

Washington State Managed Care Quality Strategy

October 2020

Preface

The Washington State Managed Care Quality Strategy is a technical document required by the Code of Federal regulations (CFR), 42 CFR 438.340, and the Center for Medicare and Medicaid Services programs to ensure the delivery of quality health care by Managed Care Organizations (MCO). It is not intended to comprehensively describe all of the activities that the Health Care Authority (HCA) undertakes to ensure Medicaid program quality.

In accordance with 42 CFR 438.340, at a minimum, quality strategies must address:

- The State-defined network adequacy and availability of services standards for Managed Care Organizations (MCO), Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plans (PAHP) required by 438.68.
- Examples of evidence-based clinical practice guidelines the State requires in accordance with 438.236.
- The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by MCOs, PIHPs and PAHPs.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 438.330(c).
- The performance improvement projects to be implemented in accordance with 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.
- Arrangements for annual, external independent reviews, in accordance with 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP and Primary Care Case Management (PCCM) entity contracts that have shared savings, incentive payments, or other financial rewards.
- A description of the State's transition of care policy required under 438.62(b)(3).
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities.
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
- The mechanisms implemented by the State to comply with 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).
- The information required under 438.360(c) (relating to non-duplication of External Quality Review (EQR) activities); and
- The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.

NOTE: Washington (WA) State does not have any PAHP entities.

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Section I: Introduction and Overview

The term “Apple Health” includes both Medicaid and Children’s Health Insurance Program (CHIP) populations. The Washington State Quality Strategy (QS) outlines a comprehensive plan that incorporates assessment, monitoring, coordination and ongoing performance improvement processes and activities that are directed at continually improving the Medicaid Apple Health managed care program. The QS is the vehicle used by the Washington State Health Care Authority to communicate the vision, goals and monitoring strategies addressing health care quality, timeliness, and access. The QS also serves to meet the requirements specified by the Code of Federal Regulations (CFR) 438.340, which requires the development and maintenance of a Medicaid Quality Strategy.

Purpose

HCA has developed a Quality Strategy that summarizes a systematic approach to plan, measure, assess, and improve health care services to Apple Health enrollees. The strategy describes the methods HCA uses to measure and enforce material terms of Managed Care Plan (MCP), Pre-Paid Inpatient Health Plan (PIHP), and Primary Care Case Management (PCCM) contracts. In Washington State, PCCM contracts with tribal clinics and Urban Indian Health Centers to provide PCCM services for American Indian/Alaska Native (AI/AN) are not subject to Quality Strategy oversight as these contracts do not include language about financial rewards based on quality performance. The Quality Strategy aligns with managed care quality activities, agency goals, and Federal managed care requirements.

The purpose of the QS includes:

- Articulating guiding principles for developing and implementing a quality strategy and prioritizing activities related to quality management;
- Describing activities related to the development, evaluation and updating of the strategy to reflect stakeholder input and continuous improvement;
- Providing structure and assignment of responsibilities for implementing the activities as described in the QS;
- Identifying procedures for assessment of quality and appropriateness of care delivered by Managed Care Organizations;
- Establishing clear aims and objectives to drive improvements in care delivery and outcomes, and identifying the metrics by which progress will be measured;
- Outlining the monitoring activities that will be used to ensure that the services provided to Medicaid managed care members conform to professionally recognized standards of practice, contract requirements, and state and federal rules and regulations;
- Describing processes used to identify and pursue opportunities for improvements in health outcomes, accessibility, and value-based payment methodologies;
- Clearly articulating the complex set of programs and populations that require support as part of an integrated managed care delivery system.

Medicaid Managed Care in Washington

Medicaid managed care has a long history in Washington State and is the health delivery system most widely utilized for Apple Health as it is organized to manage cost, utilization, and quality for the population. Beginning in 1985, Centers for Medicare & Medicaid Services (CMS) allowed the state to mandatorily enroll the Medicaid TANF (Temporary Assistance for Needy Families) population into a single

plan. At that time, Medicaid also had a contract with a Health Maintenance Organization (HMO-Group Health Cooperative) so that individuals could voluntarily enroll within a small number of counties. Based upon the successes of these early efforts, Medicaid managed care was later expanded and is currently operated statewide.

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

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

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

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

In recognition of the federal government's trust responsibility for providing health services to individuals who are American Indian/Alaska Native (AI/AN), including the Indian Health Services (IHS) and programs administered by tribal governments under compacts or contracts with IHS, the Affordable Care Act created protections that benefit AI/AN individuals who enroll in qualified managed care plans.

Apple Health coverage is available to individuals who are AI/AN and meet income requirements. AI/AN individuals eligible for Apple Health can choose to enroll in a managed care plan or Apple Health coverage without a managed care plan; with either choice, they can receive care from a health clinic or facility operated by the Indian Health Service (IHS), a Tribe or tribal consortium, or an urban Indian health program. AI/AN individuals can enroll into managed care at any point during the year and change managed care plans up to once a month. MCOs coordinate with and pay all Indian Health Care Providers (IHCP) who provide a service to AI/AN enrollees regardless of the IHCP's decision whether or not to contract with the MCO.

HCA must seek advice from designees of Indian health programs and urban Indian organizations in the state when Medicaid and CHIP matters have a direct effect on individuals who are AI/AN, Indian health programs or urban Indian health programs.

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

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

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

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

Many HCA divisions and staff administer health care coverage for Apple Health clients, including low-income adults, families, pregnant individuals, children, the elderly, and individuals with disabilities. Apple Health covers nearly 50 percent of all Washington children and more than 50 percent of all births in Washington. More than 1.6 million Washingtonians currently receive managed health care through Apple Health in all of Washington's 39 counties. The HCA Apple Health client eligibility dashboard helps to explore changes and shifts in the Apple Health population over time using client eligibility data. HCA uses this and other data dashboards to promote transparency and help inform the public and interested stakeholders about the citizens of Washington that depend on Apple Health for their health care coverage. View the Apple Health dashboard at hca.wa.gov/about-hca/client-eligibility-data-dashboard.

Quality Strategy Mission and Vision

HCA's goals, Vision and Mission Statement, and Core Values for Apple Health align with the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care.

Washington Health Care Authority's Vision and Mission Statements serve as a guide for ensuring quality remains a top priority. These statements create a strong foundation for Apple Health and the services it provides to Medicaid recipients of Washington State.

Vision Statement: "A healthier Washington."

Mission Statement: "Provide high-quality health care through innovative health policies and purchasing strategies."

Managed Care Strategy: "Ensure high quality, cost-effective care to all clients within the Medicaid program."

Through the alignment of these visionary statements, HCA is able to strategically practice continuous quality improvement on the structure, process, and outcomes of managed care programs.

Using the Vision and Mission Statements and Core Values, Washington Apple Health has developed three primary high-level goals. These include:

1. Reward the delivery of person- and family-centered high value care;
2. Drive standardization and care transformation based on evidence;
3. Strive for smarter spending and better outcomes, and better consumer and provider experience

Definition of “Quality”

Medicaid managed care federal regulations provide a definition of quality in 42 CFR 438.320, which Apple Health follows:

“Quality”... means the degree to which a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Management (PCCM) entity increases the likelihood of desired outcomes of its enrollees through:

- Its structural and operational characteristics
- The provision of services that are consistent with current professional, evidence-based-knowledge, and
- Interventions for performance improvement.

In order for HCA to effectively manage quality, the agency strives to establish meaningful metrics, monitor performance, and advance improvement in health system outcomes.

Section II: Quality Oversight for Medicaid Managed Care

The table below shows the linkages between the CMS and Washington Apple Health Quality Strategies.

Table 1: CMS, Apple Health, and WA Managed Care Oversight Goal Crosswalk

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

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

Washington Managed Care Program Aims

The purpose of the Quality Strategy document is to reflect upon what Washington State is doing to increase the likelihood of desired outcomes through Managed Care Program structural and operational characteristics; ensure that the provision of services are consistent with current professional, evidence-based-knowledge; and to ensure that interventions for performance improvement are identified and implemented. The following list of Washington aims are intended to ensure that Apple Health enrollees receive evidence-based health care services, preventive care, and optimal management of chronic

conditions. Washington uses a specific set of Quality Strategy aims and objectives that set the direction as to where HCA's efforts are directed in oversight of managed care.

Summary of Access, Timeliness, and Quality Concepts

Quality

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

Access

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

Timeliness

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

Concepts related to Aims and Objectives

An "aim" is a result or outcome that actions are intended to achieve. Aims help to set the direction where all efforts are directed, and usually represent broad and long-term outcomes. By establishing aims (similar to goals) that are specific to managed care oversight, it helps HCA to outline the path that the organization must take to achieve desired outcomes for Apple Health managed care. This is especially important in terms of the overall Quality Strategy that is used.

Objectives are short-term activities that HCA identifies which allow HCA to focus energies and activities on being the most efficient and productive in taking steps to meet desired aims. Objectives can be evaluated and adjusted as needed. This adjustment occurs based on regular feedback, analysis, and re-evaluation of specific strategies.

Washington's Quality Strategy has specific aims that connect to the program mission. Targeted objectives have been developed to create progress in achieving each aim. Objectives associated with each aim are a mix of performance standards and program activities. Meeting performance standards and completing program activities described in each objective are an indicator of the effectiveness of Washington's Quality Strategy.

Quality Strategy Aims and Objectives for Medicaid Managed Care Oversight

Aim 1: Assure the quality & appropriateness of care for Apple Health managed care enrollees.

Objectives

- 1.1 Ensure appropriate utilization of physical health services.
- 1.2 Ensure appropriate utilization of behavioral health services.
- 1.3 Adjust value-based purchasing measures to drive quality improvement initiatives that are substantive and clinically meaningful in promoting health status for enrollees.
- 1.4 Increase the application and use of practice guidelines and evidence-based practices within managed care in a culturally appropriate manner.
- 1.5 Improve the clinical integration and coordination between physical health and behavioral health.
- 1.6 Ensure continuity of care for clients who are in an active course of treatment for a chronic or acute health condition, or who have a documented, established relationship with a provider.

Aim 2: Assure enrollees have timely access to care.

Objectives

- 2.1 Evaluate strategies to manage health inequities and use opportunities to listen, learn, and seek input from communities impacted by health inequity.
- 2.2 Ensure access to care for members receiving services to treat mental health conditions.
- 2.3 Ensure access to care for members receiving services to treat substance use disorders.
- 2.4 Ensure MCOs maintain and monitor appropriate and adequate provider networks, sufficient to provide adequate access to all services covered under the Contract for all enrollees, including those with limited English proficiency or physical or mental disabilities (42 CFR 438.206(b)(1)).
- 2.5 Support the delivery system by ensuring that MCOs use creative methodologies to recruit providers utilizing available funding streams that expand/enhance access for difficult to recruit or retain provider types.

Aim 3: Assure medically necessary services are provided to enrollees as contracted.

Objectives

- 3.1 Ensure MCOs do not deny, limit, or discontinue medically necessary contracted services for enrollees.
- 3.2 Ensure that MCOs appropriately utilize care coordination and care management services to meet each enrollee's needs.
- 3.3 Ensure that MCOs use appropriate application of criteria and guidelines for clinical decision-making based on clinical evidence and regulatory requirements.
- 3.4 Ensure MCOs monitor and document the consistent application of medical necessity criteria and guidelines.

Aim 4: Demonstrate continuous performance improvement.

Objectives

- 4.1 Ensure MCOs obtain and maintain accreditation from the National Committee for Quality Assurance of Health Plans (NCQA).
- 4.2 Ensure MCOs fully execute Quality Assessment and Performance Improvement (QAPI) programs that meet the requirements of 42 CFR 438.330.
- 4.3 Ensure MCOs manage Performance Improvement Project (PIP) programs that demonstrate the ability to develop and execute effective PIPs.
- 4.4 Ensure that MCOs use annual member experience of care survey data in the plan's quality improvement processes to identify meaningful areas where the healthcare experience can be improved for enrollees.
- 4.5 Conduct routine technical assistance and communication meetings between HCA and MCOs to support program improvement.
- 4.6 Ensure transparency by publicly reporting on MCO quality.
- 4.7 Ensure that MCO value-based contracting goals are achieved and maintained to improve quality performance.

Aim 5: Assure that MCOs are contractually compliant.

Objectives

- 5.1 Ensure TEAMonitor compliance reviews demonstrate MCO contract standards are met, and identify non-compliance for those standards that are not met.
- 5.2 Implement appropriate use of corrective action and MCO sanctions to support enrollee care and services, program operations, and contractual compliance. Ensure MCO sanctions are compliant with 442 CFR 438, Subpart 1 and MCO Managed Care contract standards.

Aim 6: Eliminate fraud, waste and abuse in Apple Health managed care programs.

Objectives

- 6.1 Ensure MCOs administer the prior-authorization system to prevent potential waste and abuse, and safeguard medically necessary and cost-effective services prior to the provision of services when appropriate.
- 6.2 Ensure MCOs implement mechanisms to verify that claimed services were actually provided.
- 6.3 Ensure MCOs implement an effective Program Integrity program to identify aberrant provider activities.

Programs and Populations

Washington State is committed to whole-person care, integrating physical health, mental health, and substance use disorder treatment services for quality results and healthier residents. Most of Washington's 1.9 million Medicaid enrollees are enrolled in a MCO with a smaller fee-for-service program serving select populations (e.g., dual-eligible Medicare/Medicaid clients, American Indian/Alaskan Native clients). Although the percentage changes with the shifting population, approximately 84% of Apple Health clients are served through the primary integrated managed care programs.

Within Apple Health managed care, many populations are addressed, including individuals with special health care needs. Over time, the delivery system has continued to become more sophisticated and capable of serving a broader array of enrollees. HCA has slowly moved focused populations into managed care, expanding the system's ability to meet the needs of these individuals and reducing the number of populations served in the fee-for-service delivery system. Currently the following populations are enrolled (broadly defined):

- Low-income Apple Health programs (Modified Adjusted Gross Income or MAGI-based), including families, pregnant individuals and Temporary Assistance for Needy Families (TANF)-related (Apple Health Family)
- Low-income children in the State's Children's Health Insurance Program (CHIP). Washington law requires Apple Health coverage for children (Apple Health for Kids) in households up to 250 percent federal poverty level (FPL); the state uses Medicaid CHIP funding to cover additional children up to 312 percent FPL.
- Medicaid-expansion adult medical coverage (Apple Health Adult Coverage or AHAC) for low-income adults (MAGI-based). The adult expansion program was implemented in 2014.
- Aged, Blind, and Disabled (Apple Health Blind and Disabled or ABD), including Supplemental Security Income (SSI)-related eligibility (referred to as "Classic Medicaid"). Apple Health managed care was re-procured in 2012 to meet the needs of the blind and disabled population. Later, the aged population was enrolled with the exception of those dually-eligible clients with Medicare and Medicaid services.
- Foster Care, Adoption Support, and Alumni of Foster Care (aged out of foster care).
- Other special populations, including:
 - Children with Special Health Care Needs (CSHCN),
 - Clients enrolled in Washington Secretary of State's Address Confidentiality Program, and
 - Clients receiving Home and Community Based Services (HCBS) waiver services through DSHS (enrolled 2015).
 - Clients with other health insurance as primary (enrolled 2018).
 - Dually-eligible clients with Medicare and Medicaid services (for behavioral health managed care enrollment only through Behavioral Health Services Only (BHSO))

Apple Health Integrated Managed Care (AH-IMC)

Implementation began in April 2016 due to legislative direction (Senate Bill E2SSB 6312) and was fully implemented statewide in January 2020. This program integrates physical and behavioral health (mental health and substance use disorder treatment services) under one contract. This program serves Medicaid-eligible adults, pregnant individuals, individuals with disabilities, and low-income families as well as CHIP-eligible children. Managed care organizations are contracted regionally for this program:

- Great Rivers (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) (implemented January 2020)
- Greater Columbia (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima counties) (implemented January 2019)
- King (King County) (implemented January 2019)
- North Central (Chelan, Douglas, Grant, and Okanogan counties). Chelan, Douglas, and Grant was implemented as AH-IMC in January 2018; Okanogan was added to the region in January 2019.
- North Sound (Island, San Juan, Skagit, Snohomish, and Whatcom counties) (implemented July 2019)
- Pierce (Pierce County) (implemented January 2019)
- Salish (Clallam, Jefferson, and Kitsap counties) (implemented January 2020)
- Southwest Washington (Clark, Klickitat, and Skamania counties). Clark and Skamania were implemented first as AH-IMC in April 2016, called "early adopters." Klickitat was added to the region in January 2019.
- Spokane (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties) (implemented January 2019)
- Thurston-Mason (Mason and Thurston counties) (implemented January 2020)

Behavioral Health Services Only (BHSO)

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

Apple Health offers Behavioral Health Services Only (BHSO) statewide via the AH-IMC contract and the contracted AH-IMC MCOs. The same MCOs available to provide AH-IMC in a region are available for eligible clients to select for BHSO enrollment. BHSO eligible clients include:

- Individuals with primary insurance through Medicare (traditional or Part C), referred to as dual-eligible enrollees
- Individuals who are alumni of the state's foster care system or children who are receiving adoption support and have chosen to opt out of the AH-IFC program
- Certain individuals who have private insurance coverage such as employer-paid premiums (Premium Health Insurance Paid Program (PHIPP)).
- Clients with coverage requiring spenddown who have met their spenddown.
- American Indian/Alaska Native (AI/AN) clients may opt in or out of BHSO coverage at any time.

BHSO services are administered by MCOs with enrollee program code designation. Washington State operates BHSO services under a 1915b waiver and classifies BHSO as a Prepaid Inpatient Health Plan (PIHP) managed care program.

Apple Health Integrated Managed Care (AH-IMC) Wraparound

All contracted IMC plans are required to hold two contracts, one Medicaid AH-IMC contract serving AH-IMC and BHSO enrollees and another state-funded AH-IMC Wraparound contract supporting the same enrollees with non-Medicaid services. The AH-IMC Wraparound contract requires MCOs provide clinically appropriate non-Medicaid services to enrollees within available funding (e.g., room and board for behavioral health residential settings).

Apple Health Integrated Foster Care (AH-IFC)

Implemented in April 2016 due to legislative direction, this program provides services to children and youth in foster care, those receiving adoption support services (a program that removes barriers for families adopting children with special needs by providing ongoing medical and financial supports), and former foster care youth (referred to as alumni). It was initially implemented as a non-integrated program, called Apple Health Foster Care, providing physical health and some mental health services. In January 2019, HCA integrated the program according to Legislative direction to provide physical and behavioral health (mental health and substance use disorder treatment services) under one contract, called Apple Health-Integrated Foster Care (AH-IFC). HCA contracts with one MCO to provide this program statewide. The AH-IFC program administers benefits and provides enhanced health care coordination specifically focused to support the enrolled children, youth, and adults who are:

- Under the age of 21 in foster care (out-of-home placement) through Department of Child, Youth, and Families (DCYF)
- Under the age of 21 receiving adoption support services through the State of Washington
- Young adults in extended foster care (18-21 year olds) through the DCYF
- Young adults ages 18-26 who aged out of foster care on or after their 18th birthday (alumni)
- Children and youth reunified with their families (eligible for 12 months after foster care ends)
- AI/AN children and youth under Tribal jurisdiction who have opted into the program.

The AH-IFC program is a voluntary MCO program due to the Legislature opting to operate only one MCO choice for this population. DCYF determined it is in the best interest of children and youth in their care or custody to be enrolled in the single MCO, thus these clients are auto-enrolled into this program. Adoption support and alumni clients have the ability to opt out of the AH-IFC program into the fee-for-service delivery system for physical health benefits and enroll into one of the available AH-IMC MCOs of their choosing for Behavioral Health Services Only (BHSO) in order to receive behavioral health benefits.

Apple Health Integrated Foster Care (AH-IFC) Wraparound

The contracted AH-IFC plan is required to be contracted as an AH-IMC plan as well as hold two IFC contracts: one Medicaid AH-IFC contract and another state-funded AH-IFC Wraparound contract supporting the same enrollees with non-Medicaid services. Similar to the AH-IMC Wraparound contract, the AH-IFC Wraparound contract requires the IFC plan to provide clinically appropriate non-Medicaid services to enrollees within available funding (e.g., room and board for behavioral health residential settings).

Behavioral Health Administrative Services Organization (BH-ASO)

Washington State supports certain services be available to anyone regardless of their insurance status or income level. The crisis system managed previously by the Behavioral Health Organization is operated by a contracted entity in each region called a Behavioral Health Administrative Services Organization (BH-ASO). BH-ASOs provide crisis services to any individual in the region, including MCO-enrolled individuals experiencing a behavioral health crisis. Crisis services are provided regardless of residence, income, insurance status, or ability to pay. In addition, these entities administer services such as:

- 24/7 regional crisis hotline for mental health and substance use disorder treatment crises
- Mobile crisis outreach teams
- Short-term substance use disorder treatment crisis services for individuals who are intoxicated or incapacitated in public
- Application of behavioral health involuntary commitment statutes, available 24/7 to conduct Involuntary Treatment Act (ITA) assessments and file detention petitions
- Regional behavioral health Ombuds
- Outpatient behavioral health services and voluntary psychiatric inpatient hospitalizations for individuals who are not eligible for Apple Health, at the discretion of the BH-ASO and within available funding

The BH-ASO is not a managed care entity required to be covered by the Quality Strategy and is included in this description for informational purposes. Crisis services provided to Apple Health enrollees are contracted through the MCOs and thus HCA holds MCOs to quality requirements affecting the crisis system. As true with all subcontracted functions, MCOs are then required to hold their subcontractors accountable as necessary to uphold the HCA-MCO contractual agreements.

Primary Care Case Management (PCCM) Entities

HCA contracts with tribal clinics and Urban Indian Health Centers to provide Primary Care Case Management (PCCM) services for American Indian/Alaska Native (AI/AN) clients. Federally, they are classified as PCCM Entities, per 42 C.F.R. 438.2, due to the additional coordination support available. They are subject to federal regulatory requirements that apply to PCCM Entities; however, are not subject to Quality Strategy oversight as these contracts do not include language about financial rewards based on quality performance. States contracting with PCCM entities whose contracts with the State provide for shared savings, incentive payments or other financial reward for the PCCM Entity for improved quality outcomes are required to provide External Quality Review (EQR) oversight, QAPI program contractual requirements, and incorporation within the Quality Strategy (42 C.F.R. 438.310(c)(2)).

Table 2: Apple Health managed care delivery system programs.

Managed Care Delivery System			Population Served				
Contract Name	Funding Source	Type of Managed Care program (42 C.F.R. §438.2)	Apple Health Integrated Managed Care enrollees, including blind/disabled, CHIP, TANF,	BHSO enrollees (e.g., Medicaid/Medicare dual eligible, those who have opted out of IFC)	Integrated Foster Care enrollees in DCYF foster care, receiving adoption support, and alumni of DCYF foster care	Clients not eligible for Medicaid	American Indian/Alaskan Native (AI/AN) Apple Health clients
IMC	<ul style="list-style-type: none"> Medicaid 	MCO (IMC) & PIHP (BHSO)	X	X			X
IMC Wraparound	<ul style="list-style-type: none"> General Fund State Proviso State Funds 	none	X	X			X
IFC	<ul style="list-style-type: none"> Medicaid 	MCO			X (v)		X
IFC Wraparound	<ul style="list-style-type: none"> General Fund State Proviso State Funds 	none			X (v)		X
BH-ASO*	<ul style="list-style-type: none"> Substance Abuse Federal Block Grant Mental Health Federal Block Grant General Fund State Proviso State Funds 	none				X	
PCCM	<ul style="list-style-type: none"> Medicaid 	PCCM Entities					X

(v) Note the IFC program is voluntary. Adoption support and alumni may opt out into the fee-for-service program for physical health benefits and enroll in a BHSO of their choosing for behavioral health benefits.

* This grid reflects the contracts HCA holds directly for population and contract clarity. The BH-ASOs are also mandatory delegates within the IMC and IFC programs as they provide critical services to Apple Health (Medicaid) enrollees (i.e., crisis and Ombuds).

Quality Organizational Structure

The lead HCA division for Apple Health managed care contracts implementation and oversight is Medicaid Program Operations and Integrity (MPOI), which secures managed care contracts through a competitive procurement process, implements new programs and benefits, manages day-to-day operations, and monitors compliance. MPOI staff works across HCA and between state agencies (e.g., Department of Health, Department of Social and Health Services) in partnership with health care providers and community stakeholders to develop and manage high-quality, evidence-based, health care programs and purchasing of services that enhance Apple Health clients' ability to access appropriate, quality health care. Cross-collaboration is crucial to maintaining strong managed care programs and support strong quality initiatives.

In 2017, the HCA Clinical Quality and Care Transformation (CQCT) Division formed a committee structure to inform HCA's Chief Medical Officer (CMO) in quality initiatives, focusing on the selection of valid, reliable, evidence-based performance measures for Apple Health and other purchasing programs for both reporting purposes and ties to payment and value. The CMO is advised by research and analytical expertise from a cross-divisional clinical data team and by an operations workgroup, the clinical implementation team. A Clinical Quality Council reviews team guidance and makes recommendations to the CMO.

HCA Interagency Quality Measurement Monitoring and Improvement (QMMI) Committee

The purpose of the interagency Quality Measurement Monitoring and Improvement (QMMI) committee is to create a healthier Washington by moving the delivery system to a single standard of measurable, evidence-based, high quality care. HCA develops clinical policies and manages care using data-driven, population-oriented strategies that are mirrored by the programs with which HCA contracts. With this structure in place, the agency can use a single, measurable standard of evidence-informed high-quality care; address identified gaps in quality through program requirements; work to create a single standard of metrics across HCA programs; use the ability to see that quality is improving, and see that programs are addressing gaps observed in the measures.

The following goals define the overall purpose of the QMMI process to achieve a single, measurable standard of evidence-informed high quality care:

- Systematically monitor clinical quality measures
- Select, implement, complete, and monitor QMMI quality activities and initiatives
- Identify and monitor emerging clinical issues to gauge QMMI action, and
- Lead clinical quality contracting and measurement to drive quality performance through state purchasing contracts.

As a result of partner efforts, the agency has created a list of measures for statewide reporting in Apple Health, Public Employee and School Employee Benefits Board contracts, and value-based purchasing. 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.

The QMMI objectives for projects include establishing metrics, monitoring performance, and advancing improvement in health care and health systems outcomes—especially those that drive towards equity and support improving social determinants of health.

When selecting measures for use with contracts, QMMI considers whether the measure has potential to:

- Improve health outcomes
- Increase alignment across state contracts
- Decrease the administrative burden of measurement, and
- Decrease/avoid unintended consequences.

Review and Approval of the Quality Strategy

With each update of the Quality Strategy, Washington distributes the draft for both internal and external review and feedback from a variety of stakeholders. Modifications to the Quality Strategy are made in response to public comments, stakeholder and partner feedback, and any Apple Health contract amendments. Since its last Quality Strategy submission, submitted to CMS on 9/29/17 with receipt of CMS approval in October 2017, the Washington Medicaid program has undergone a number of significant changes. Most notably, the managed care program became integrated statewide effective 1/1/2020.

In addition to publicly posting the draft Strategy, the draft is discussed and reviewed with clinical and quality leadership within HCA (QMMI), the Medical Care Advisory Committee (Washington’s Title XIX Committee), tribal representatives through the Tribal Consultation process, quality leadership of the MCOs, and HCA Executive Leadership.

After considering input from these groups, final approval for agency adoption is determined by the HCA Delivery System Leadership Committee (DSLCL). The final Quality Strategy and supporting reports and documents are then available at the following web-link:

HCA site: <https://www.hca.wa.gov/about-hca/apple-health-medicaid-and-managed-care-reports>

Copies of the final Quality Strategy are provided to all contracted managed care programs.

Quality Strategy Effectiveness Analysis

Washington’s annual External Quality Review (EQR) Technical Report summarizes findings on access and quality of care including a description of the manner in which the data from all activities conducted in accordance with CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by contracted managed care programs.

Significant Changes to the Quality Strategy

In addition to the triannual update, the Quality Strategy is updated when there is a significant change to Washington’s Apple Health Program. A significant change is defined when at least one of the following actions occurs:

- Re-procurement of the Apple Health contract;

- Addition of a new population to the Apple Health program (NOTE: addition of a new population will not trigger a new Quality Strategy when the existing Quality Strategy activities sufficiently monitor the new populations, and additional substantive monitoring activities are unnecessary).
- Addition of a new group of services to the Apple Health program; or
- A change to CMS or state regulations that impact the Washington Managed Care Quality Strategy.

CMS Review

Following public input, the draft quality strategy is submitted to CMS for review according to CFR 438.340(3)(i)(ii).

Section III: Assessment Activities

There are several mechanisms HCA uses to monitor and enforce MCO compliance with the standards set out within this Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care beneficiaries. The following sections provide an overview of the key mechanisms utilized to enforce these standards and identify ongoing opportunities for improvement.

Quality and Appropriateness of Care

To monitor quality of services provided, ensure the accuracy of reporting, and analyze appropriate comparative information about all MCOs and PIHPs, HCA:

- Reviews MCO interim and annual performance against measure benchmarks;
- Requires, reviews and approves each MCO's QAPI, including how the MCO will assess and improve upon its own performance against its QAPI program on an annual basis;
- Conducts structured annual monitoring;
- Sets parameters for the performance improvement projects (PIP) described in the "Strategies and Interventions that Support Quality" section of this report, including changes to such programs based on Agency-identified quality priorities and opportunities for targeted improvement;
- Conducts regular MCO All-Plan meetings, to engage with MCOs, address issues as they arise, and provide technical assistance;
- Reviews all accreditation and EQRO compliance reports to determine areas of deficiency. If needed, HCA will establish MCO corrective action plans and monitor to ensure that the action plans are implemented.
- HCA works closely with the EQRO to develop and understand opportunities for improvement as a result of the EQRO's data analyses and identification of health disparities with resulting recommendations;
- Publishes managed care performance data in order to promote transparency, and to provide stakeholders and partners with the opportunity to assist in identifying opportunities for improvement;
- Designs and administers the Value-Based Purchasing program discussed later in this report; and

- Utilizes the EQRO quality performance reports, to drive improvement and performance against the Quality Strategy.

External Quality Review Organization (EQRO) functions related to Access, Timeliness, and Quality

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review (EQR) of health care services provided to enrollees, to assess the accessibility, timeliness, and quality of care they provide. EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQR must address in a manner consistent with CMS protocols.

MPOI conducts federally-required External Quality Review activities and is responsible for the contract with the agency's contracted External Quality Review Organization (EQRO) as required by 42 CFR Subpart E. An EQRO is an organization that meets the competence and independence requirements set forth in 42 C.F.R. 438.354. MPOI is responsible for ensuring the EQRO has sufficient information to perform the contracted EQR activities and all EQR activities are publically posted on an annual basis to the HCA website

Federal regulations requires states to contract with an EQRO to produce an annual Technical Report addressing each of the Medicaid managed care plans and EQR activities conducted. The annual technical report that is produced by the EQRO summarizes findings on access and quality of care, including:

- A description of the manner in which the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality of care provided by each MCO;
- An assessment of each MCO's strengths and weaknesses for the quality of care provided;
- Recommendations for improving the quality of health care services provided by each MCO; and
- Comparative information about all MCOs

The state may opt to perform the EQRO activities, mandatory or optional, or may contract them to an EQRO or another entity. See Table 3 for EQR mandatory and optional activities and which entity performed the activity.

HCA follows CMS External Quality Review Protocols for EQR activities, which can be found at Quality of Care External Quality Review at Medicaid.gov: (<https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>).

The State may exempt an MCO from EQR requirements if the following conditions are met (42 C.F.R. 438.362):

- 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.

Accessing Reports

Reports produced by the EQR are placed on the HCA website below. The Technical Report is available within the “External Quality Review (EQR) annual reports (technical report)” section (42 C.F.R. 438.350): <https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports>

HCA 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 (42 CFR 438.364(c)(2)(ii)). Requests should be directed to HCA’s public disclosure process: publicdisclosure@hca.wa.gov

Table 3: EQR Activities

EQR Activity (Activities are as allowed by 42 CFR 438.358)	CMS Requirement Status	Apple Health MCO	Apple Health PIHP
1. Technical Report	Mandatory	EQRO (Mandatory to be contracted out to EQRO and be one overall report)	
2A. Compliance Review <i>*TEAMonitor review</i>	Mandatory	HCA	HCA
2B. Selected contracted elements of the Compliance Review: Health Information Systems	Mandatory	EQRO	EQRO
3. PIP: Performance Improvement Project Validation <i>*TEAMonitor review</i>	Mandatory	HCA	HCA
4. Performance Measure Validation	Mandatory	EQRO	RDA
5. Network Adequacy Validation	Mandatory activity to be contracted out to EQRO once CMS protocol released	HCA	HCA
6. Quality Rating System	Mandatory	EQRO	EQRO
7. Focused Quality Studies on Clinical Area	Optional	EQRO	EQRO
8. Surveys: Consumer survey to assess quality of care <i>*Consumer Assessment of Healthcare Providers & Systems (CAHPS)</i>	Optional	EQRO	N/A

Description of Activities in Table 3

Technical Report

The Technical Report reflects on the performance across Medicaid managed care programs in the state as required by CFR, addressing all MCO and BHSO enrollees. Data related to the quality, timeliness, and

access to care furnished by Medicaid managed care is analyzed and synthesized into an annual report for HCA, CMS, Apple Health Medicaid managed care contractors, and stakeholders. This report must be performed by the state's contracted EQRO, be available online, and be submitted to CMS by April 30th annually. The Technical Report is written in accord with 42 C.F.R. § 438.364, External Quality Review Results, and include EQRO-contracted findings as specified by C.F.R. as well as EQR activities conducted by the state, such as compliance monitoring and PIP validation. The technical report includes all EQR-activities conducted and includes:

- a. A section that addresses the effectiveness of the state's quality strategy and determine whether any updates to the quality strategy are necessary based on the results of the EQR.
- b. An assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Apple Health recipients;
- c. Recommendations for improving the quality of health care services furnished by each MCO;
- d. Methodologically comparative information about all MCOs; and
- e. An assessment of quality of data collected and recommendations regarding improving data collection and usability to improve performance improvement both for the state and MCOs.

Compliance Review: TEAMonitor

The compliance review is required to ensure the plan follows the State Standards required by CMS, including the following areas (see State Standards section for details). In addition to the CMS requirements, this is also a mechanism used to hold the managed care plans accountable to contractual expectations.

- a. Availability of services (§ 438.206)
- b. Assurance of adequate capacity and services (§ 438.207)
- c. Coordination and continuity of care (§ 438.208)
- d. Coverage and authorization of services (§ 438.210)
- e. Provider selection (§ 438.214)
- f. Confidentiality (§ 438.224)
- g. Grievance and appeal systems (§ 438.228)
- h. Subcontractual relationships and delegation (§ 438.230)
- i. Practice guidelines (§ 438.236)
- j. Quality Assessment and Performance Improvement (§ 438.330)
- k. Health information systems (§ 438.242)

Performance Improvement Project (PIP) Validation

The MCRA Section performs validation of MCO/PIHP clinical and non-clinical performance improvement projects annually to address clinical and non-clinical areas of focus to improve the quality-of-care provided. MCO's are required to conduct PIPs designed to improve the quality-of-care or services received by managed care recipients. PIPs are reviewed as part of TEAMonitor.

The MCO must demonstrate that they have an ongoing program for PIPs that involves all of the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning & initiation of activities for increasing or sustaining improvement.

Each MCO's performance is trended and monitored so that both the quality of the PIP program and whether identified PIP projects are actually producing sustained improvements can be determined.

Performance Measure Validation

HCA conducts annual validation of performance measures as required by CFR. NCQA HEDIS® rules do not allow inclusion of all members, so handling of performance measures and the validation of them must be handled separately to ensure compliance with CFR, as follows:

MCOs: The EQRO conducts annual monitoring and validation of MCO Performance Measures via the Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit following methods described in the most recent version of the National Committee for Quality Assurance (NCQA) HEDIS® Compliance Audit™.

- Measures: Medicaid HEDIS measures are updated annually based on NCQA HEDIS Technical Specifications and are listed in the MCO/HCA contracts.
- Populations: HEDIS reporting follow NCQA requirements and include all enrollees NCQA allows, including AH-IMC, AH-IFC, and CHIP. BHSO enrollees are not eligible for inclusion per NCQA rules due to the scope of BHSO benefits.
- Report: The EQRO produces a HEDIS Audit report which addresses the validation of performance measures.

PIHPs: DSHS Research and Data Analysis (RDA) conducts annual monitoring and self-validation of PIHP Performance Measures as approved by the state's 1915b waiver.

- Populations: BHSO enrollees are included for these measures to ensure there is focus on how the overall system is serving this specialty population.
- Report: The EQRO includes results of RDA's validation within the Technical Report.

Network Adequacy Validation

Managed care plan networks are monitored by MPOI. This requirement is to verify managed care plan networks, and make the results of the review accessible to the public within the Technical Report. Mandatory activity to be contracted out to EQRO once CMS protocol released. This activity requires the EQRO to review the prior 12 months and is required for implementation within one year after CMS' release of a new EQR protocol.

Quality Rating System (438.334)

This is a requirement to display the ratings of each Medicaid managed care program and make that information accessible to the public. States must implement this within three years after CMS releases guidance on measures and methodology.

HCA developed an Enrollee Quality Report prior to the release of this CFR requirement, which serves the same purpose: to provide MCO information about quality of care and consumer experience to clients who are choosing a plan on the Health Benefit Exchange website. It is also provided to new enrollees within the Welcome to Apple Health Member Handbook. This report is labelled the Washington Apple Health Plan Report Card for easy reference (informally termed the “Star Report”). Until CMS releases the Quality Rating System guidance, Washington State continues to annually produce the Enrollee Quality Report to inform clients about managed care options.

Focused Quality Studies on Clinical Area

CFR allows states an optional EQR activity to perform an in-depth look at how specific clinical areas of the managed care program are performing.

- a. Study: The T.R. settlement negotiations agreed upon quality oversight of the Wraparound with Intensive Services (WISe) benefit in order to support continuous quality improvement, which HCA implemented through the EQRO contract.
- b. Populations: This addresses all Medicaid program types served with the WISe program, including AH-IMC, CHIP, AH-IFC, and BHSO programs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

CFR allows states another optional EQR activity to provide information about consumer experience within health plans. HCA requires MCOs to perform an NCQA CAHPS survey annually as part of the contractually-required NCQA accreditation. Quality improvement efforts can then target low performing or meaningful areas of consumer issues to improve the health care experience.

- a. Study: Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
- b. Populations: CAHPS surveys follow NCQA protocol and include all enrollees NCQA allows for the specific survey, including AH-IMC, AH-IFC, and CHIP. BHSO enrollees are not eligible for inclusion per NCQA rules due to the scope of BHSO benefits.
- c. Survey: The specific CAHPS survey is specified in the Apple Health and EQRO contracts to assess enrollee experience.

Compliance Monitoring: TEAMonitor

Federal requirements mandate compliance monitoring every three years as a mandatory EQR activity. Additionally, federal regulations require Readiness Review monitoring prior to newly implemented contracts (42 CFR, Part 438, Subpart E). HCA opts to conduct more frequent monitoring by performing annual TEAMonitor reviews and adding a Technical Assistance Monitoring (TAM) review for new contracts. Medicaid Compliance Review and Analytics (MCRA) staff coordinate and manage the formal compliance monitoring, termed TEAMonitor in Washington, including the use of three types of reviews.

Readiness Review (RR) Process (42 CFR 438.66(d)):

The first type of review is the Readiness Review, which is an evaluation of Apparently Successful Bidder (ASB, e.g., an MCO) readiness to implement a new program before a contract goes into effect to determine if the organization is prepared for the new contract requirements. The Readiness Review allows HCA to verify if an organization is ready for a new contract, such as when a region transitioned to the integrated care system. This review occurs before the contract is signed to verify the MCO understands the expectations and documentation reflects this. Below is the process used for the Readiness Review activities:

- HCA sends each ASB the Readiness Review documentation requirements. The requirements cover areas of implementation required by CFR and additional areas of Contract. Each element must be addressed sufficiently for program implementation for the ASB to pass Readiness Review and are scored as met, partially met, or not met. Not met elements prevent the organization from passing the Readiness Review and HCA does not offer the contract for signature.
- ASBs submit the required documents back to HCA for review.
- HCA reviews all documents submitted and identifies any deficiencies. Deficiencies are communicated verbally to each ASB during on-site visits and in writing in Initial Readiness Review Reports sent to ASBs after the on-site visit.
- ASBs respond to identified deficiencies. HCA reviews the secondary submission following the Initial Readiness Review Report to ensure all deficiencies were addressed sufficiently for implementation.
- A final Readiness Report is sent to each ASB prior to system and program implementation. All Final Reports either approve, approve with corrective action, or disapprove the ASB for program go-live.
- Elements requiring corrective action or additional follow up are identified in the Final Report.
- Technical assistance and monitoring of implementation activities continue before and after implementation to address emerging issues.
- The agency submits a report to CMS on the program's state of readiness prior to system and program implementation.

Technical Assistance Monitoring (TAM) Review Process:

Technical Assistance Monitoring (TAM) reviews are the next type of review, which HCA conducts approximately three to six months after the start of a new contract to monitor how the Contractor is performing new work, in order to provide technical assistance and provide early information about how Contractors are performing. TAM reviews are performed early into a new contract to monitor how the MCO is performing the new work. This review process is similar to the Readiness Review process, and acts as a follow-up to the Readiness Review. The Contractors submit documentation to show their understanding of elements of the new work, and that demonstrates how the new contract was incorporated into their policies or was implemented for their enrollees. This includes updated documentation regarding elements that were not fully resolved during Readiness Review. MPOI reviews the documentation and provides feedback and scores.

The TAM scoring process is similar to the Readiness Review process, using a Met, Partially Met, and Not Met scoring system. A "Met" score means the reviewer determined the submitted response met all aspects of the requirement and the organization is compliant with the contractual obligation. A "Partially Met" score means the organization provided some information showing understanding and partial

compliance; however, the organization did not fully meet the requirement. A “Not Met” score signifies that the organization did not meet the contractual requirement or missed a significant aspect. Scores that are “Partially Met” and “Not Met” are discussed during the on-site visit and follow-up is required. During the on-site visit, findings and interview questions to key staff at the MCOs are discussed, giving an opportunity to provide technical assistance, provide additional context about findings, and receive feedback about program status. For elements that are Partially Met or Not Met, MCRA provides technical assistance, specifies follow up at the next review, or requires corrective action depending on the severity of the finding. Significant non-compliance or enrollee care concerns receive corrective action.

TEAMonitor Review Process (42 CFR 438.358(b)(3)):

The third type of review is the annual TEAMonitor review to monitor how the Contractor performed during the previous year and determine compliance with contractual obligations. TEAMonitor is an annual review, and includes policy document review, enrollee-specific file review, and an on-site review. TEAMonitor monitors for compliance with contractual obligations already in place. HCA reviews the contract for policies and requirements that were new for the last year, and includes requests for documentation supporting the organization’s understanding and implementation of that policy and/or requirement. Corrective action plans from the prior year’s review are also reviewed for completion. The on-site review includes discussion of findings from the document and file reviews and questions that have arisen after the request for documents was sent.

The TEAMonitor scoring process is similar to the TAM process, using a Met, Partially Met, and Not Met scoring system; however, all findings scored as Partially Met and Not Met elements require corrective action. During the on-site visit, findings and interview questions to Contractor key staff are discussed, giving an opportunity to provide technical assistance, provide additional context about findings, and receive feedback about program status.

If an organization’s submitted information does not meet the requirement, the organization is provided that feedback and a correction is required. At this time, the organization may ask for technical assistance from HCA, and that assistance can be provided either in a conference call or during another on-site visit. This information is requested again in the next year’s TEAMonitor review to ensure compliance and documentation from the organization reflect this. Topics that cannot wait for the next year’s process are addressed outside of the process and followed up at the frequency the concern demands.

TEAMonitor Compliance Monitoring

The formal compliance monitoring process is conducted by a multidisciplinary team of staff responsible for formally monitoring MCOs. TEAMonitor includes subject matter experts from across the agency as well as the Department of Social and Health Services for specialty expertise.

MCRA staff are responsible for:

- Development of an annual, on-site contract monitoring schedule;
- Collection of MCO/PIHP material (for the desk review portion of a monitoring review);
- Development and maintenance of a secure website for document collection;
- Development of interview questions for key MCO/PIHP staff during the on-site visit;
- Methods of evaluation, including development of standardized monitoring tools, guidelines, checklists, scoring tools, and report formats; and
- Assignment of expert reviewers to assess MCO/PIHP’s compliance with standards
- Technical assistance, quality improvement, and corrective action plans

TEAMonitor uses standardized guidelines and checklists to ensure consistency in the monitoring review process. TEAMonitor's contract monitoring adheres to 42 CFR 438.358(b)(3), Activities Related to External Quality Review (see State Standards section for details). The monitoring review process uses standards, methods, and data collection tools from the federal Department of Health and Human Services (DHHS) monitoring protocols (42 CFR 438.352).

When necessary, HCA imposes corrective actions and appropriate sanctions for standards not in compliance. MCOs and PIHPs are required to correct deficiencies and MPOI tracks corrective actions to ensure compliance.

Following completion of a monitoring review, a TEAMonitor compliance monitoring compliance report is sent to each MCO/PIHP. The compliance 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 required for areas that have deficiencies identified.

Corrective Action Plans (CAP) are required from the MCOs and PIHPs when deficiencies are identified. CAPs are due from MCO's and PIHPs approximately thirty 30 days after the receipts of the TEAMonitor report. CAPs are reviewed by TEAMonitor staff. 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.

Corrective actions are tracked by the MCRA team until completion. The MCRA 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/PIHPs (which may generate a targeted review), new contract requirements, statewide issues, or a particular focus area. For example, TEAMonitor focused on Care Coordination case files to ensure MCOs implemented new contractual requirements correctly.

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

In addition to the federally required EQR activities, HCA's MPOI division monitor compliance directly through ongoing desk reviews of policies and procedures, including grievances, fraud and abuse, credentialing, 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.

Nonduplication of EQR activities (438.360)

Additional standards and monitoring guidelines such as those promulgated by the National Committee for Quality Assurance (NCQA) and HCA standards and guidelines are 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. HCA requires MCOs to be NCQA accredited and tracks NCQA standards for impact, duplication, and conflict with Medicaid and Contractual requirements. HCA actively seeks administrative simplification and alignment between NCQA and contractual requirements when programmatic appropriate to do so and allowed by CMS. HCA

contractually requires MCOs to allow HCA observers at the NCQA accreditation reviews and MPOI staff attend these to inform monitoring practices, EQR activities, and ensure duplication is avoided.

Section IV: Strategies and Interventions that Support Quality

Quality Assessment and Performance Improvement (QAPI)

To complement activities associated with the Quality Strategy, and in alignment with Washington's Quality Strategy Aim #4—"Demonstrate Continuous Performance Improvement", each MCO maintains and operates its own QAPI program as required by 42 CFR 438.330. Each MCO is required to have one QAPI program for all services it furnishes to its Enrollees. As required by each Apple Health managed care contract, the MCO must define its QAPI program structure and process, and assign responsibility for the QAPI program to appropriate individuals.

Each MCO QAPI program structure must include at least the following elements:

- Assessment of the quality of care received by enrollees, as measured by HEDIS® and other quality performance measures;
- Goals and interventions to improve the quality of care received, including primary care and behavioral health bi-directional clinical integration;
- Assessment of health equity, including identification of health disparities;
- Service to a culturally and linguistically diverse membership;
- Service to members with complex health issues and special health care needs;
- Patient safety initiatives and tracking of the critical incident management system;
- Inclusion of enrollee voice and experience, which may include consumer surveys, grievances, and feedback from Ombuds process;
- Inclusion of provider voice and experience, which may include feedback through involvement in Contractor committees, provider complaints, provider appeals and surveys;
- Involvement of a designated physician in the quality improvement (QI) program, including involvement of designated behavioral health care provider; and
- A quality improvement committee that oversees the quality functions of the Contractor.

The MCO Quality Improvement Committee must:

- Include practicing provider participation;
- Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data, and performance improvement;
- Institute actions to address performance deficiencies, including policy recommendations; and
- Ensure appropriate follow-up.

MCOs must maintain written QAPI program descriptions that include the following:

- A listing of all quality-related committee(s);
- Descriptions of committee responsibilities and oversight;
- Contractor staff and practicing provider committee participant titles;
- Meeting frequency;
- Maintenance of meeting minutes, signed and dated reflecting decisions made by each committee, as appropriate;

- All contractually required elements of the QAPI program structure;
- Proposed methods to meet the requirements under the Contract to evaluate and report performance measure results in a manner that distinguishes individuals who have indicators of need of mental health and/or substance use disorder treatment; and
- Processes for monitoring, aggregating, and presenting information regarding physical and behavioral health providers for provider groups with at least 1,000 Enrollees, Performance in a Provider Performance (PPP) format that encourages self-correction and includes, but is not limited to performance relative to:
 - Adherence to applicable evidence-based practices and practice guidelines;
 - Appointment access standards; and
 - Utilization and quality metrics such as readmissions, average length of stay, and transitional health care services to ambulatory services.
- Compliance with all quality management requirements stipulated by settlement agreements.
- A sufficient number of physical health and behavioral health staff members to completely implement all QAPI program requirements on a timely basis.

An annual quality work plan is due from each MCO. The work plan is required to contain:

- Goals and objectives for the year, including objectives for patient safety; how the MCO plans to serve a geographically, culturally and linguistically diverse membership; and how the MCO plans to address individuals with special health care needs, health equity issues, and health care under- and over-utilization;
- Timeframes to complete each activity;
- Mechanisms that the MCO will use to assess the quality and appropriateness of care furnished to enrollees in the culturally and linguistically diverse membership, including individuals with special health care needs and identified health equity concerns; and
- Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of the MCO's quality goals and objectives.

Each MCO provides an annual written QAPI Program Evaluation that provides an overall report of the effectiveness of the MCO's QAPI program. The report reflects on required quality improvement program structure and activities in the work plan and includes at a minimum:

- Analysis of and actions taken to improve health equity;
- Inclusion of consumer voice;
- Contractually required HEDIS performance measure and utilization data pictorially displayed using charts and graphs, trended over time and compared against the Medicaid NCQA 90th percentile and Washington State average. Both clinical and non-clinical performance measures must be trended and evaluated in the MCO report;
- Accompanying written analysis of performance, including data comparisons to the Medicaid NCQA 90th percentile and Washington State average;
- Findings on quality and utilization measures and completed or planned interventions to address under or overutilization patterns of care for physical and behavioral health.
- An evaluation of the impact of interventions, including any planned follow-up actions or interventions;
- A written assessment of the success of contractually required performance improvement projects.

As part of the findings on quality and utilization measures, the following measure set is reported in the annual QAPI program evaluation regarding under- and over-utilization:

- Preventable hospitalizations, including readmissions;
- Avoidable emergency department visits;
- Early Periodic Screening, Diagnosis, and Treatments (EPSDT) or well-child care;
- Childhood and adolescent immunizations;
- Mental health treatment penetration;
- Adult Access to Primary Care;
- Prenatal and postpartum care; and
- Comprehensive Diabetes Care.

Performance Improvement Projects (PIPs)

HCA both values and expects its contracted Managed Care Organizations to manage effective Performance Improvement Programs that demonstrate the ability to develop and execute effective projects in alignment with Washington Quality Aim #4—“Demonstrate continuous performance improvement”. Through the use of PIPs, HCA is looking to see that MCOs develop quality improvement projects that demonstrate measurable quality improvement. MCOs are required to manage and implement an ongoing program of PIPs that focus on clinical and non-clinical areas for both MCO and BHSO programs. Federal requirements mandate states perform validation of PIPs conducted. HCA performs PIP validation and additionally requires MCOs to submit PIPs proposed for the upcoming year for review, feedback, and approval. HCA assesses for the area of focus, design and implementation, and evaluation methodologies.

Each PIP must be designed to achieve significant improvement in health outcomes and Enrollee satisfaction, and include the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures; and
- Planning and initiation of activities for increasing or sustaining improvement.

One approach used by Washington for managed care quality improvement, through the use of PIPs, has focused on the opportunity to create greater alignment between and across MCOs. Benefits to an aligned approach include:

- Quicker decisions and decreased time to execution;
- MCOs focus limited resources on the right activities to promote growth and decrease costs while increasing performance;
- Improved MCO self-governance;
- Ensuring that MCO processes consistently deliver what is expected;
- Every function delivers to a common strategy; MCOs can deploy duplicate resources to strategic challenges; and,
- MCOs can better anticipate the outcomes of changes which leads to safer risk-taking.

In 2012, HCA created a collaborative PIP in which the state required the topic and all MCOs were required to collaborate to move statewide Medicaid performance with DOH facilitating the improvement effort. This has supported the MCOs in collaboration and working together on other quality initiatives. This also

allows HCA to take steps to address common challenges among MCOs by capitalizing on individual plan best practices and facilitating information-sharing amongst MCOs.

MCOs must have an ongoing program of PIPs that focus on clinical and non-clinical areas. The MCO must report the status and results of all required clinical and non-clinical performance improvement projects to HCA, as required by 42 CFR 438.330(c)(3). On an annual basis, the MCO must submit current year PIP proposals to HCA. Each completed project is documented on a PIP Worksheet that is found in the CMS protocol entitled "Conducting Performance Improvement Projects."

MCO contracts specify which clinical and non-clinical PIP activities are required as areas of focus. An example of a specific list of required PIPs can be found in the AH-IMC model contract section 7.2 at the following link: www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf

Performance Measure Alignment

Formed by the HCA Executive Leadership Team, QMMI, guided by a Clinical Quality Council (CQC), selects measures to include in Apple Health and PEB managed care contracts for annual MCO reporting. Measures are selected based on the needs and risks of the populations served.

The measures in the Statewide Common Measure Set (SCMS) are defined and recommended by the legislatively-created statewide Performance Measure Coordinating Committee (PMCC). The SCMS are evidence-based Clinical Performance Measures. 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.

Statewide common measures are excluded from Apple Health managed care contracts. Measures are excluded for the following reasons:

- 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 (BRFS) 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 Gross Domestic Product. The HCA Finance Division calculates this measure.

Medicaid Transformation

A few years ago, HCA started looking for new ways to improve the care given to Apple Health members. By working directly with community members and across departments in state government, HCA arrived at the following goals for improving the care provided by Medicaid:

- Provide individuals served by Apple Health with health care that is coordinated among care providers, in particular physical health providers (primary care, pediatrics, specialty care, etc.) and behavioral health providers (counseling, psychiatry, substance use disorder treatment, etc.);

- Change the way doctors and other care providers are paid by measuring and rewarding the quality of care individuals receive;
- Focus on caring for the whole person, including an individual's physical, emotional, and social health;
- Make care equally available to all Washington residents, including the most vulnerable for example, those who are homeless, unemployed, or incarcerated; and
- Provide more and better support to individuals as they grow older.

In 2017, Washington State and the Centers for Medicare and Medicaid Services (CMS) finalized an agreement for a five-year Medicaid transformation project to improve the state's health care systems, provide better health care, and control costs. Through December 2021, the state will receive up to \$1.5 billion in federal investment to restructure, improve and enhance the Apple Health (Medicaid) service delivery system. The emerging system draws strength, stability, efficiency and flexibility from state-community partnerships. These regional collaborations are streamlining delivery of person-centered, integrated health services, while also addressing social determinants of health, and holding down costs.

Medicaid Transformation is the result of a Section 1115 waiver, a contract between federal and state governments that waives certain Medicaid requirements, as long as the state can demonstrate the investment will be effective. Under Medicaid Transformation, the state can use Medicaid funds for innovative projects, activities, and services that would not otherwise be allowed. The funds are not a grant: the state must show that it will not spend more federal dollars on its Medicaid program than it would have spent without the waiver.

The goals for Medicaid Transformation are the following:

- Reduce avoidable use of intensive services and settings—such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports, and jails.
- Improve population health—taking specific aim at prevention and management of diabetes, cardiovascular disease, mental illness, substance use disorders, and oral health.
- Accelerate the transition to value-based payment—using payment methods that take into account the quality of services and other measures of value.
- Ensure Medicaid cost growth is below national trends—through services that improve health outcomes and reduce the growth rate of overall care costs.

Medicaid transformation will be accomplished primarily through the use of three initiatives:

- Initiative 1: Transformation through Accountable Communities of Health
- Initiative 2: Transformation through Long-term Services and Supports (LTSS)
- Initiative 3: Transformation through Supportive Housing and Supported Employment

Transformation through Accountable Communities of Health

This initiative lets communities improve the health system at the local level. Each region, led by its Accountable Community of Health (ACH), is pursuing Transformation projects, specific to the needs of its region. These projects focus on:

- Health systems and community capacity building—adopting a value-based payment system; developing the health care workforce, and making improvements in population health management, including enhanced data collection and analytic capacity.

- Care delivery redesign—integrating physical and behavioral health care, improving care coordination, making better transitions between services and settings, and improving diversion interventions (helping individuals access the most appropriate service or facility for their needs).
- Prevention and health promotion—focusing on opioid use, maternal and child health, access to oral health services, and chronic disease prevention and management.

Transformation through Long-Term Services and Supports

The state is creating a “next generation” system of care that supports families in caring for loved ones. This system is focused on delaying or avoiding more intensive long-term services and supports when possible, creating better linkages within the health system, and continuing a commitment to a robust system for those who need it.

This next generation will create a system of care that will:

- Provide additional options for individuals with long-term care needs that do not require them to impoverish themselves, or lose their estates.
- Increase access to services for individuals on the cusp of poverty, which may slow functional decline or need to seek out-of-home placement, as well as slow spend-down of resources.
- Slow the growth trend of the traditional Medicaid caseload.
- Provide family caregivers with supports and knowledge to continue providing unpaid care while also taking care of themselves.
- Assist individuals to remain in the setting of their choice for as long as possible.
- Support individuals using person-centered options counseling to utilize their limited resources to maintain independent living without Medicaid long-term services and supports.

New Programs include:

- Medicaid Alternative Care (MAC): benefit package for individuals who are eligible for Medicaid but choose not to access traditional Medicaid funded LTSS.
- Tailored Supports for Older Adults (TSOA): a new eligibility category and benefit category for individuals at risk of future need for Medicaid LTSS but who currently do not meet Medicaid financial eligibility criteria.

Benefits under these programs include:

- Caregiver assistance services
- Training and education
- Specialized medical equipment and supplies
- Health maintenance and therapies: clinical or therapeutic services for caregivers to remain in role or care receiver to remain at home
- Personal assistance services: services involving the labor of another person to help care receiver complete everyday activities in order to remain in their home.

Transformation through Foundational Community Supports: supportive housing and supported employment

Targeted supportive housing and supported employment benefits are available to Apple Health clients who are most likely to benefit. Initiative 3 is built around the growing body of evidence linking

homelessness and unemployment with poor physical and mental health. While Medicaid funds cannot be used to provide housing or jobs, supportive services can promote stability and positive health outcomes while preventing homelessness and dependence on costly medical and behavioral health care, and long-term institutional care.

The Foundational Community Supports (FCS) program is a component of Washington State's 1115 Waiver Medicaid Transformation Project. Launched in 2018, FCS provides statewide supportive housing and supported employment services to vulnerable populations with complex physical or behavioral health care needs. The primary goal of these services is to promote self-sufficiency, promote integration into the community, and reduce potentially avoidable use of more intensive services (i.e. eliminate the need for involuntary hospitalizations), by helping individuals with significant support needs obtain and maintain stable housing or competitive employment. To be eligible for these services, individuals must meet age criteria, have a behavioral health treatment need or qualifying physical disability, and meet at least one of the housing or employment risk criteria outlined below.

Eligible clients may access an array of person-centered housing and employment services following enrollment. Examples of services provided under FCS include helping clients identify and apply for housing or employment opportunities provided under FCS and providing ongoing supports following placement in a job or housing unit. The program type that the client is enrolled in (supportive housing, supported employment, or both) determines which services clients may access.

Peer Support Specialists with lived experience in recovery from behavioral health challenges often provide the Foundational Community Support services. "Peer Support" means services provided by certified peer counselors to Medicaid-enrolled individuals under the consultation, facilitation, or supervision of a Mental Health Professional or Substance Use Disorder Professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Clients actively participate in decision-making and the operation of the programmatic supports.

Risk Criteria for FCS Services

Supported Employment

- Unemployed for at least 90 consecutive days due to a mental or physical impairment.
- Inability to obtain or maintain employment due to age, physical disability, or traumatic brain injury.
- Receipt of inpatient substance use disorder (SUD) treatment services in the past two years.
- At risk of deterioration of mental illness or SUD.
- Behaviors or care needs that disrupt employment or schooling or have resulted in terminations from work and/or expulsions from school.

Supportive Housing

- Indication of chronic homelessness as defined in 24 CFR 578.3.
- History of frequent or lengthy stays in jails, behavioral health inpatient treatment facilities, hospitals, or skilled nursing facilities.
- Two or more adult residential care stays in the past 12 months.
- A Predictive Risk Intelligence System (PRISM) risk score of 1.5 or higher.

In passing Second Substitute Senate Bill 5732, the 2013 Washington State Legislature directed the Division of Behavioral Health and Recovery (DBHR) to increase the use and development of evidence-based, research-based, and promising practices in mental health and substance use disorder treatment services. Research links evidence-based practices to predictable, beneficial outcomes for participants. Programs that adhere closely to an evidence-based model are more effective than those that do not follow the model. In general, process measures provide an objective, structured way to determine if practices are consistent with ways that the current research has shown will result in desired outcomes. The use of fidelity scales assists with evaluation of how closely the evidence-based practice is being followed.

DBHR promotes a learning community approach to fidelity for supportive housing and supported employment services. Agencies may learn strategies from other agencies also experiencing the same challenges. Training events that promote the fidelity exist to share strategies to achieve outcomes based on thoroughly researched models. DBHR also uses fidelity reviews as a continuous quality improvement process to get the best outcomes from the FCS services that are provided. Fidelity to the FCS model is reviewed so that programs can identify their strengths as well as target their efforts to elements needing more support.

Delivery System & Provider Payment Initiatives

The five-year Delivery System Reform Incentive Payment (DSRIP) program is one of the foundations of Medicaid Transformation in Washington. DSRIP is a plan approved by the Centers for Medicare and Medicaid Services (CMS) that allows the state to support transformative community health projects.

Washington State is using DSRIP to invest in projects that will help doctors, clinics, hospitals, and other providers successfully adopt value-based payment (VBP) contracts with Medicaid MCOs. VBP contracts reward providers for delivering high-quality, integrated, coordinated, whole-person care, instead of simply the amount of care they provide.

Up to \$169 million over five years is available to reward regions for reaching VBP milestones. These milestones include integrating physical and behavioral health, and increasing VBP arrangements between providers and MCOs. Recipients may include ACHs, participating providers, and other partnering organizations. Examples of the various types of recipients include primary care providers, behavioral health providers, Indian Health Care Providers (IHCP), hospitals, health centers, and county and tribal governments.

HCA releases funds to regions on regular cycles, following the period of time in which the funds are earned. Initially, both VBP Incentives and Project Incentives are payments that reward reporting, known as Pay-for-Reporting (P4R). As the work progresses, payments increasingly become performance-based, known as Pay-for-Performance (P4P). P4R funds are earned by reporting progress on achieving project implementation milestones, whereas P4P funds are earned by meeting pre-determined performance or improvement targets.

Starting in early 2020, ACHs will receive annual VBP Adoption Incentives for achieving VBP milestones, and for earlier arrangements that were in place in 2018. In 2021, regions will begin receiving annual Project Incentives earned through P4P to reward performance achieved in 2019. The "lags" between earning funds and funds availability are based on the time required for data compilation and analysis, completed by HCA and an independent assessor.

Once funds are earned by a region, ACHs determine which partners will receive funds, when funds will be distributed, and in what amounts. Decisions are made openly and inclusively through consultation with regional partners and public meetings.

HCA releases each region's earned funds to a third-party financial executor based on the independent assessor's determination of regional achievement of the reporting and/or performance targets. The financial executor then distributes regional funds based on the ACHs' direction. The financial executor electronically transfers payments directly to the ACH-designated recipient. The ACH does not distribute funds directly to providers.

HCA's goal is to achieve a healthier Washington by containing costs while improving outcomes, patient and provider experience, and equity through innovative, value-based purchasing (VBP) strategies.

Washington has developed a document titled the "HCA Value-based Purchasing Roadmap", first published in 2016 and updated yearly. The roadmap lays out how HCA is changing the way that health care is delivered by implementing new payment models that encourage population-based care. The roadmap braids major components of payment redesign model tests, the Statewide Common Measure Set, ACHs Medicaid Transformation, and the Dr. Robert Bree Collaborative care transformation recommendations and bundled payment models. HCA built the roadmap upon the following foundational principles:

- Continually strive for smarter spending, better outcomes, and better consumer and provider experience.
- Reward the delivery of person-and family-centered, high-value care.
- Reward improved performance of HCA's Medicaid, Public Employee Benefits Board (PEBB), and School Employee Benefits Board (SEBB) programs and their contracted health systems.
- Align payment and delivery reform approaches with other purchasers and payers, where appropriate, for greatest impact and to simplify implementation for providers.
- Drive standardization and care transformation based on evidence.
- Increase the long-term financial sustainability of state health programs.

A primary strategy in achieving HCA's goal is capitalizing on the state's authority and purchasing power to advance Value-Based Purchasing (VBP).

As the largest health care purchaser in Washington State, HCA purchases care for more than 2 million Washingtonians through Apple Health (Medicaid), PEBB, and SEBB programs. Annually, HCA spends more than \$12 billion between the three programs. This gives HCA the market power to drive transformation as a convener and innovator.

HCA's vision for a healthier Washington in 2021 is that:

- All HCA programs implement VBP according to an aligned purchasing philosophy.
- Accountable delivery system networks and plan partners comprise most of HCA's purchasing business.
- HCA exercises significant oversight and quality assurance over its contract partners, and implements corrective action as necessary.

By 2021, HCA will tie 90 percent of payments made to providers for service delivery to quality, ensuring shared accountability for each patient's well-being and total cost of care. This requires thoughtful, evidence-based, collaborative management of physical, behavioral, and social determinants of health

needs. To move away from fee-for-service, HCA adopted the framework created by CMS through the Health Care Payment and Learning Action Network (LAN).

HCA is implementing a “one HCA” purchasing philosophy across Medicaid, PEBB, and SEBB programs. This philosophy ensures that HCA is holding business partners and servicing providers accountable to consistent standards, building on successes, and learning from challenges across agency programs.

Managed Care Organization Premium Withhold

HCA has set a target for 90 percent of provider payments under state-financed health care to be linked to quality and value by 2021. This includes Apple Health, through which HCA purchases health care for approximately 1.9 million Washingtonians. Implementing value-based contracts with the Apple Health MCOs is imperative to the state’s ability to achieve its purchasing goals by 2021.

HCA pays MCOs a per member per month (PMPM) premium rate that covers all of a client’s care. The MCOs pay providers with the premiums to perform services for Apple Health clients. To connect payment to quality of care and to value, HCA withholds two percent (2%) of an MCO’s monthly premium to be returned based on performance in the following areas:

- VBP arrangements with providers
- Qualifying provider incentives
- Achieving quality improvement targets

Over time, the withhold amount and benchmarks for each performance area may increase.

HCA has adopted the Health Care Payment Learning and Action Network (HCP-LAN) Framework created by CMS to define value-based payment. To meet HCA targets, at least one percent (1%) of premium payments must be incentives and disincentives in LAN category 2C or higher. Provider incentives are additional payments or withholds based on provider performance. Additionally, an MCO needs to pay at least 50 percent of provider payments in the form of VBP arrangements in LAN category 2C or higher, which is HCA’s definition of VBP. A third party reviews and validates the self-reported (by each MCO) provider incentive payments and VBP arrangements. Finally, MCOs must achieve the top national Medicaid quartile or demonstrate statistically significant improvement on select quality measures.

Alternative Payment Methodologies (APM4): Value-Based Payment for Federally Qualified Health Centers (FQHC)

Primary care providers offer some of the most innovative and integrated delivery models in the state, yet their reimbursement structure stifles further innovation. Face-to-face, encounter-based payments currently drive reimbursement for Federal Qualified Health Centers (FQHC), resulting in a system that creates an incentive to deliver care based on volume over value. While these statutory and regulatory requirements help to maintain access, these regulatory requirements make changes to payment especially difficult.

With strong support from these clinics, the state introduced a value-based alternative payment methodology in Medicaid for FQHCs and rural health centers. The model tests how increased financial flexibility can support promising models that expand care delivery. On July 1, 2017, 16 clinics began using a new alternative payment methodology for Medicaid managed care enrollees. The new model provided flexibility in delivering primary care services, expanded primary care capacity, and created financial incentives for improved health care outcomes while meeting federal requirements.

Alternative Payment Methodology 4 (APM4) supports FQHCs in the transition from an encounter-based reimbursement methodology to a value-based alternative payment methodology that rewards for quality of care provided to Medicaid managed care enrollees.

APM4 provides additional flexibility in delivering primary care services, expands primary care capacity, and creates financial incentives for improved health care outcomes while meeting federal requirements. This methodology allows participating providers to enhance their capacity for managing population health.

APM4 applies only to Medicaid managed care enrollees and does not include current managed care organization contractual arrangements or flow of payments. APM4 converts the entire encounter-based rate into a baseline per member per month rate, which is adjusted prospectively for trend and according to quality performance.

Within this basic framework, clinics perform annual reconciliation to ensure that federal reimbursement requirements are met. However, instead of resolving underpayments or overpayments through a settlement process, APM4 prospectively adjusts payments based on a clinic’s performance on quality measures. Given its experimental nature, APM4 is not mandated for all clinics and maintains an opt-in/opt-out approach.

APM4 allows clinics to improve access to care by focusing on improvement against specific quality measures and allowing clinicians to work at the top of their license. This payment methodology provides flexibility for primary care providers to have a larger member panel without the burden of increasing the number of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 also incentivizes alternatives to face-to-face visits and allows clinics to offer convenient access to primary care services.

Section V: State Standards

In an effort to provide adequate access to Washington’s Apple Health population, all CMS standards are listed below for Access, Structure and Operations, and Quality Measurement, with a description of how the corresponding contracts have operationalized the standard to ensure compliance with federal regulations. The specific Apple Health program which applies is listed in the left column, with explanation for operationalizing the standard within that program next to it, both listed below the applicable CFR citation and standard. Apple Health does not include Long-Term Services and Supports (LTSS) services within the managed care delivery system so CFR specific to Managed LTSS are not addressed below.

Access Standards

Regulatory Reference	Description
§438.206	Availability of Services
§438.206(b)(1)	Maintains and monitors a network of appropriate providers
MCO, BHSO	In a managed care delivery system, the MCOs agree through contract to provide all services to enrollees with care available sufficient to meet the health needs of enrollees. Each MCO must maintain and monitor a network of appropriate providers that is supported by written contractual agreements and is sufficient to provide adequate access to all services under the contract.

	<p>For IMC and IFC, this includes physician services, inpatient and outpatient hospital services, therapies, pharmacy, home care services and substance use disorder and mental health services (referred to jointly as behavioral health services).</p> <p>For BHSO, this includes only behavioral health services.</p> <p>In establishing and maintaining the network, each MCO must consider the anticipated and actual Apple Health enrollment, the expected utilization of services, and population needs, such as demographics and health care needs of the population enrolled, including those with limited English proficiency or physical or mental disabilities. The MCO must consider the number and type of providers (e.g., license, training, and specialization) required to provide the contracted services, the number of providers accepting MCO patients, and geographic location of providers and enrollees.</p> <p>MCOs quarterly provide documentation of their provider network including six critical provider types (Hospital, Pharmacy, Pediatricians, Primary Care Providers, Obstetrics, and Behavioral Health) and all contracted specialty providers. The report includes information regarding the MCO'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.</p>
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist
IMC, IFC	MCOs must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. A women's health specialist may serve as a primary care provider.
BHSO	Women's health specialist is not a covered benefit for BHSO managed care as it is only behavioral health services, so this regulation is not applicable. BHSO enrollees have access to women's health services through the fee-for-service delivery system.
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional
MCO, BHSO	MCOs must provide for a second opinion to enrollees from a qualified health care professional within the MCO network, or arrange for the enrollee to obtain one from outside the network, at no cost to the enrollee.
§438.206(b)(4)	Adequate and timely coverage of services not available in network
MCO, BHSO	If the MCO is unable to provide medically necessary, covered services for an enrollee within their contracted network, HCA requires MCOs to ensure adequate and timely coverage through out-of-network providers.
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment
MCO, BHSO	Out-of-network services must be provided at no additional cost to the enrollee.

§438.206(b)(6)	Credential all providers as required by §438.214										
MCO, BHSO	MCOs are required to follow NCQA credentialing standards for Health Plans, which is in alignment with §438.214.										
§438.206(b)(7)	Network includes sufficient family planning providers to ensure timely access to covered services										
MCO	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 to ensure timely access to covered services.										
BHSO	Family planning is not a covered benefit for BHSO managed care as it is only behavioral health services, so this regulation is not applicable. BHSO enrollees have access to family planning services through the fee-for-service delivery system.										
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services										
MCO, BHSO	<p>MCOs shall have contracts in place with all providers that meet state standards for access, taking into account the urgency of the need for services and comply with appointment standards that are no longer than the following. The BHSO program network oversight for timely access to care and services is addressed as described below when the benefit is applicable to the contract (i.e., incorporating behavioral health provider types only).</p> <p>Appointment Standards</p> <table border="1"> <thead> <tr> <th>Provider Type</th> <th>Appointment Standard</th> </tr> </thead> <tbody> <tr> <td>Transitional healthcare services by a Primary Care Provider (PCP)</td> <td>Within seven (7) calendar days of discharge from inpatient, institutional care for physical or behavioral health disorders, or discharge from a SUD treatment program</td> </tr> <tr> <td>Transitional healthcare services by a home care nurse, a home care Mental Health Professional or other behavioral health professional</td> <td>Within seven (7) calendar days of discharge from inpatient, institutional care for physical or behavioral health disorders, or discharge from a SUD treatment program if ordered by PCP or as part of the discharge plan</td> </tr> <tr> <td>PCP preventive care office visits</td> <td>Within thirty (30) calendar days</td> </tr> <tr> <td>PCP/BH non-urgent, symptomatic (i.e., routine care) office visits, including behavioral health services from a behavioral health provider</td> <td>Within ten (10) calendar days</td> </tr> </tbody> </table>	Provider Type	Appointment Standard	Transitional healthcare services by a Primary Care Provider (PCP)	Within seven (7) calendar days of discharge from inpatient, institutional care for physical or behavioral health disorders, or discharge from a SUD treatment program	Transitional healthcare services by a home care nurse, a home care Mental Health Professional or other behavioral health professional	Within seven (7) calendar days of discharge from inpatient, institutional care for physical or behavioral health disorders, or discharge from a SUD treatment program if ordered by PCP or as part of the discharge plan	PCP preventive care office visits	Within thirty (30) calendar days	PCP/BH non-urgent, symptomatic (i.e., routine care) office visits, including behavioral health services from a behavioral health provider	Within ten (10) calendar days
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PCP preventive care office visits	Within thirty (30) calendar days										
PCP/BH non-urgent, symptomatic (i.e., routine care) office visits, including behavioral health services from a behavioral health provider	Within ten (10) calendar days										

	<p>PCP urgent, symptomatic office visits Emergency care</p> <p>Second opinion appointments</p> <p>Network providers must meet the distance and drive time standards below in every service area. HCA designates a zip code in a service area as urban or non-urban for purposes of measurement.</p> <p>Distance Standards</p> <table border="1"> <thead> <tr> <th data-bbox="532 758 857 804">Provider Type</th> <th data-bbox="857 758 1198 804">Urban</th> <th data-bbox="1198 758 1500 804">Non-Urban</th> </tr> </thead> <tbody> <tr> <td data-bbox="532 804 857 863">PCP</td> <td data-bbox="857 804 1198 863">2 within 10 miles</td> <td data-bbox="1198 804 1500 863">1 within 25 miles</td> </tr> <tr> <td data-bbox="532 863 857 921">Obstetrics</td> <td data-bbox="857 863 1198 921">2 within 10 miles</td> <td data-bbox="1198 863 1500 921">1 within 25 miles</td> </tr> <tr> <td data-bbox="532 921 857 1094">Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services</td> <td data-bbox="857 921 1198 1094">2 within 10 miles</td> <td data-bbox="1198 921 1500 1094">1 within 25 miles</td> </tr> <tr> <td data-bbox="532 1094 857 1152">Hospital</td> <td data-bbox="857 1094 1198 1152">1 within 25 miles</td> <td data-bbox="1198 1094 1500 1152">1 within 25 miles</td> </tr> <tr> <td data-bbox="532 1152 857 1211">Pharmacy</td> <td data-bbox="857 1152 1198 1211">1 within 10 miles</td> <td data-bbox="1198 1152 1500 1211">1 within 25 miles</td> </tr> <tr> <td data-bbox="532 1211 857 1308">Mental Health Professionals and SUDPs</td> <td data-bbox="857 1211 1198 1308">1 within 25 miles</td> <td data-bbox="1198 1211 1500 1308">1 within 25 miles</td> </tr> </tbody> </table> <p>Drive Time Standards</p> <p>Urban Areas</p> <p>Rural Areas</p> <p>Large Rural Geographic Areas</p>	Provider Type	Urban	Non-Urban	PCP	2 within 10 miles	1 within 25 miles	Obstetrics	2 within 10 miles	1 within 25 miles	Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services	2 within 10 miles	1 within 25 miles	Hospital	1 within 25 miles	1 within 25 miles	Pharmacy	1 within 10 miles	1 within 25 miles	Mental Health Professionals and SUDPs	1 within 25 miles	1 within 25 miles	<p>Within 24 hours</p> <p>Available 24 hours per day, seven (7) days per week</p> <p>Within thirty (30) calendar days of the request, unless the enrollee requests a postponement of the second opinion to a date later than thirty (30) calendar days</p> <p>90 minutes Service sites are accessible by public transportation with the total trip, including transfers, not to exceed ninety minutes each way.</p> <p>30 minutes A thirty-minute drive from the enrollee's primary residence to the service site.</p> <p>90 minutes A ninety-minute drive from the enrollee's primary residence to the service site.</p>
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Mental Health Professionals and SUDPs	1 within 25 miles	1 within 25 miles																					

	<p>Exceptions: HCA may, at its sole discretion, grant exceptions to the distance and drive time standards. If the closest provider is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest provider may be a provider not participating with the MCO.</p> <p>The above travel standards do not apply under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).</p>
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service
MCO, BHSO	Network providers are required to offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week
MCO, BHSO	<p>The following services are available by a toll-free telephone number on a 24-hour-a-day, seven-day-a-week, 365 days a year basis</p> <p>Medical or mental health advice for enrollees from licensed health care professionals.</p> <p>Triage concerning the emergent, urgent or routine nature of medical and mental health conditions by licensed health care professionals.</p> <p>Authorization of urgent and emergency services, including emergency care for mental health conditions and services provided outside the MCO's service area.</p> <p>Emergency fills without authorization, or guarantee authorization and payment after the fact for any emergency fill dispensed by a contracted pharmacy. The MCO must post the emergency fill policy on its website to be visible and easy to access for providers.</p>
§438.206(c)(1)(iv)(v)(vi)	Mechanisms/monitoring to ensure compliance by providers. Monitor providers regularly to determine compliance. Take corrective action if a network provider fails to comply.
MCO, BHSO	MCOs must establish mechanisms to ensure compliance by providers and monitor regularly. Corrective action must be initiated and documented if there is a failure to comply.
§438.206(c)(2)	Culturally competent services to all enrollees
MCO, BHSO	MCOs 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.

§438.206(c)(3)	Network providers provide physical access, reasonable accommodation, and equipment for enrollees with physical or mental disabilities.
MCO, BHSO	MCOs are required to contract network providers to give physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities.
§ 438.207	Assurances of Adequate Capacity and Services
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment including the standards at §438.68 and §438.206(c)(1).
MCO, BHSO	The MCOs are required to assess network adequacy at least annually, and at any time there has been a significant change in the MCOs operations that would affect adequate capacity or services, including changes in services, benefits, geographic service areas, payments or enrollment of a new population. The MCO must address any deficits identified in the analysis and report to the State on their assessment.
§438.207(b)	Offer an appropriate range of preventive, primary care, and specialty services. Maintain network sufficient in number, mix, and geographic distribution.
IMC, IFC, BHSO	<p>MCOs are required to have an appropriate range of preventive, primary care, and specialty services for the populations they serve for each program. MCOs must maintain an adequate number of providers distributed across sufficient service sites to meet the needs of the anticipated number of enrollees applicable to the covered services for each program. They must consider:</p> <ul style="list-style-type: none"> • Anticipated enrollment • Expected utilization of services based on enrollee characteristics (cultural, ethnic, racial, linguistic, and health care needs) • Numbers and types of network providers required to furnish services • Number of network providers who are not accepting new patients • Geographic location of providers and enrollees (distance, travel time, means of transportation enrollees normally use, and physical access for enrollees with disabilities)
§ 438.208	Coordination and Continuity of Care
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs and a designated person or entity responsible for coordinating services. Enrollees must be provided information on how to contact their designated person or entity responsible for coordinating services.
MCO	MCOs are required to ensure each enrollee has a PCP responsible for the provision, supervision, and coordination of health care to meet enrollee needs and is notified of how to contact his or her PCP. MCOs are required to provide support services to assist PCPs in providing additional coordination such as support for care transitions of enrollees.

BHSO	The MCO is the designated entity to coordinate the behavioral health care for BHSO members and notifies the member of this through the member handbook. The MCO identifies members requiring care coordination support through multiple mechanisms and is available upon request. Primary care is not a covered benefit for BHSO managed care as it is only behavioral health services; however, BHSO enrollees have access to primary care through the fee-for-service delivery system.
§438.208(b)(2)(i) - (iv)	Coordinate services between settings of care, including discharge planning, services from any other MCO/PIHP, services received in fee-for-service Medicaid, and services received from community and social support providers.
MCO, BHSO	<p>The MCO is required to coordinate care between settings of care, including:</p> <ul style="list-style-type: none"> • Discharge planning from hospital or institutional settings; • The services the enrollee receives from another Apple Health MCO, such as when the enrollee switches MCOs; • The services the enrollee receives in fee-for-service Medicaid; and • The services the enrollee receives from community and social support providers. <p>The MCO must require providers 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.</p>
§438.208(b)(3)	MCOs must make a best effort to conduct initial screening of each enrollee's needs within 90 days of enrollment.
MCO, BHSO	MCOs are required to conduct an initial screening of all new enrollees within 60 days of enrollment for all new enrollees, beginning the first (1st) of the month after the month of enrollment. This includes Family Connects (family members connecting to the same MCO as another family member in the same household) and Reconnects (members reconnecting to the same MCO as was previously enrolled in). Multiple attempts to reach the enrollee are made, if the MCO is not able to reach the member in the initial contact.
§438.208(b)(4)	Share with the State or other MCOs and PIHPs serving the enrollee the results of its identification and assessment to prevent duplication of services.
MCO, BHSO	HCA clearly identifies roles and responsibilities between MCOs serving the enrollee responsible for, or are contributing to, enrollee care management in order to assure no duplication or gaps in services. If more than one MCO is serving the enrollee, HCA coordinates sharing of the initial screening identification and assessment activities to prevent duplication of services.
§438.208(b)(5)	Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.
MCO, BHSO	If an enrollee changes enrollment to another MCO, the MCO must coordinate transition of the enrollee to the new MCO's Care Coordination system to ensure services do not lapse and are not duplicated.

BHSO	For Enrollees who receive their physical health benefits in the Medicare or Medicaid fee-for-service delivery system, the BHSO must develop data sharing protocols with the enrollee's PCP.
§438.208(b)(6)	Ensure that in the process of coordinating care, each enrollee's privacy is protected.
MCO, BHSO	Throughout care coordination, each enrollee's privacy must be protected according to health care privacy regulations, including requirements in 45 C.F.R., parts 160 and 164 subparts A and E as well as 42 C.F.R Subpart 2, to the extent that they are applicable.
§438.208(c)(1)	State mechanisms to identify persons needing LTSS or with special health care needs
MCO, BHSO	<p>The state utilizes multiple mechanisms to identify enrollees needing long-term services and supports or those with special health care needs:</p> <p>The Department of Health receives positive lead screening client data from laboratories statewide. This data is matched to MCO enrollment and sent to MCOs.</p> <p>Children and youth who have been served by the Local Health Jurisdiction within the last 12 months in the Child with Special Health Care Needs (CSHCN) are identified on HCA's MCO enrollment file by data provided from the LHJs via the Department of Health.</p> <p>Enrollees who are receiving services from the Developmental Disabilities Administration are identified on HCA's MCO enrollment file.</p> <p>Washington uses a predictive modeling tool, called the Predictive Risk Intelligence System (PRISM), to predict risk for each enrollee. MCOs may use this score to support identification of individuals with special health care needs, identify individuals with at least one chronic health care condition and at risk for a second chronic condition and who are estimated to have 50% or higher costs in the succeeding 12 months based on the patient's disease profile and pharmacy utilization.</p> <p>MCOs conduct an Initial Health Screen for all new enrollees as well as look at diagnostic criteria and risk scores to identify individuals with special health care needs. The MCO's Initial Health Screen must contain behavioral, developmental, oral and physical health questions. The MCO also must use evidence based screening tools including (but not limited to), tobacco use assessment, and housing and housing instability assessment.</p>

§438.208(c)(2)	Implement mechanisms to comprehensively assess enrollees identified in paragraph (c)(1) of this section as needing LTSS or having special health care needs by appropriate health care professionals
MCO, BHSO	If the enrollee’s Initial Health Screen described above is positive or the MCO otherwise identifies the enrollee as a enrollee as needing long-term services and supports or having special health care needs, an Initial Health Assessment (IHA) is conducted to determine what further clinical assessment or ongoing services the enrollee needs. An IHA is conducted within sixty (60) calendar days of the identification of special needs or Initial Health Screen that indicates the need for care coordination. The assessment shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources. These needs may include clinical and non-clinical services and referrals to appropriate health care professionals, specialists, and community resources.
§438.208(c)(3)(i)	Treatment plans developed by an individual meeting LTSS service coordination requirements, with enrollee participation, and in consultation with any providers caring for the enrollee.
MCO, BHSO	MCOs are required to complete or verify completion of an individualized treatment plan. MCOs must offer additional services to their special health care needs clients, including coordination in connecting with long term services and supports. The treatment plan must address integration and coordination of clinical and non-clinical disciplines and services.
§438.208(c)(3)(ii)	Be trained in person-centered planning using a person-centered process and plan as defined in § 441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans
MCO, BHSO	Apple Health does not include LTSS services within the managed care delivery system so CFR specific to Managed LTSS are not addressed.
§438.208(c)(3)(iii)-(iv)	Approved in a timely manner in accord with applicable state standards.
MCO, BHSO	If the MCO requires PCP approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee’s health condition.
§438.208(c)(3)(v)	Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee’s circumstances or needs change significantly, or at the request of the enrollee.
MCO, BHSO	The MCO must ensure the treatment plan is modified as needed to address the emerging needs of the enrollee and at least every 12 months, or when the enrollee’s circumstances or needs change significantly.

§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs
MCO, BHSO	MCOs are required to allow enrollees with special health care needs to utilize a specialist as a PCP or directly access a specialist as appropriate for the enrollee's condition and identified needs.
§ 438.210	Coverage and Authorization of Services
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service.
MCO, BHSO	Services are specified within the scope of services section of each contract.
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under fee-for-service Medicaid and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter.
MCO, BHSO	Services must be provided in the same amount, duration, and scope as those furnished to beneficiaries under fee-for-service Medicaid and for enrollees under the age of 21. Medical necessity is defined in HCA WAC 182-500-0070, which is reflected in the MCO contracts so MCOs are held to the same standard. The definition of medical necessity covers prevention, diagnosis, treatment, and maintenance of functional capacity.
§438.210(a)(3)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition.
MCO, BHSO	MCOs use nationally recognized utilization management guidelines or decision-making criteria for managing service authorization and appeal requests. MCOs are prohibited from denying or reducing services due solely to diagnosis, type of illness, or condition.
§438.210(a)(4)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity or for purpose of utilization control.
MCO, BHSO	MCOs may establish utilization controls, including utilization review criteria for authorization decisions, provided that utilization control measures do not deny medically necessary, contracted services to enrollees. The MCO's utilization control measures are not required to be the same as those in the Medicaid fee-for-service program.

§438.210(a)(4)(ii)(A)	MCOs may place utilization limits as long as the services that are furnished can reasonably be expected to achieve their purpose.
MCO, BHSO	MCOs are allowed to use utilization controls such as limits on services as long as services are able to reasonably be expected to achieve the purpose. Authorization requests for services beyond the limits are reviewed for medical necessity on a client-specific basis through the limitation extension process, and requests for clients under age 21 are reviewed due to EPSDT regulations.
§438.210(a)(4)(ii)(B)	The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee’s ongoing need for such services and supports
MCO, BHSO	Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than every six (6) months. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, ongoing medications, and medications for chronic conditions. MCOs are required to assess their compliance with this requirement at least annually.
§438.210(a)(4)(ii)(C)	Family planning services are provided in a manner that protects and enables the enrollee’s freedom to choose the method of family planning to be used.
MCO	MCOs are required to ensure that any utilization control measures imposed on family planning services are imposed in a manner that the enrollee’s right to choose the method of family planning is protected. MCOs are required to cover all Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies. Additionally, enrollees have the right to self-refer for certain services to participating or non-participating local health departments and family planning clinics paid through separate arrangements with the State. Enrollees may also choose to receive such services through the MCO. MCOs are required to ensure that enrollees are informed of all options of where to receive services.
BHSO	Family planning is not a covered benefit for BHSO managed care as it is only behavioral health services, so this regulation is not applicable. BHSO enrollees have access to family planning services through the fee-for-service delivery system.

<p>§438.210(a)(5)(i) §438.210(a)(5)(ii)(A)-(D)</p>	<p>Specify what constitutes “medically necessary services”, including qualitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures</p>
<p>MCO, BHSO</p>	<p>Medically necessary is defined in WAC 182-500-0070 and contract as follows:</p> <p>A service requested which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an 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 client requesting the service. "Course of treatment" may include mere observation or, where appropriate, no medical treatment at all.</p> <p>The MCO is responsible for covering services that address</p> <p>The prevention, diagnosis, and treatment of an enrollee’s disease, condition, and/or disorder that results in health impairments and/or disability,</p> <p>Ability for an enrollee to achieve age-appropriate growth and development,</p> <p>Ability for an enrollee to attain, maintain, or regain functional capacity.</p>
<p>§438.210(b)(1) §438.210(b)(2)(i)</p>	<p>Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services and have mechanisms to ensure consistent application of review criteria for authorization decisions</p>
<p>MCO, BHSO</p>	<p>MCOs 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 policies and procedures regarding authorization of services and are monitored annually by the MCOs to ensure compliance with regulation and policy.</p> <p>State rules require MCOs have a process similar to the decision process in WAC 182-501-0165 for the hierarchy of evidence presented for each authorization decision to ensure consistency of handling. Additionally, MCOs must provide for routine inter-rater reliability testing to ensure the application of utilization management criteria is consistently applied by each staff member involved in determining authorizations.</p>
<p>§438.210(b)(2)(ii)</p>	<p>Consult with the requesting provider for authorization of medical services when appropriate.</p>
<p>MCO, BHSO</p>	<p>The MCOs consult with the requesting provider, when appropriate, in the process of authorizing services and provide education and ongoing guidance to providers about its UM protocols, including admission, continued stay, and discharge criteria.</p>

§438.210(b)(2)(iii)	Authorize LTSS based on an enrollee’s current needs assessment and consistent with the person-centered service plan.
MCO, BHSO	Apple Health does not include LTSS services within the managed care delivery system so CFR specific to authorization of LTSS are not addressed.
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate individual who has expertise in addressing the enrollee’s medical, behavioral health, or long-term services and supports needs.
MCO, BHSO	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 health condition, and must not be denied solely because of diagnosis, type of illness, or condition.
§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
MCO, BHSO	The MCO must notify the enrollee and the provider requesting the service of the outcome of the utilization review. If the decision is not in the enrollee’s favor, a notice of adverse benefit determination is provided to the member and requesting provider. The notice must meet the requirements of 42 C.F.R. 438.404.
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)
MCO, BHSO	<p>Decisions are to be made and notices are to be provided as expeditiously as the enrollee’s health condition requires.</p> <p>For standard requests, decisions to approve, deny or request additional information are to be made within five (5) calendar days. If additional information is requested, the MCO must give the provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the necessary information. 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:</p> <ul style="list-style-type: none"> • The enrollee or the provider requests an extension; or • The MCO justifies and documents a need for additional information and how the extension is in the enrollee’s interest. <p>If the MCO 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.</p> <p>For cases in which the enrollee’s 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 (urgent) authorization or denial of services.</p>

	<p>For urgent handling, decisions to approve, deny or request additional information are to be made within two (2) calendar days. If additional information is requested the MCO must give the provider one (1) calendar day to submit the information and then approve or deny the request within two (2) calendar days of the receipt of the necessary information. A possible extension of up to fourteen (10) additional calendar days is allowed under the following circumstances:</p> <ul style="list-style-type: none"> • The enrollee or the provider requests an extension; or • The MCO justifies and documents a need for additional information and how the extension is in the enrollee’s interest. <p>If the MCO 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.</p> <p>For situations in which the request for care or services occurs at the time the event is occurring (called concurrent review), decisions are to be made within one (1) business day.</p> <p>For authorizations occurring after the service occurred (called post-service), the decisions are to be made within thirty (30) calendar days.</p> <p>For authorizations of outpatient prescriptions and over-the-counter drugs, decisions to approved, deny, or request additional information must be made no later than the following business day after the receipt of the request. If the provider does not respond to the MCOs request for additional information within three (3) business days of the request the MCO must make a decision based on the information on hand.</p>
§438.210(e)	Each contract between the State and MCO must provide that compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services.
MCO, BHSO	MCOs are required not to structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Structure and Operations Standards

Regulatory Reference	Description
§438.56	Disenrollment requirements and limitations
§438.56 (a)	Each MCO complies with the enrollment and disenrollment requirements and limitations in §438.56.
MCO, BHSO	<p>Most Washingtonians apply for or renew their Apple Health coverage through Washington Healthplanfinder (HPF), administered by the Washington Health Benefit Exchange (HBE). Eligible individuals can select or change their managed care plan through HPF, the ProviderOne client web portal, or calling the HCA toll free line. Individuals who do not select their managed care plan are auto-assigned by HCA.</p> <p>As part of their application for coverage, individuals choose their MCO. Information on an individual certified for coverage is sent to the individual's selected MCO through a Health Insurance Portability and Accountability Act (HIPAA)compliant 834, Benefit Enrollment and Maintenance Format (45 C.F.R. 162.103). An individual's enrollment in IMC and IFC is backdated to the beginning of the current month; enrollment in BHSO is prospective to the beginning of the next month.</p> <p>Apple Health enrollees may change MCOs monthly, regardless of reason. Enrollees who move to other regions are kept in the same plan, if available, or enrolled into a MCO available in the region and have the option of changing their health plan.</p> <p>For AI/AN individuals, enrollment into managed care is voluntary and they must opt in. AI/AN enrollees may opt out at any time and changes take effect the following month. Managed care contractors must respect and support the enrollment choices of AI/AN enrollees, including disenrollment into the fee-for-service Medicaid program.</p> <p>Enrollees placed in the Patient Review and Coordination (PRC) program are restricted from changing their enrolled MCO for a minimum of twelve months after placement in the PRC program by HCA. Exceptions are made for the following reasons:</p> <ul style="list-style-type: none"> • Access to medical care, especially if the enrollee was assigned to an MCO and has established providers in a different MCO, • An established provider moves from one plan to another, • The enrollee is in the Secretary of State's Address Confidentiality Program, • The enrollee is American Indian or Alaskan Native, • The enrollee is in PRC voluntarily. or • The enrollee moves to a residence outside the MCO's service areas. • Family members of PRC-enrolled clients may still change enrollment.

	<p>Enrollees may request to be out of managed care either orally or in writing by contacting HCA’s customer service center. IFC enrollment and disenrollment are addressed by a specialty unit within HCA’s eligibility team. Enrollees may be disenrolled from mandatory programs for the following reasons:</p> <ul style="list-style-type: none"> • A health care need that requires continuation of an established treatment plan meeting chapter WAC 182-538 related to the IMC program; • The client is American Indian or Alaskan Native. <p>Denials of disenrollment requests will be based on the reasons cited in the request information. Enrollees denied plan change or disenrollment for cause may request an appeal of the decision through a state hearing.</p> <p>Enrollees are informed about the enrollment and disenrollment process in the MCO handbook. MCOs must refer any requests for disenrollment to the state. 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. The MCO contracts specify how and why the MCO may request disenrollment of an enrollee for cause. The State monitors disenrollments through disenrollment statistics and communications with MCOs and state enrollment staff.</p>
§438.100	Enrollee Rights
§438.100 (a)	Each MCO must have written policies regarding enrollee rights and ensure compliance with applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights.
MCO, BHSO	MCOs are required to have written policies regarding enrollee rights and ensure compliance with applicable federal and state laws that pertain to enrollee rights. The MCO ensures its employees and contracted providers observe and protect enrollee rights though monitoring activities reviewed on a quarterly basis.
§438.100 (b)(2)(i)	MCOs must ensure enrollees have the right to receive information in accordance with §438.10.
MCO, BHSO	<p>The MCO provides an enrollee handbook specific to the program, which includes an explanation of benefit coverage and how to obtain care:</p> <ul style="list-style-type: none"> • At least once a year, • Upon request, and • Within fifteen (15) business days after the MCO is notified of the client’s enrollment. <p>The MCO must provide information to enrollees and potential enrollees in a manner and format that may be easily understood and readily accessible. All written materials for potential enrollees and enrollees must meet the following requirements:</p>

- Use easily understood language and format
- Use a font size no smaller than 12 point
- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency
- Include a tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Tagline will be provided in large print upon request by the enrollee.
- Use of large print in a font size no smaller than 18 point
- Address service areas covered by each MCO
- Include information on grievances, appeals, adverse benefit determinations, and administrative hearings definitions and processes;
- Include a Provider Directory, available in paper form upon request and electronic form
- Address medical and behavioral health advance directives
- Written notice of termination of a contracted provider within 15 calendar days after receipt or issuance of the termination notice of a provider
- Enrollee handbooks providing enrollees of their right to disenroll, communicated at least annually
- Information on the MCO formulary, applicable only to IMC and IFC programs as the BHSO program does not include drug coverage

MCOs must submit all enrollee material to HCA for review and approval prior to use. The material is reviewed using a checklist composed of contractual and federal requirements. Any deficiencies found in the documents are returned to the MCO for correction prior to approval.

§438.100 (b)(2)(ii-iv) and (3)	MCOs must ensure an enrollee’s rights
MCO, BHSO	<p>The MCO staff and subcontractors must ensure compliance by staff and subcontractor adherence to the following enrollee rights:</p> <ul style="list-style-type: none"> • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion. • Request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §§164.524 and 164.526. • Be furnished health care services in accordance with §§438.206 through 438.210.
§438.100 (d)	MCO’s must be in compliance with other Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.
MCO, BHSO	The monitoring of MCO compliance with applicable Federal and State laws is performed by the State as part of TEAMonitor review. TEAMonitor includes reviews of policies, procedures, and subcontracts.
§438.214	Provider Selection
438.214(a)	Written policies and procedures for selection and retention of providers
MCO, BHSO	Each MCO must implement written policies and procedures for the selection and retention of providers within their network.

§438.214(b)(1)-(2)	Uniform credentialing and re-credentialing policy that each MCO must follow that addresses acute, primary, behavioral, substance use disorders, and LTSS providers.
MCO, BHSO	Policies and procedures follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the MCO. MCOs must have a credentialing and re-credentialing system that aligns with NCQA standards and measures, which address acute care, primary care, behavioral health, and substance use disorder treatment providers. MCOs are not contracted to provide LTSS services, thus this provider type is not addressed within the credentialing process.
§438.214(b)(2)	Documented process for credentialing and re-credentialing that each MCO/PIHP must follow.
	<p>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 re-credentialing process, monitoring process and activities, and the MCO’s oversight of any entity delegated for credentialing. This system includes the elements described below.</p> <p>The MCO must have a rigorous process to select and evaluate practitioners. Credentialing procedures include a process for:</p> <ul style="list-style-type: none"> • Making credentialing and re-credentialing decisions; • Managing credentialing files that meet the MCO’s established criteria; • Delegating credentialing and re-credentialing; • Ensuring that credentialing and re-credentialing 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 re-credentialing decision within 60 calendar days to 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 re-credentialed; and • Ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty designation.

	<p>The MCO must have evidence of a Credentialing Committee including a schedule of regular meetings and minutes documenting the meeting schedule. The associated documentation for credentialing decisions must include:</p> <ul style="list-style-type: none"> • Verification of sources used, • Criteria for credentialing and re-credentialing, • Initial credentialing verification, • Application and attestation, • Initial sanction information, • Practitioner office site quality, • Re-credentialing verification, • Re-credentialing cycle length, • Ongoing monitoring, • Notification to authorities and practitioner appeal rights, • Assessment of organization providers, • Delegation of credentialing, and • Oversight Activities.
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment
MCO, BHSO	The MCO's credentialing and re-credentialing policies and procedures address provider selection and retention. These must confirm the MCO may not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCO is required to have a process in place for self-monitoring for this standard, in addition to state oversight.
§438.214(d)	MCOs may not employ or contract with providers excluded from Federal health care programs
MCO, BHSO	<p>The MCO 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. Credentialing and re-credentialing processes ensure providers are not excluded prior to the MCO making a decision to contract with the provider.</p> <p>MCOs are notified by MPOI 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.</p>

§438.224	Confidentiality
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements
MCO, BHSO	<p>MCOs must develop data exchange protocols, including consent to release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including sharing of claims and pharmacy data, treatment plans or care plans, crisis plans, critical incidents and Advance Directives necessary to coordinate service delivery, and care management for each enrollee in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.</p> <p>MCOs ensure security for individually identifiable health information by:</p> <ul style="list-style-type: none"> • 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 identification, and hardened password authentication to protect confidential information; • Physically securing any computers, documents or other media containing the confidential information; • Encrypting all confidential information that is stored on portable devices including but not limited to laptop computers and flash memory devices; • Requiring the same standards of confidentiality of all of its subcontractors.

§438.228	Grievance and Appeal System
§438.228	Each MCO has a grievance and appeal system that meets requirements of subpart F
MCO, BHSO	<p>MCOs are required to have a grievance and appeal system that includes access to the state’s administrative hearing system.</p> <p>The MCO must acknowledge each grievance and appeal. The MCO assists enrollees, as needed, in their oral or written grievance and appeals. The appeal process provides 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. The appeal process is available through the MCO before the enrollee has the right to an administrative hearing.</p> <p>The MCO resolves each grievance and appeal, and provides notice, as expeditiously as the enrollee’s health condition requires, but no later than the federal 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 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. The enrollee may be responsible for services if the state administrative hearing decision is adverse to the enrollee. In processing an appeal, the MCO must meet all continuation of benefits requirements (42 C.F.R. 438.420).</p> <p>An enrollee may file a State administrative hearing after receiving notice under 42 C.F.R. 438.408. If the MCO 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 administrative hearing. The MCO must be a party to the State fair hearing and comply with hearing decisions promptly and expeditiously.</p> <p>The MCO is 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 are required to analyze the records to identify trends and areas for quality improvement at least annually.</p>

§438.230	Subcontractual relationships and delegation.
§438.230(b)	MCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.
MCO, BHSO	<p>The MCO maintains ultimate responsibility for adhering to and fully complying with all terms and conditions of its contract with the state. If any MCO activity or obligation under its contract with the state are delegated to a subcontractor:</p> <ul style="list-style-type: none"> • 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’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 determines that the subcontractor has not performed satisfactorily.
§438.230(c)(1)(i)	The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
MCO, BHSO	HCA contract management staff reviews MCO subcontracts and delegation agreements for compliance with standards. The review ensures that all subcontract elements required in the MCO contracts and regulations are included in subcontracts and delegation agreements. If the standard is not met, the MCO is required to correct missing or incorrect information.
§438.230(c)(1)(ii)	The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO’s contract obligations.
MCO, BHSO	Sub-contractual relationships and delegation standards must meet the conditions of 42 C.F.R. 438.230. The MCO 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 retains the responsibility and accountability for the function(s). The MCO 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.

<p>§438.230(c)(1)(iii)</p>	<p>The contract must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO determine that the subcontractor has not performed satisfactorily.</p>
<p>MCO, BHSO</p>	<p>Contract language developed by HCA requires the MCO to evaluate the prospective subcontractor’s ability to perform the activities prior to delegation. The MCO 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 must monitor the delegates’ performance. If the MCO identifies deficiencies or areas for improvement, the delegate must take corrective action.</p>
<p>§438.230(c)(2)</p>	<p>The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.</p>
<p>MCO, BHSO</p>	<p>The subcontractor must agree to comply with all applicable Medicaid laws, regulations, including applicable regulatory guidance and contract provisions.</p>
<p>§438.230(c)(3)</p>	<p>Subcontractor agrees that The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect.</p>
<p>MCO, BHSO</p>	<p>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’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.</p>

Measurement and Improvement Standards

Regulatory Reference	DESCRIPTION
§ 438.236	Practice Guidelines
§438.236(b)	<p>Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.</p>
MCO, BHSO	<p>MCOs are required to adopt and use clinical practice guidelines to help practitioners make decisions about appropriate health care for specific clinical circumstances and promote prevention and early detection of illness/disease. Practice guidelines must meet the following requirements:</p> <ul style="list-style-type: none"> • Be age appropriate to address the special needs or considerations that are driven by age; • Consider the needs of enrollees and support client and family involvement in care plans; • Be adopted in consultation with contracting Health Care Professionals within the State of Washington, or, when applicable, are adopted in consultation with the behavioral health professionals in the MCO’s contracted network. • Be reviewed and updated at least every two (2) years and more often if national guidelines change during that time. <p>Practice guidelines must be developed based on the United States Preventative Services Task Force (USPSTF) as the primary source. They may also adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines, such as:</p> <ul style="list-style-type: none"> • Voluntary health organizations; • The National Institute of Health Centers; • The Substance Abuse and Mental Health Services Administration; • The American Society of Addiction Medicine (ASAM) for guidelines to determine appropriate levels of care for substance use disorder treatment.

§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees
MCO, BHSO	Practice guidelines must be distributed by the MCO to all affected providers within 60 days of adoption or revision. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers. Practice guidelines must be distributed to enrollees upon request.
§438.236(d)	Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
MCO, BHSO	Practice guidelines are to be the basis for MCO utilization management decisions and the MCOs must have a process for ensuring clinical guidance, including UM decisions, enrollee education, and coverage of services, are consistent with the practice guidelines.
§ 438.330	Quality Assessment and Performance Improvement Program
§438.330(a)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program.
MCO, BHSO	HCA requires each MCO to have a quality assessment and performance improvement (QAPI) program for its client services (42 C.F.R. 438.310(a)(1)). The QAPI must incorporate Performance Improvement Projects (PIP).
§438.330(b)(1) & §438.330(d)	Each MCO and PIHP must conduct PIPs and measure and report to the state its performance List out PIPs in the quality strategy
MCO, BHSO	<p>MCOs shall have an ongoing program of PIPs that focus on clinical and non-clinical areas. PIPs identified by the MCO are subject to review and approval of HCA including, but not limited to area of focus, design and implementation, and evaluation methodologies.</p> <p>PIP topics are specified by each managed care contract within the Quality Assessment and Performance Improvement section, subsection Performance Improvement Projects. The expectations for MCO topic selection are evaluated on an annual occurrence and updated as appropriate.</p> <p>See HCA's website for currently required PIP topics: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts/</p> <p>Each PIP shall be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction and shall include the following elements:</p>

	<ul style="list-style-type: none"> • Measurement of performance using objective quality indicators. Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the performance measures. • Planning and initiation of activities for increasing or sustaining improvement.
§438.330(b)(2) & §438.330(c)	<p>Each MCO and PIHP must measure and report performance measurement data as specified by the state</p> <p>List out performance measures in the quality strategy</p>
MCO	<p>The MCO must report HEDIS and other contract specified performance measure data to HCA and compare their performance to national benchmarks, state program performance, and/or prior health plan performance. MCOs are required to measure and report performance measures as specified by each managed care contract within the Quality Assessment and Performance Improvement section, subsection Performance Measures. The selected performance measures are evaluated at least annually and updated to align with national standards, state quality initiatives, and program changes.</p> <p>See HCA's website for currently required performance measures: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts/</p>
BHSO	<p>As HEDIS performance measures do not include the BHSO population, BHSO performance measures are produced by the DSHS/Research and Data Analysis Division (RDA) in partnership with HCA and delivered to the BHSO annually. This data reflects performance in the prior calendar year data collection period. BHSO performance measures are specified by each managed care contract within the Quality Assessment and Performance Improvement section, subsection Performance Measures. The selected performance measures are evaluated at least annually and updated to align with national standards, state quality initiatives, and program changes.</p> <p>See HCA's website for currently required performance measures: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts/</p>
§438.330(b)(3)	<p>Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services</p>
MCO, BHSO	<p>The MCO must be able to identify patterns of under- or overutilization through claims and encounter data for enrollees.</p>

§438.330(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs
MCO, BHSO	<p>MCOs conduct a consumer experience survey using NCQA’s CAHPS® survey as part of the annual HEDIS audit and NCQA accreditation. MCOs must comply with any national performance measures that may be identified and developed by the Center for Medicare and Medicaid Services (CMS) in consultation with HCA and other relevant stakeholders.</p> <p>MCOs are required to report on performance measures and results from CAHPS to HCA to assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs.</p>
§438.330(b)(5)	MCO/PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS and participate in efforts by the State to prevent, detect, and remediate critical incidents.
MCO, BHSO	<p>MCOs must assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including:</p> <ul style="list-style-type: none"> • Assessment of care between care settings; • A comparison of services and supports received with those set forth in the enrollee’s treatment/service plan; and • Participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§ 441.302 and 441.730(a) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per § 441.302(h).
§438.330(e)	<p>Annual review by the state of each quality assessment and performance improvement program</p> <p>If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.</p>
MCO, BHSO	<p>HCA requires that an MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. The MCO must provide an annual written QAPI Program Evaluation of the overall reporting of the effectiveness of the Contractor’s QAPI program. (42 C.F.R. §438.330(c)(2)(i) and (ii)). The report shall reflect on required QI program structure and activities in the Work Plan.</p>

§ 438.242	Health Information Systems
§438.242(a)	Each MCO must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility
MCO, BHSO	<p>MCOs play a key role in developing and maintaining health information systems. MCOs are required by contract to maintain databases on numerous datasets including administrative, encounter and clinical data. Datasets include information on utilization management decision, (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.</p> <p>HCA requires each MCO to:</p> <ul style="list-style-type: none"> • Maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the standards, information and performance reporting requirement objectives of section 1903(r)(1)(F) of the Act and the MCO quality improvement efforts, and also provides information that supports the MCO'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 consistency and collecting service information in standardized formats to the extent feasible and appropriate (42 CF.R. 438.242(b)(3)(i), 438.606, 438.242(3)(ii), and 438.242(3)(iii)); • Make all collected data available to HCA 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(b)(4), 438.606); • Report the status of physician incentive plans as requested by HCA (42 C.F.R. 422.208); and • Ensure subcontractors comply with all information system requirements the MCO is required to meet.

§438.242(b)(1)	The States MCO claims processing system is compliant with Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.
MCO, BHSO	Per Section 6504(a) of the Affordable Care Act, State claims processing and retrieval systems must be able to collect data elements necessary to allow electronic processing and retrieval as required by section 1903(r) (1)(f) of the Act.
§438.242(b)(2)	Each MCO must collect data on enrollee and provider characteristics and on services furnished to enrollees
MCO, BHSO	MCOs are required to maintain data fields on race, ethnicity and language characteristics to facilitate effective communication and improve health care services.
§438.242(b)(3)	Each MCO must ensure data received is accurate and complete
MCO, BHSO	<p>Each MCO's health information system must be able to produce valid encounter data. MCOs are required to submit encounter data according to contract requirements.</p> <p>MCOs are required to submit complete, accurate and timely data for all services for which the MCO has incurred any financial liability whether directly or through subcontracts or other arrangements in compliance with encounter submission guidelines published by HCA.</p> <p>The MCO must report the paid date, paid unit and paid amount for each encounter.</p> <p>HCA performs encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration and rate setting.</p> <p>MCOs must have systematic processes for screening the provider submitted data for completeness, logic, and consistency using National Correct Coding Initiative (NCCI) edits as directed by HCA.</p> <p>The managed care contracts set standards for encounter data reporting and submission.</p>

§438.242(c)(1)	Contracts between a State and a MCO must provide for collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.
MCO, BHSO	MCOs must follow HCA's Encounter Data Reporting Guide, which requires sufficient enrollee encounter data is collected and provided for contracted services in which the MCO pays. This includes formats for reporting, requirements for patient and encounter specific information, and information regarding the treating provider.
§438.242(c)(2)	Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.
MCO, BHSO	MCOs are required to submit encounter data regarding services in which the MCO paid to HCA monthly.
§438.242(c)(3)	Submission of all enrollee encounter data that the State is required to report to CMS under §438.818.
MCO, BHSO	MCOs are required to submit encounter data regarding services in which the MCO paid to HCA monthly.
§438.242(c)(4)	Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.
MCO, BHSO	MCOs must ensure that all Subcontractors required to report encounter data and behavioral health supplemental transactions have the capacity to submit all HCA required data to enable the MCO to meet the reporting requirements in the Encounter Data Guide and Behavioral Health Supplemental Transaction Data Guide published by HCA.
§438.242(d)	The State must review and validate that the encounter data collected, maintained, and submitted to the State by the MCO
MCO, BHSO	HCA performs encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration and rate setting.

Section VI: Appendices

Appendix A: Quality Strategy Acronym List

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
AH-IFC	Apple Health Integrated Foster Care
AH-IMC	Apple Health Integrated Managed Care
ALTSA	Aging & Long-Term Care Services Administration within DSHS
AMG	Amerigroup Washington, Inc.
BHSO	Apple Health Behavioral Health Service Organization
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCW	Coordinated Care of Washington
CHIP	Children’s Health Insurance Program or State Children’s Health Insurance Program
CHPW	Community Health Plan of Washington
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CQC	Clinical Quality Council
CQCT	Clinical Quality & Care Transformation—a Division within HCA
CSS	Community Support Services: wrap-around supports that assess housing needs (Transforming Medicaid, Initiative #3)
DBHR	Division of Behavioral Health and Recovery—a Division within HCA
DCYF	Department of Children, Youth and Families
DOH	Department of Health
DSHS	Department of Social and Health Services

DSLCL	Delivery System Leadership Committee
DSRIP	Delivery System & Provider Payment Initiatives
EQR	External Quality Review
EQRO	External Quality Review Organization
FCS	Foundational Community Supports
HCA	Health Care Authority
HEDIS®	Healthcare Effectiveness Data and Information Set
HPF	(Washington) Healthplanfinder
HIPAA	Health Insurance Portability and Accountability Act
LTSS	Long-Term Services and Supports
MAC	Medicaid Alternative Care: long-term care benefit package
MCO	Managed Care Organization
MCP	Managed Care Program: means a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.
MCRA	Medicaid Compliance Review and Analytics
MHW	Molina Healthcare of Washington
MPOI	Medicaid Program Operations & Integrity—a Division within HCA
NCQA	National Committee for Quality Assurance
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider
PCCM	Primary Care Case Management
PIHP	Prepaid Inpatient Health Plan: Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangement that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QMMI	Quality Measurement Monitoring and Improvement
QS	Quality Strategy
RDA	Research & Data Analysis within DSHS
TSOA	Tailored Supports for Older Adults: a new eligibility category and benefit category
UHC	UnitedHealthcare Community Plan
UM	Utilization Management
VBP	Value Based Purchasing
WISe	Wraparound with Intensive Services