended practices;
- Ensure utilization management decisions, benefit coverage, enrollee education materials, and disease management programs are consistent with the guidelines;
- Include at least two behavioral health-specific guidelines and document why the guidelines were adopted; and
- Use the American Society of Addiction Medicine (ASAM) guidelines for chemical dependency to determine appropriate levels of care for chemically dependent enrollees (Chapter 388-05 WAC).

The MCOs/PIHPs must use the guidelines in utilization decisions, enrollee education, and coverage of services.

Oversight Activities

MCO or PIHP practice guidelines are reviewed by the TEAMonitor/EQRO monitoring functions. MCO/PIHP websites are examined for of the list of practice guidelines and guideline descriptions. MCO/PIHP policies and procedures are reviewed for compliance with CFR. Providers receive guidelines through the utilization management process, provider manual, websites, newsletters, the provider credentialing process. State staff examine these for completeness and accuracy.

438.242 Health information systems

State Duties

The Washington Healthcare Exchange, HCA and DBHR collect and process information to support the ongoing operations of the Quality Strategy (42 C.F.R. § 438.204(f)). The Washington Healthcare Exchange, supported by HCA staff determines eligibility. The Washington Healthcare Exchange also collects client demographic data, including primary language, race, ethnicity and special needs.

Race and ethnicity categories follow the standard categories developed by the Bureau of Census, they are commonly used throughout the state to collect race and ethnicity data. These categories are: White, Black or African American, Asian, Native Hawaiian or other Pacific Islander, Hispanic or Latino, and Other.

Additional questions on the Apple Health application to find out if clients have special needs:

- Do you have trouble speaking, reading or writing English?
- Do you need materials sent to you in another language?
- Do you need an interpreter? (If yes, we will help you through an interpreter).
- What language do you speak?

This information is passed to HCA or DBHR using compatible computer systems. The eligibility information system is included in the Medicaid Management Information System which includes FFS medical claims and managed care encounter data. Reports and data from the Medicaid Management Information System support the Quality Strategy by providing encounter data, utilization trend data and information for calculation of performance indicators.

At the time of enrollment and monthly, HCA sends identifiers of enrollee's race, ethnicity, prevalent non-English spoken language and children with special health care information to each MCO/PIHP (42 C.F.R. §§ 438.204(b)(1), 438.10(c)(1), 438.208(c)(1)). The state uses this information to allow managed care organization disenrollments and exemptions for Tribal members.

MCO/PIHP Duties

MCOs/PIHPs are required to maintain data fields on race, ethnicity and language characteristics to facilitate effective communication and improve health care services.

MCOs/PIHPs play a key role in developing and maintaining health information systems. MCOs/PIHPs are required by contract to maintain databases on numerous datasets including administrative, encounter and clinical data. Datasets include information on utilization management decisions, (i.e., adverse benefit determinations, appeals, external independent reviews), grievances, disenrollments, and credentialing. Through the performance measure audit process, each plan's data system is examined for completeness and accuracy in capturing performance measure, claims/encounters, and enrollee eligibility data.

HCA received an exception from CMS to use HEDIS® methods to examine the MCOs information systems. The HEDIS® Compliance Audit Methods are consistent with the CMS Validating

Performance Measure protocol. As a result, MCOs submit HEDIS® Baseline Assessment tool instead of the Information Systems Capability Assessment (ISCA) tool (the latter developed by CMS). The NCQA Baseline Assessment tool contains much of the same information in the ISCA, including an assessment of structural and process components of the information system, focusing on collection, data processing, system upgrades, data completeness and integration of data for performance measure reporting. HCA employs contracted auditors, certified by the NCQA to conduct this audit activity.

DBHR uses the EQRO to conduct the ISCA to assess the structural and process components of the DBHR information system. DBHR does not delegate production of performance measures to its PIHPs; these measures are produced by the state for each PIHP. An independent ISCA audit is performed of the state's Medicaid Management Information System every two years.

Each MCO's/PIHP's health information system must be able to produce valid encounter data. MCOs/PIHPS are required to submit encounter data according to contract requirements. MCOs/PIHPs are required to submit complete, accurate and timely data for all services for which the contractor has incurred any financial liability whether directly or through subcontracts or other arrangements in compliance with encounter submission guidelines published by HCA. The contractor must report the paid date, paid unit and paid amount for each encounter. HCA performs encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration and rate setting.

HCA/DBHR requires each MCO/PIHP to:

- Maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the standards, information and performance reporting requirements objectives of the BBA and the MCO/PIHP quality improvement efforts, and also provides information that supports the MCO's/PIHP's compliance with state and federal standards;
- Maintain records and information on utilization, grievances and appeals and regularly review the information (42 C.F.R. §§ 438.242(a), 438.416);
- Ensure that data received from providers are accurate and complete by verifying the accuracy and timeliness of reported data and screening data for completeness, logic, and consistency and collecting service information in standardized formats to the extent feasible and appropriate (42 C.F.R. §§ 438.242(b)(3)(i), 438.606, 438.242(3)(ii), and 438.242(3)(iii));
- Make all collected data available to MPOI/DBHR and upon request to CMS and certify all payment-based data and documentation by the CEO, CFO, or an individual who reports to and has delegated authority to sign for them (42 C.F.R. §§ 438.242(4), 438.606);
- Report the status of physician incentive plans as requested by HCA/BHA (42 C.F.R. § 422.208); and
- Ensure subcontractors comply with all information system requirements the MCO/PIHP is required to meet.

The managed care contracts set standards for Encounter Data reporting and submission that meet the requirements of Section 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. Section 1396b(m)(2)(A)(xi). This includes formats for reporting, requirements for patient and encounter specific information, information regarding treating provider, and timeframes for data submission.

The Medicaid Management Information System is required to possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, and incorporate safeguards against fraud and abuse.

Oversight Activities

The state contracts with an EQRO to assess the state's information systems capabilities for both the behavioral health system and the MCO's physical health contracts. When MCOs/PIHPs submit encounter data to the state, data audits are conducted to ensure data timeliness, completeness and accuracy. The state also give MCOs/PIHPs regular reports on data quality and completeness.

438.330 Quality assessment and performance improvement program

State Duties

DBHR/HCA develops contract language requires MCOs/PIHPs to meet the CFR requirements and contract specifications for the quality assessment and performance improvement (QAPI) program. MCOs/PIHPs conduct clinical and non-clinical performance improvement projects (PIPs) and report their results annually. The MCOs are contractually required to annually calculate and report the results of state-defined CPMs. DBHR calculates performance measures for each Behavioral Health Organization annually.

The results from annual MCO/PIHP monitoring activities (including PIP reviews, clinical performance measure and patient experience results) are provided to the HCA External Quality Review Organization for validation. HCA assesses the results to determine the degree to which a MCO/PIHP: increased the likelihood of desired outcomes through its structural and operational characteristics; provided services consistent with current professional, evidence-based knowledge; and implement interventions for performance improvements (42 C.F.R. § 438.320). The results are summarized in an annual, external quality review report and made publically available (42 C.F.R. § 438.310).

PCCM entities in the state are not subject to C.F.R. § 438.310. PCCM contractual agreements do not currently provide for shared savings, incentive payments or other financial rewards for the PCCM entities for improved outcomes and therefore, are not subject to the provisions of 42 C.F.R. §§ 438.330(b)(2)(3)(c)(e), 438,340, 438.350.

MCO/PIHP Duties

MPOI/DBHR requires each MCO/PIHP to have a quality assessment and performance improvement (QAPI) program for its client services (42 C.F.R. § 438.310(a)(1)). At minimum, the QAPI must incorporate requirements for collection and submission of performance data and mechanisms to

detect both under-utilization and over-utilization of services (42 C.F.R. §§ 438.330(b)(2), 438.330(b)(3)).

MCOs/PIHPS are required to have clinical and non-clinical PIPs designed according to 42 C.F.R. § 438.330. PIP examples include those focused on improving mental health services, well-child care visit rates in infants, children and adolescents, and psychiatric readmissions (within 30 days of discharge) for people with mental health conditions. CMS, in consultation with the state and other stakeholders, may specify performance measures and performance improvement projects required by states in their MCOs/PIHPs contracts (42 C.F.R. § 438.330(a)(2)).

PIPs must be designed to achieve, significant and sustainable improvement, in clinical care and non-clinical areas which result in improved health outcomes and enrollee satisfaction. PIPs are designed to identify and introduce best practices or evidence-based interventions to improve the quality of care and services for their at-risk enrollees.

PIPs reflect continuous quality improvement concepts including identifying areas of care and service that need improvement, conducting a root cause analysis, implementing system interventions to improve quality, evaluating the effectiveness of interventions using objective quality indicators, making additional changes, and planning and initiating activities for increasing or sustaining improvement. MCOs/PIHPs are required to report the status and results of their improvement projects annually and to complete them in a reasonable time period that allows new information on quality every year.

Annual assessment of the impact and effectiveness of the quality program is conducted by the MCO/PIHP. Contract language requires MCOs/PIHPs to:

- Maintain an ongoing quality assessment and performance improvement (QAPI) program;
- Maintain an ongoing PIP program in clinical and non-clinical areas designed to improve health outcomes and enrollee satisfaction;
- Use state data and information to identify and correct problems and improve enrollee health care and services. Examples of data include EQR findings, audits and contract monitoring activities, performance measures and survey results, and enrollee grievances;
- Have mechanisms to detect both under-utilization and over-utilization; and
- Assess the quality and appropriateness of care provided to special health care needs enrollees.

MCOs/PIHPs must submit performance results using standard clinical and patient experience measures (42 C.F.R. § 438.330). State-defined measures include a combination of SCMS measures approved by the Performance Measures Coordinating Committee, SCO Measures and HEDIS measures. CPMs include comprehensive diabetes care, antidepressant medication management, drugs to be avoided in the elderly, mental health or substance use disorder service utilization and widely accepted behavioral health measures including outpatient care provided within seven days of discharge from psychiatric hospitalization.

HEDIS measures are audited or validated by HCA's HEDIS auditor according to HEDIS specifications for calculating performance measures. The current version of the HEDIS Compliance Audit Standards, Policies and Procedures are used to assess HEDIS measures. DBHR state-defined measures are validated by the EQR as part of their PIHP review.

Oversight Activities

The state must review the impact and effectiveness of each MCO/PIHP quality assessment and performance improvement program annually. The review includes:

- An evaluation of the MCO/PIHP PIPs;
- The results of CPMs using the Quality Improvement Score, designed by the state to evaluate improvement in select CPMs over time; and
- An examination of MCO/PIHP Quality Assessment and Improvement:
  - Program description
  - Program evaluation
  - Work plan.

In-depth monitoring of intervention effectiveness is done during annual reviews of PIPs. EQR and state staff use the CMS protocol checklist to review each protocol indicator. EQR and state staff also evaluates MCO/PIHP performance on required performance measures, looking for improved performance measures over time.

Reporting and Evaluation

The following reports are generated as part of MPOI/DBHR's overall evaluation of MCOs/PIHPs health information systems:

- HEDIS compliance audit (data systems audit).
- ISCA compliance audit of the state's Medicaid Management Information System
- Encounter data submission report (see below for description).
- Periodic encounter data validation reports.
- ISCA compliance audit of the PIHPs' data systems.
- PIHP annual encounter data validation reports.

The Medicaid Management Information System contains more than 100 automated audits that are applied to MCO/PIHP encounter data submissions. MCO/PIHP submissions are manually reviewed for format, accuracy, and possible duplication. MCOs/PIHPs receive reports on data quality and completeness. HCA/DBHR creates monthly reports showing service utilization using encounter data.

The EQRO summarizes and evaluates all gathered information and assesses each MCO's/PIHP's compliance with this standard. The EQRO makes recommendations for improving the quality of information furnished by each MCO/PIHP.

438.332 State review of the accreditation status of MCOs/PIHPs

State Activities

The state requires that each MCO is accredited by the National Committee for Quality Assurance at a level of accredited or better. Contractors who fail to obtain accreditation at a level of accredited or better or fails to maintain accreditation are in breach of the contract. HCA may terminate the contract according to the Termination by Default section of the contract.

The MCO is required to allow a state representative to accompany any accreditation review in an official observer status. The state requires the MCO to submit a copy of its most recent accreditation review. The state makes the accreditation status for each MCO available on the website (42 C.F.R. § 438.10(c)(3)).

Oversight Activities

The state monitors the accreditation review period of each contracted MCO. The state may at its discretion observe the accreditation evaluation for each MCO.

Handling Disputes and Sanctions

HCA/DBHR notifies the MCO/PIHP in writing about the basis and nature of any sanctions and, if applicable, provides a reasonable deadline for solving the issue before imposing sanctions. The HCA/PIHP may request dispute resolution, if they disagree with HCA/DBHR's position. If the MCO/PIHP fails to meet its contractual obligations HCA/DBHR may impose sanctions, including withholding payment and/or withholding enrollee assignments. Examples of contract breach include:

- Fails to provide medically necessary services;
- Charges enrollee premiums or charges;
- Discriminates against enrollees;
- Misrepresents or falsifies information;
- Fails to comply with physician incentive plan requirements;
- Distributes unapproved marketing material; or
- Violates any other requirements of sections 1903(m) or 1932 of the Social Security Act.

Sanctions may include:

- Civil monetary sanctions;
- Appointing of temporary management if the contractor repeatedly failed to meet substantive requirements in Sections 193(m) or 1932 of the Social Security Act;
- Suspending all new enrollments; and
- Suspending payment for those enrolled after the effective date of the sanction and until CMS is satisfied that the reason for the sanction has been solved.

If the MCO/PIHP requests dispute resolution, the state may withhold payment until the default is resolved or the dispute is resolved in favor of the MCO/PIHP.

Improvement and Interventions

Since the last publication of the Quality Strategy, the state and its' partners can claim a number of successes within the agencies serving Apple Health clients. On the whole, the MCOs/PIHPs have made significant progress meeting the standards defined in federal regulations, contract terms and enforced through structured monitoring and EQRO activities.

Backed by a strong analytics team, Healthier Washington and managed care programs have achieved a number of successes and furthered the agency and its' partners quality measurement and improvement efforts. Among our successes:

- Washington is a recognized national leader in Medicaid administration. Strong, progressive staff, supported by consistent, legislative support, and the Governor's endorsement helped us obtain funding for Healthier Washington.
- Healthier Washington initiatives, such as the Accountable Communities of Health and Practice Transformation HUB help highlight community strengths, identify gaps, and support providers and social services organizations as they improve the delivery of care and address health care disparities. The ACHs' in partnership with health plans, providers, public health and community resources are the backbone for improving the health of citizens.
- DSHS and HCA and its partners developed and published two sets of performance measures (Service Coordination Organization and the Statewide Common Measure Set) and are aligning measures across MCO/PIHP contracts. Use of CPMs coupled with value-based purchasing strategies send a common message to contractors and the provider community about the importance of improving performance.
- Quality Measurement, Monitoring and Improvement provides an ongoing avenue for focused measurement on the larger Apple Health population, and sub-populations at higher risk for poor health outcomes.
- The HCA Analytics, Interoperability and Measurement program developed an outward facing data dashboard for use by Accountable Communities of Health and state staff which help inform community members about the state of health care quality, including areas needing improvement.
- In partnership with Washington Department of Social and Health Services, the Research and Data Analysis Administration developed and implemented a predictive modeling tool, called PRISM. MCOs/PIHPs use the tool to facilitate care coordination activities for clients with complex needs or at risk of poor health outcomes. The tool has added value to the work of staff delivering Health Home services.

- Performance improvement projects (including statewide, cross-plan collaborative PIPs, public reporting of performance data, and other quality activities) have become more comprehensive and meaningful. For instance, MCOs collaborate with the Washington Department of Health on an initiative to improve the quality and quantity of well-child care among MCO enrollees. DBHR is sponsoring a project to increase use of formal and information supports for youth receiving WISe services.
- With other agencies that serve youth, MPOI/DBHR formed the Children's Behavioral Health Data and Quality Team to identify and address Service Coordination Organization challenges and opportunities to serve Apple Health-enrolled children and youth.
- Washington is a recognized leader in integrated, managed care arrangements. This status brought Center for Health Care Strategies technical assistance grants, such as purchasing for long-term care patients and re-thinking care. Moving to fully integrated managed care, slated for completion in 2020, will further the state's interest in ensuring whole-person care for Apple Health clients.
- Washington Apple Health implemented Section 2703 of the Affordable Care Act, Health Home program, available to eligible Apple Health clients, including those enrolled in MCO/PIHP arrangements. The state provides Health Home services for Medicaid, and Medicaid-Medicare eligible clients meeting certain diagnostic, risk and cost criteria. Through a separate Medicare-Medicaid Financial Alignment initiative, the state leveraged Health Home and realized significant savings as a result of the program.

Delivery System Reforms

As described in the introduction of this strategy, under Healthier Washington, the state and its partners aim to transform health care in Washington State by leveraging its state purchasing power to reform the Washington delivery system. The Medicaid Demonstration which began January 2017 is one tool that will accelerate delivery system transformation, starting with Medicaid. The Demonstration provides funding for three key state initiatives:

1. Funding for transforming the Medicaid delivery system within each region with the goal of improving whole-person care. ACHs' conducted community needs assessments and from that activity are implementing projects aimed at:
    - Building health systems capacity—workforce development; system infrastructure technology and tools; and system supports to assist providers in adopting value-based purchasing and payment.
    - Redesigning care delivery—integrated delivery of physical and behavioral health services; care focused on specific populations; alignment of care coordination and case management to serve the whole person; and outreach, engagement, and recovery supports.
    - Promoting health and disease prevention—prevention activities for targeted populations and regions.

2. Expanded options for clients who receive long-term services and supports so they can stay at home and delay or avoid more intensive services. New benefits include support for unpaid caregivers, avoiding or delaying the need for more intensive Medicaid-funded services, and tailoring support for older adults.

3. Support clients' access to housing and wrap around support, assessing housing needs, identifying appropriate resources and developing independent living skills needed to remain in stable housing.

BHOs are encouraged and MCOs are required to participate in ACHs and the ACH regions are intentionally aligned with the Regional Service Areas for Medicaid purchasing. The Demonstration represents an opportunity for the MCOs to engage with community partners to align delivery system reform efforts and develop an improved system that includes clinical-community linkages. ACHs are comprised of social services partners and more traditional health care providers, so the ACHs are ideal conveners to promote the importance of social determinants of health as Washington moves to a system that focuses on value and health outcomes.

ACHs are required under the Demonstration to develop a value-based purchasing transition plan that supports MCOs in their movement to increased value-based contract arrangements. Value-based purchasing is the foundation of the Demonstration's reform efforts. This payment model recognizes that the transformed system must be reinforced by MCO value-based purchasing and clinical improvement expectations placed on providers. In this way, the Demonstration represents an incentive to partnering providers to use the current ACH partnership and incentive structure to further support the Demonstration goals and objectives.

The performance measures under the Demonstration align with the state's statewide common measure set and value-based related MCO contract measures. This supports additional alignment between Demonstration projects and expectations of MCOs and payment models. Over the course of the Demonstration, there is increased accountability tied to performance measures, which aligns with the broader movement to value-based purchasing over the coming years.

MCO and ACH coordination is an incredible opportunity to synergize the efforts of all parties towards common improvement objectives under the umbrella of the Demonstration. MCOs, clinicians and social service providers are integral partners with the ACHs, regional service areas are intentionally aligned, and value-based purchasing planning and alignment is built in as a foundational element of the Demonstration projects designed by ACHs.

The legislature has passed many state laws in recent years creating structural reforms in how Apple Health services are purchased or managed. One such bill created Behavioral Health Organizations to purchase and administer public behavioral health and substance use disorder services under managed care. A second initiative supported the full integration of physical and behavioral health care. To date, Fully Integrated Managed Care contracts has been implemented in one of nine regions

in Washington. A second region joins in 2018. By 2020, the remaining seven Washington regions will have fully integrated managed care systems.

Legislation also created several sets of performance measures and provided the necessary authority for the state to test and evaluate value-based purchasing strategies. The state is beginning to align measures across contracting arrangements. By 2018, HCA will have implemented value-based purchasing in all managed care contracts.

The state is deeply engaged in implementing these various pieces of legislation and the Demonstration initiatives. In the coming years, the state will begin evaluating these initiatives using quantitative and qualitative results and experience to learn more about the optimal public health, health care and social services systems that best achieves the Triple Aim: improved health, lower health care costs, and improved care experience.

Conclusion

This Quality Strategy is a compilation of state, community, and MCO/PIHP activities aimed at improving Washingtonians' health by improving the health care and social services they receive. Washington has invested in multiple structural changes to improve the care delivery system, including Accountable Communities of Health, the Practice Transformation HUB, Health Homes, the creation of Behavioral Health Organizations and Fully Integrated Managed Care, common performance measures, and value based purchasing. These key ingredients hold promise for strengthening the health care system in our State.

The Quality Strategy describes the managed care quality program, including standards for safe, effective, and, quality health care. MCO/PIHP contracts include information on the monitoring processes, protocols, and strategies HCA/DBHR uses to ensure compliance with these standards. The contracts also include a description of how HCA/DBHR complies with BBA and other federal Medicaid requirements, including external quality review. The Quality Strategy incorporates elements of contract requirements, Washington insurance and HMO licensing requirements, and federal Medicaid managed care rules and regulations.

A variety of methods are used to ensure compliance and improved clinical quality performance over time. The state uses ongoing and annual audits, reports, and other types of reviews to assess how the strategy is working and to make any necessary corrective actions. MPOI/DBHR uses the information received through monitoring and evaluation activities to improve the quality program for Medicaid managed care in Washington and achieve the mission of whole-person care for our clients.

Appendix A: Managed Care Benefits

The following table describes the 2017 benefits (services) covered (paid) for clients enrolled in the HCA/DSHS MCO, PIHP, or PCCM program and who pays for the service. This list is not all-inclusive. The scope of service for managed care clients—whether fee-for-service (FFS) or enrolled in managed care—is essentially the same (although specific items may differ). MCOs and PIHPs employ plan-specific authorization and billing specifications.

Table: 2017 Benefits Covered for Clients, by Plan Type

ITEM	MCO	PIHP	PACE	PCCM
Ambulance Services	X		Medicaid FFS	Medicaid FFS
Applied Behavioral Analysis	X		Medicaid FFS	Medicaid FFS
Behavioral Health Services	X		Medicaid FFS	Medicaid FFS
Mental health inpatient care		X		
Mental health outpatient community care	X	X	Medicaid FFS	Medicaid FFS
Mental health psychiatric visits	X	X	Medicaid FFS	Medicaid FFS
Mental health medication management	X	X		
Substance use disorder (SUD) detoxification		X		
SUD Diagnostic Assessment		X		
SUD Residential Treatment		X		
SUD Outpatient Treatment		X		
Blood/Blood Products/Related Services	X		Medicaid FFS	Medicaid FFS
Chiropractic Care	X		X	DSHS
Crisis Services		X		
Dental Care	Medicaid FFS		Medicaid FFS	Medicaid FFS
Diagnostic Services (lab and X-ray)	X		Medicaid FFS	Medicaid FFS
Habilitative Services	X		Medicaid FFS	Medicaid FFS
Health Care Professional Services	X		Medicaid FFS	Medicaid FFS
Hearing evaluations and aids	X		Medicaid FFS	Medicaid FFS
Home Health Services	X		Medicaid FFS	Medicaid FFS
Hospice Services	X		Medicaid FFS	Medicaid FFS

ITEM	MCO	PIHP	PACE	PCCM
Hospital Services (Inpatient/Outpatient)	X		Medicaid FFS	Medicaid FFS
Intermediate care facility/services for persons with intellectual disabilities	HCA Contract		Medicaid FFS	Medicaid FFS
Interpreters, Medical	HCA Contract		HCA Contract	HCA Contract
Maternity care and delivery services	X		None	Medicaid FFS
Medical Equipment, Durable	X		Medicaid FFS	Medicaid FFS
Medical Equipment, Nondurable	X		Medicaid FFS	Medicaid FFS
Medical Nutrition Services	X		Medicaid FFS	Medicaid FFS
Nursing Facility Services	Medicaid FFS		Medicaid FFS	Medicaid FFS
Nursing (including private duty) Services	X		Medicaid FFS	DSHS
Organ Transplants	X		Medicaid FFS	DSHS
Orthodontic Services	X		Medicaid FFS	Medicaid FFS
Ostomy Supplies	X		Medicaid FFS	Medicaid FFS
Out-of-State Services	X		Medicaid FFS	Medicaid FFS
Outpatient Rehabilitation (OT, PT, ST)	X		Medicaid FFS	Medicaid FFS
Personal Care Services	None		Medicaid FFS	Medicaid FFS
Prescription Drugs	X		Medicaid FFS	Medicaid FFS
Private Duty Nursing	X		Medicaid FFS	Medicaid FFS
Prosthetics/Orthotics	X		Medicaid FFS	Medicaid FFS
Reproductive health services	X		Medicaid FFS	Medicaid FFS
Respiratory care (oxygen)	X		Medicaid FFS	Medicaid FFS
School-based medical services	HCA Contract		None	HCA Contract
Vision care exams, refractions, and fittings	X			Medicaid FFS
Vision hardware, frames and lenses	X			Medicaid FFS
Transportation, Brokered	HCA Contract		HCA Contract	HCA Contract