

Managed Care Program Annual Report (MCPAR) for Washington: Apple Health Integrated Foster Care (IFC)

Due date	Last edited	Edited by	Status
06/29/2026	09/03/2026	ALESIA SPRUILL MCKOY	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Indicator	Response
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If “No”, please complete the following questions under each plan.	No (Excel submission)

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Washington
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Alesia McKoy
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	alesia.mckoy@hca.wa.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	ALESIA SPRUILL MCKOY
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	alesia.mckoy@hca.wa.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	09/03/2026

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2025
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2025
A6	Program name Auto-populated from report dashboard.	Apple Health Integrated Foster Care (IFC)

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	Coordinated Care of Washington Community Health Plan of Washington Molina Healthcare of Washington Incorporated United Healthcare Community Plan Wellpoint

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Washington Healthplanfinder State Government Entity Enrollment Broker Other, specify - Coordinated Care, Enrollment Broker for Out of State Alumni

Add In Lieu of Services and Settings (A.9)

This section must be completed if any in lieu of services or settings (ILOSs) *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** (See 42 CFR 438.3(e)(2) and 438.16).

Indicator	Response
ILOS name	Intensive Behavioral Supportive Supervision (IBSS)

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,953,505
BI.2	Statewide Medicaid risk-based managed care enrollment Enter the average number of individuals enrolled in risk-based Medicaid managed care per month during the reporting year (i.e., average member months). Include all MCOs and at-risk PIHPs and PAHPs only, and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,611,346

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	Data validation entity Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff Proprietary system(s)
BIII.2	HIPAA compliance of proprietary system(s) for encounter data validation Were the system(s) utilized fully HIPAA compliant? Select one.	Yes

Topic X: Program Integrity

Number	Indicator	Response
BX.1	Payment risks between the state and plans Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter “No PI activities were performed during the reporting period” as your response. “N/A” is not an acceptable response.	Periodic Audit - Financial; Periodic Audit – Encounter Data Validation; Audit of Service-Based Enhancement (SBE) payments to MCOs for: Delivery Case Rate Tribal Encounter Differential (Mental Health & SUD) Tribal FQHC (Medical, Mental Health & SUD) Non-Native Tribal FQHC (Medical, Mental Health & SUD) Health Homes - Outreach, Engagement and Health Action Plan Health Homes - Intensive Health Home Care Coordination Health Homes - Low-level Health Home Care Coordination Foundational Community Support – Housing Foundational Community Support – Pre-Employment Foundational Community Support – Employment New Journeys (coordinated specialty care (CSC) program providing early intervention for ages 15 to 40 experiencing first episode of psychosis (FEP)) – Reviews included engagement outreach and recovery resiliency. Fee-For-Service/Managed Care duplicate payment – DME focus.
BX.2	Contract standard for overpayments Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	Allow plans to retain overpayments
BX.3	Location of contract provision stating overpayment standard Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Sections 5 & 12 of the IFC Contract (5.6, 12.1, 12.5 & 12.10) for overpayments made by the plans to their network providers
BX.4	Description of overpayment contract standard Briefly describe the overpayment standard selected in indicator B.X.2.	Plans are allowed to keep overpayments recovered from their network providers. The plans must report the identification and recovery of overpayments to the state within 30 days of the identification or recovery and must recover identified

overpayments within 60 days of identification. The state may assess liquidated damages if the plans fail to identify and recover overpayments as required.

BX.5**State overpayment reporting monitoring**

Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.

The state requires the plans to report all program integrity activities on a monthly deliverable that includes audit detail, encounter detail, identified and recovered overpayment amounts. The state reviews and validates overpayment recoveries against submitted encounter data and meets with the plans quarterly to discuss their program integrity performance and clarify any discrepancies between reported program integrity activities and submitted encounter data. In addition, the plans are required to submit an annual report of program integrity activities that rolls up and reports identified and recovered overpayments and cost avoidance amounts for the prior calendar year.

BX.6**Changes in beneficiary circumstances**

Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).

The state issues the 834 Benefit and Enrollment Maintenance report to each MCO every day to ensure eligibility files are up to date. In addition, the files are audited each month to ensure enrollment files are accurate. The state also requires the plans to report demographic changes through MC-Track using the Newborn Payment Assistance Request Form (NB PARF) for newborn retro-enrollment and the Payment Assistance Request Form (PARF) for all other payment and enrollment inquiries to include but not limited to Service Base Enhancements (DCR, WISe, etc.), regular premium payments and other demographic changes that may impact eligibility (DOD, out-of-state address, etc.).

BX.7a**Changes in provider circumstances: Monitoring plans**

Does the state monitor whether plans report provider "for cause" terminations in a timely

Yes

manner under 42 CFR
438.608(a)(4)? Select one.

BX.7b	Changes in provider circumstances: Metrics Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	Federal database checks: Excluded person or entities During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
BX.8b	Federal database checks: Summarize instances of exclusion Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.	Provider Enrollment's screening results with possible exclusions were sent to QMT in which we confirmed active exclusions for 7 enrolled providers. QMT mailed Termination letters to those 7 providers which were reported to DEX.

BX.9a	Website posting of 5 percent or more ownership control Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	Yes
BX.9b	Website posting of 5 percent or more ownership control: Link What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.hca.wa.gov/about-hca/other-administrative-activities/audits-and-reporting
BX.10	Periodic audits If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	Periodic audits were in process during 2025. Results will be published upon completion in 2026.

Topic XIII. Prior Authorization



Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Yes
BXIII.1a	Timeframes for standard prior authorization decisions Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	No
BXIII.2a	Timeframes for expedited prior authorization decisions Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	No

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	Apple Health Integrated Foster Care (IFC 01/01/2025)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2025
C11.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.hca.wa.gov/billers-providers-partners/program-information-providers/model-managed-care-contracts
C11.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C11.4a	Special program benefits Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health
C11.4b	Variation in special benefits What are any variations in the availability of special benefits within the program (e.g. by service	N/A

area or population)? Enter
"N/A" if not applicable.

C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	20,059
C11.6	Changes to enrollment or benefits Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.	There were no major changes to the population or benefits during the reporting year.

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
C1II.1	Submission Date of Most Recent MLR Report When is the last date the state submitted the MLR Summary Report in the Medicaid Data Collection Tool (MDCT) MLR Portal for this program?	12/31/2026
C1II.2	Most Recent MLR Reporting Period Please report the beginning date of that MLR reporting period.	01/01/2025
N/A	Please report the end date of that MLR reporting period.	12/31/2025
C1II.3	MLR Validation Completion Has the state completed the validation of plan MLR data for the current MCPAR reporting period by the submission date of this report for all plans? (See detailed reporting in Section D1.II by plan.)	No
C1II.3a	Anticipated Validation Date When does the state anticipate doing so?	05/2027

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	Uses of encounter data For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	Criteria/measures to evaluate MCP performance What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	Encounter data performance criteria contract language Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	5.17-5.17.11.3
C1III.4	Financial penalties contract language Provide reference(s) to the contract section(s) that	5.17.9.3

describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.

C1III.5 Incentives for encounter data quality N/A

Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with N/A if the program does not use incentives to reward encounter data quality.

C1III.6 Barriers to collecting/validating encounter data

Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.

Barriers we experienced though not limited to were data quality issues, timeliness, data format compatibility, technical challenges, and contractor reluctance/resistance.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	State's definition of "critical incident", as used for reporting purposes in its MLTSS program If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	State definition of "timely" resolution for standard appeals Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	IFC Contract Subsection 13.3.1.12.1 : For standard resolution of Appeals and for Appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Enrollee that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for Appeal. For any extension not requested by an Enrollee, the Contractor shall resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires
C1IV.3	State definition of "timely" resolution for expedited appeals Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	"IFC Contract Subsection 13.4.4.1: For expedited resolution of Appeals, Appeals of Concurrent Review authorizations, or Appeals of mental health drug authorization decisions, including notice to the affected parties, the Contractor shall make a decision within seventy-two (72) hours after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice of the decision."
C1IV.4	State definition of "timely" resolution for	"IFC Contract Subsection 13.2.1.7: The Contractor shall complete the resolution

grievances

Provide the state's definition of timely resolution for grievances in the managed care program.

Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

of a Grievance and notice to the affected parties as expeditiously as the Enrollee's health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance. The Contractor may extend the timeframe for processing a Grievance by up to fourteen (14) calendar days if the Enrollee requests the extension. For any extension not requested by an Enrollee, the Contractor must document that there is need for additional information and that the delay is in the Enrollee's best interest and give the Enrollee prompt oral notice of the delay. "

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.



Complete

C2.V.3 Standard type: Maximum time or distance

1 / 41

C2.V.2 Measure standard

2 in 10 miles, travel time not to exceed 30 minutes from the enrollee's primary residence. 90 minute maximum for public transit.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Urban

C2.V.6**Population**

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

2 / 41

C2.V.2 Measure standard

1 in 25 miles, travel time not to exceed 60 minutes.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Non-urban

C2.V.6**Population**

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

3 / 41

C2.V.2 Measure standard

1 in 25 miles, travel time not to exceed 60 minutes.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Non-urban

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

4 / 41

C2.V.2 Measure standard

2 in 10 miles, travel time not to exceed 30 minutes from the enrollee's primary residence. 90 minute maximum for public transit.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Urban

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

5 / 41

C2.V.2 Measure standard

1 in 25 miles, travel time not to exceed 60 minutes.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Non-urban

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

6 / 41

C2.V.2 Measure standard

2 in 10 miles, travel time not to exceed 30 minutes from the enrollee's primary residence. 90 minute maximum for public transit.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Urban

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

7 / 41

C2.V.2 Measure standard

1 in 25 miles, travel time not to exceed 60 minutes.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

8 / 41

C2.V.2 Measure standard

1 in 25 miles, travel time not to exceed 60 minutes.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Substance Use
Disorder (SUD)

C2.V.5 Region

Statewide

C2.V.6**Population**

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

9 / 41

C2.V.2 Measure standard

1 in 25 miles, travel time not to exceed 60 minutes.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health

C2.V.5 Region

Statewide

C2.V.6**Population**

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Service fulfillment

10 / 41

C2.V.2 Measure standard

Error rate 10% or less

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Encounter Data Analysis, Custom method - NPI Validation

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Service fulfillment

11 / 41

C2.V.2 Measure standard

Error rate 10% or less

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Encounter Data Analysis, Custom method - NPI Validation

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Service fulfillment

12 / 41

C2.V.2 Measure standard

Error rate 10% or less

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Substance Use
Disorder (SUD)

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Encounter Data Analysis, Custom method - NPI Validation

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Service fulfillment

13 / 41

C2.V.2 Measure standard

Error rate 10% or less

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Encounter Data Analysis, Custom method - NPI Validation

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Service fulfillment

14 / 41

C2.V.2 Measure standard

Error rate 10% or less

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Encounter Data Analysis, Custom method - NPI Validation

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Service fulfillment

15 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Review of Grievances Related to Access

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Service fulfillment

16 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Review of Grievances Related to Access

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Service fulfillment

17 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Substance Use
Disorder (SUD)

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Review of Grievances Related to Access

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Service fulfillment

18 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Review of Grievances Related to Access

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Service fulfillment

19 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Review of Grievances Related to Access

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Network participation and ease of getting a timely appointment

20 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Secret Shopper: Network Participation, Secret Shopper:
Appointment Availability

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Network participation and ease of getting a timely appointment

21 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Secret Shopper: Network Participation, Secret Shopper:
Appointment Availability

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Network participation and ease of getting a timely appointment

22 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Substance Use
Disorder (SUD)

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Secret Shopper: Network Participation, Secret Shopper:
Appointment Availability

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Network participation and ease of getting a timely appointment

23 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Statewide

C2.V.6**Population**Adult and
pediatric**C2.V.7 Monitoring Methods**Secret Shopper: Network Participation, Secret Shopper:
Appointment Availability**C2.V.8 Frequency of oversight methods**

Varies by plan



Complete

C2.V.3 Standard type: Network participation and ease of getting a timely appointment

24 / 41

C2.V.2 Measure standard

N/A

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Statewide

C2.V.6**Population**Adult and
pediatric**C2.V.7 Monitoring Methods**Secret Shopper: Appointment Availability, Secret Shopper:
Network Participation**C2.V.8 Frequency of oversight methods**

Varies by plan



Complete

C2.V.3 Standard type: Appointment wait time

25 / 41

C2.V.2 Measure standard

Within 7 calendar days of discharge

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Capacity survey, direct provider outreach, and review of enrollee and/or provider complaints

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Appointment wait time

26 / 41

C2.V.2 Measure standard

Within 7 calendar days of discharge

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Transitional
Health Care
Services by a
home care nurse,
home care
registered
counselor, or a
Mental Health
Professional

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Capacity survey, direct provider outreach, and review of enrollee and/or provider complaints

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Appointment wait time

27 / 41

C2.V.2 Measure standard

Within 30 calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Non-Symptomatic
visit

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Capacity survey, direct provider outreach, and review of enrollee and/or provider complaints

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Appointment wait time

28 / 41

C2.V.2 Measure standard

Within 10 calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Non-urgent,

C2.V.5 Region

Statewide

C2.V.6

Population

symptomatic visit

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Capacity survey, direct provider outreach, and review of enrollee and/or provider complaints

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Appointment wait time

29 / 41

C2.V.2 Measure standard

Within 24 hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Urgent,
symptomatic visit

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Capacity survey, direct provider outreach, and review of enrollee and/or provider complaints

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Appointment wait time

30 / 41

C2.V.2 Measure standard

Available 24 hours per day, seven days per week.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Statewide

C2.V.6**Population**Adult and
pediatric**C2.V.7 Monitoring Methods**

Custom method - Capacity survey, direct provider outreach, and review of enrollee and/or provider complaints

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Appointment wait time

31 / 41

C2.V.2 Measure standard

Within 30 calendar days of the request

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 ProviderSpecialist: Second
Opinion
appointments**C2.V.5 Region**

Statewide

C2.V.6**Population**Adult and
pediatric**C2.V.7 Monitoring Methods**

Custom method - Capacity survey, direct provider outreach, and review of enrollee and/or provider complaints

C2.V.8 Frequency of oversight methods

Varies by plan



Complete

C2.V.3 Standard type: Provider directory accuracy

32 / 41

C2.V.2 Measure standard

Updated quarterly minimum, monthly if not mobile-enabled, and within 30 days of a reported change or 10 days of a reported error.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Plan Provider Directory Review

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Provider directory accuracy

33 / 41

C2.V.2 Measure standard

Updated quarterly minimum, monthly if not mobile-enabled, and within 30 days of a reported change or 10 days of a reported error.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Plan Provider Directory Review

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Provider directory accuracy

34 / 41

C2.V.2 Measure standard

Updated quarterly minimum, monthly if not mobile-enabled, and within 30 days of a reported change or 10 days of a reported error.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Substance Use
Disorder (SUD)

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Plan Provider Directory Review

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Provider directory accuracy

35 / 41

C2.V.2 Measure standard

Updated quarterly minimum, monthly if not mobile-enabled, and within 30 days of a reported change or 10 days of a reported error.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Plan Provider Directory Review

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Provider directory accuracy

36 / 41

C2.V.2 Measure standard

Updated quarterly minimum, monthly if not mobile-enabled, and within 30 days of a reported change or 10 days of a reported error.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Plan Provider Directory Review

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Hours of operation

37 / 41

C2.V.2 Measure standard

No less than the hours of operation offered to any other patient

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Deliverable

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Hours of operation

38 / 41

C2.V.2 Measure standard

No less than the hours of operation offered to any other patient

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Deliverable

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Hours of operation

39 / 41

C2.V.2 Measure standard

No less than the hours of operation offered to any other patient

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Substance Use
Disorder (SUD)

C2.V.5 Region

Statewide

C2.V.6**Population**

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Deliverable

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Hours of operation

40 / 41

C2.V.2 Measure standard

No less than the hours of operation offered to any other patient

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Statewide

C2.V.6**Population**

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Deliverable

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Hours of operation

41 / 41

C2.V.2 Measure standard

No less than the hours of operation offered to any other patient

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Statewide

C2.V.6

Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Custom method - Deliverable

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	"https://www.hca.wa.gov/about-hca/contact-hca , https://www.wahealthplanfinder.org , https://www.wahealthplanfinder.org/us/en/tools-and-resources/connect-with-us/virtual-help-details.html"
C1IX.2	BSS auxiliary aids and services How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	"Washington Healthplanfinder (Health Benefit Exchange) and Washington State Health Care Authority: • Provide free aids and services to people with disabilities to communicate effectively, such as: o Qualified sign language interpreters o Written information in other formats (large print, audio, accessible electronic formats, other formats) • Provide free language services to people whose primary language is not English, such as: o Qualified interpreters o Information written in other languages Washington Healthplanfinder provides customers the option to search and partner with a Broker or Navigator based on the assister's service language. Washington Healthplanfinder - Notice of Nondiscrimination website: https://www.wahbexchange.org/about-the-exchange/what-is-the-exchange/policies/nondiscrimination-accessibility/ Washington Healthplanfinder - How to Get Language Support website: https://www.wahealthplanfinder.org/us/en/tools-and-resources/how-to/language-support.html Washington Healthplanfinder - Accessibility and Inclusion website: https://www.wahealthplanfinder.org/us/en/about-us/our-organization/accessibility-and-inclusion.html Washington Health Care Authority - Notice of Nondiscrimination website: https://www.hca.wa.gov/about-hca/nondiscrimination-statement Washington Health Care Authority - ADA Accessibility website: https://www.hca.wa.gov/about-hca/ada-

accessibility Washington Health Care Authority - Language Access website: <https://www.hca.wa.gov/about-hca/language-access> Washington Health Care Authority - Language Access publication insert: <https://www.hca.wa.gov/assets/program/65-153-language-assistance-insert.pdf>

C1IX.3 BSS LTSS program data

N/A

How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4). If the program does not offer LTSS, enter "N/A".

C1IX.4 State evaluation of BSS entity performance

What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?

"Out of State Alumni: The Exchange partners with Navigators and Brokers to perform outreach and enrollment activities. The Exchange supports quality, effectiveness, and efficiency through metrics such as monthly enrollment reports and KPIs. Navigators: • Lead Organizations send monthly enrollment and outreach reports to the Exchange. • Quality, effectiveness, and efficiency is measured by the key performance indicators (KPIs):

- o Complete outreach plan and report delivered monthly
- o Monthly outreach activities reach attendance limit
- o Favorable support and responsiveness ratings from Navigators they support during the yearly Navigator Survey
- o Navigator background checks are completed timely every two years
- o Navigators pass certification quizzes within the first three attempts
- o Partner Organization subcontracts (MOUs) are executed and submitted to the Exchange timely
- o Minimum standards of Qualified Health Plan re-enrollment of customers partnered with a Navigator

Brokers: • Brokers must sign a Washington Health Benefit Exchange Producer Participation Agreement confirming:

- o They will comply with all Exchange policies and procedures including but not limited to those relate to enrollment solicitation,

submission of applications, and sales requirements. o They will comply with all applicable federal and state laws and regulations, including those governing data protection, confidentiality, and conflicts of interest, and to abide by all rules, regulations, policies, and procedures established by the Exchange, including, but not limited to, required training, annual update training, and Exchange privacy and security standards.

- Brokers must present a Scope of Appointment form to prospective customers prior to all sales presentations. o The Exchange requires Brokers to document the scope of the marketing appointment to ensure consumers understand what will be discussed between the Broker and the consumer (or their authorized representative). o Forms are to be maintained by the producer and made available upon the request of the Exchange.

Brokers and Navigators:

- Assistants are required to certify with the Exchange to access Washington Healthplanfinder.
- Assistants complete initial onboarding training and security and privacy training annually.
- Navigators also must complete a job shadow requirement.
- Brokers are required to complete a re-certification training plan and Navigators are required to complete quarterly training to retain their Washington Healthplanfinder access.
- Training provided helps keep assistants informed of systems, process, regulations, and updates to the Washington Healthplanfinder application.
- Assistants complete a User Access Agreement when onboarding and during their yearly security refresh training.

Other IFC Clients services are provided by the agency's fostercare team.

fcas@hca.wa.gov, <https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/foster-care>"

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	Does this program include MCOs? If “Yes”, please complete the following questions.	Yes
C1XII.5	Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system? (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	Did the State or MCOs complete the most recent parity analysis(es)?	Other, specify – MCOs and State reviewed their analysis.
C1XII.7a	Have there been any events in the reporting period that necessitated an update to the parity analysis(es)? (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	Yes
C1XII.7b	Describe the event(s) that necessitated an update to the parity analysis(es). Select all that apply.	Other, specify – State Plan Amendments
C1XII.8	When was the last parity analysis(es) for this program completed? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the	04/01/2026

date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).

C1XII.9	When was the last parity analysis(es) for this program submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	01/13/2025
C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website? The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes"	Yes

response means that the parity analysis for either the state or for ALL MCOs has been posted.

C1XII.12b	Provide the URL link(s). Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://www.hca.wa.gov/about-hca/data-and-reports/apple-health-medicare-and-managed-care-reports
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Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	Coordinated Care of Washington 20,059
		Community Health Plan of Washington 0
		Molina Healthcare of Washington Incorporated 0
		United Healthcare Community Plan 0
		Wellpoint 0
D1I.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1) Denominator: Statewide Medicaid enrollment (B.I.1)	Coordinated Care of Washington 1%
		Community Health Plan of Washington 0%
		Molina Healthcare of Washington Incorporated 0%
		United Healthcare Community Plan 0%
		Wellpoint 0%
D1I.3	Plan share of risk-based Medicaid managed care What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in risk-based managed care? Numerator: Plan enrollment	Coordinated Care of Washington 1.2%
		Community Health Plan of Washington 0%

(D1.I.1)Denominator:
Statewide Medicaid risk-
based managed care
enrollment (B.I.2)

**Molina Healthcare of
Washington Incorporated**

0%

**United Healthcare
Community Plan**

0%

Wellpoint

0%

D1I.4: Parent

**Organization: The name
of the parent entity that
controls the Medicaid
Managed Care Plan.**

If the managed care plan is
owned or controlled by a
separate entity (parent),
report the name of that
entity. If the managed care
plan is not controlled by a
separate entity, please
report the managed care
plan name in this field.

**Coordinated Care of
Washington**

Centene Cooperation owns
Coordinated Care of
Washington

**Community Health Plan of
Washington**

None for Community Health
Plan of Washington

**Molina Healthcare of
Washington Incorporated**

None for Molina Healthcare,
Inc.

**United Healthcare
Community Plan**

UnitedHealth Group owns
UnitedHealthcare of
Washington

Wellpoint

Elevance Health, Inc. owns
WellPoint

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
D1II.1	MLR Data Received Has the state received the MLR data specified at 42 CFR 438.8(k) from this plan for the current MCPAR reporting period as of the submission date of this MCPAR report?	Coordinated Care of Washington No
		Community Health Plan of Washington No
		Molina Healthcare of Washington Incorporated No
		United Healthcare Community Plan No
		Wellpoint No
D1II.1c	Projected Date for Receipt of MLR Data for This Reporting Period When does the state anticipate receiving MLR data for this reporting period from this plan?	Coordinated Care of Washington 122026
		Community Health Plan of Washington 12/2026
		Molina Healthcare of Washington Incorporated 12/2026
		United Healthcare Community Plan 12/2026
		Wellpoint 12/2026

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	Definition of timely encounter data submissions Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	Coordinated Care of Washington The standard for timely encounter data submissions is 30 days from the end of the month in which the claim was paid by the MCP. Community Health Plan of Washington The standard for timely encounter data submissions is 30 days from the end of the month in which the claim was paid by the MCP. Molina Healthcare of Washington Incorporated The standard for timely encounter data submissions is 30 days from the end of the month in which the claim was paid by the MCP. United Healthcare Community Plan The standard for timely encounter data submissions is 30 days from the end of the month in which the claim was paid by the MCP. Wellpoint The standard for timely encounter data submissions is 30 days from the end of the month in which the claim was paid by the MCP.
D1III.2	Share of encounter data submissions that met state's timely submission requirements What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were	Coordinated Care of Washington 99.91% Community Health Plan of Washington 99.93% Molina Healthcare of Washington Incorporated 99.66% United Healthcare Community Plan 99.66%

	compliant out of the file submissions it has received from the managed care plan for the reporting year.	Wellpoint 99.91%
D1III.3	Share of encounter data submissions that were HIPAA compliant What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	Coordinated Care of Washington 99.89% Community Health Plan of Washington 96.56% Molina Healthcare of Washington Incorporated 95.07% United Healthcare Community Plan 95.65% Wellpoint 96.02%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	Coordinated Care of Washington 68
		Community Health Plan of Washington N/A
		Molina Healthcare of Washington Incorporated N/A
		United Healthcare Community Plan N/A
		Wellpoint N/A
D1IV.1a	Appeals denied Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	Coordinated Care of Washington 20
		Community Health Plan of Washington N/A
		Molina Healthcare of Washington Incorporated N/A
		United Healthcare Community Plan N/A
		Wellpoint N/A
D1IV.1b	Appeals resolved in partial favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	Coordinated Care of Washington 0
		Community Health Plan of Washington N/A
		Molina Healthcare of Washington Incorporated

		N/A
		United Healthcare Community Plan
		N/A
		Wellpoint
		N/A
D1IV.1c	Appeals resolved in favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	Coordinated Care of Washington 48 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.2	Active appeals Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.3	Appeals filed on behalf of LTSS users	Coordinated Care of Washington N/A

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a Standard appeals for which timely resolution was provided

Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

Coordinated Care of Washington
58

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.5b Expedited appeals for which timely resolution was provided

Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.

Coordinated Care of Washington
10

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	Coordinated Care of Washington 68 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.6c	Resolved appeals related to payment denial Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A

		United Healthcare Community Plan N/A Wellpoint N/A
D1IV.6d	Resolved appeals related to service timeliness Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care	Coordinated Care of Washington 0

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO). If not applicable, enter "N/A."

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.6g Resolved appeals related to denial of an enrollee's request to dispute financial liability

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

Coordinated Care of Washington

0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.7b	Resolved appeals related to general outpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	Coordinated Care of Washington 6 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.7c	Resolved appeals related to inpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover	Coordinated Care of Washington 5 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated

inpatient behavioral health services, enter "N/A".

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7d

Resolved appeals related to outpatient behavioral health services

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".

Coordinated Care of Washington
2

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7e

Resolved appeals related to covered outpatient prescription drugs

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".

Coordinated Care of Washington
34

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7f

Resolved appeals related to skilled nursing facility (SNF) services

Coordinated Care of Washington
0

Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7g

Resolved appeals related to long-term services and supports (LTSS)

Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A". (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7h

Resolved appeals related to dental services

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7i

Resolved appeals related to non-emergency medical transportation (NEMT)

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7k:

Resolved appeals related to durable medical equipment (DME) & supplies

Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".

Coordinated Care of Washington

21

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7l:

Resolved appeals related to home health / hospice

Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover

Coordinated Care of Washington

0

Community Health Plan of Washington

N/A

this type of service, enter “N/A”.

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7m: Resolved appeals related to emergency services / emergency department

Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.

Coordinated Care of Washington
0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7n: Resolved appeals related to therapies

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.

Coordinated Care of Washington
0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.7o**Resolved appeals related to other service types**

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter "N/A".

Coordinated Care of Washington

0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

State Fair Hearings

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	Coordinated Care of Washington
		3
		Community Health Plan of Washington
		0
		Molina Healthcare of Washington Incorporated
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	0
		Community Health Plan of Washington
		0
		Molina Healthcare of Washington Incorporated
		0
D1IV.8c	State Fair Hearings resulting in an adverse decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	United Healthcare Community Plan
		0
		Wellpoint
		0
		Coordinated Care of Washington
		3
		Community Health Plan of Washington
		0
		Molina Healthcare of Washington Incorporated

		0
		United Healthcare Community Plan
		0
		Wellpoint
		0
D1IV.8d	State Fair Hearings retracted prior to reaching a decision Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	Coordinated Care of Washington 0 Community Health Plan of Washington 0 Molina Healthcare of Washington Incorporated 0 United Healthcare Community Plan 0 Wellpoint 0
D1IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	Coordinated Care of Washington 0 Community Health Plan of Washington 0 Molina Healthcare of Washington Incorporated 0 United Healthcare Community Plan 0 Wellpoint 0
D1IV.9b	External Medical Reviews resulting in an adverse decision for the enrollee	Coordinated Care of Washington 0

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter “N/A”. External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Community Health Plan of Washington

0

Molina Healthcare of Washington Incorporated

0

United Healthcare Community Plan

0

Wellpoint

0

Grievances Overview

Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.A grievance is “resolved” when it has reached completion and been closed by the plan.	Coordinated Care of Washington
		167
		Community Health Plan of Washington
		0
		Molina Healthcare of Washington Incorporated
		0
		United Healthcare Community Plan
		0
		Wellpoint
		0
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	Coordinated Care of Washington
		1
		Community Health Plan of Washington
		0
		Molina Healthcare of Washington Incorporated
		0
		United Healthcare Community Plan
		0
		Wellpoint
		0
D1IV.12	Grievances filed on behalf of LTSS users Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was	Coordinated Care of Washington
		N/A
		Community Health Plan of Washington
		N/A
		Molina Healthcare of Washington Incorporated
		N/A

filed). If this does not apply, enter N/A.

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.13 Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter “N/A” in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter “N/A” in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

D1IV.14 Number of grievances for which timely resolution was provided

Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

Coordinated Care of Washington

165

Community Health Plan of Washington

0

Molina Healthcare of Washington Incorporated

0

United Healthcare Community Plan

0

Wellpoint

0

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	Resolved grievances related to general inpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	Coordinated Care of Washington 0
		Community Health Plan of Washington N/A
		Molina Healthcare of Washington Incorporated N/A
		United Healthcare Community Plan N/A
		Wellpoint N/A
D1IV.15b	Resolved grievances related to general outpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	Coordinated Care of Washington 0
		Community Health Plan of Washington N/A
		Molina Healthcare of Washington Incorporated N/A
		United Healthcare Community Plan N/A
		Wellpoint N/A
D1IV.15c	Resolved grievances related to inpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed	Coordinated Care of Washington 0
		Community Health Plan of Washington N/A
		Molina Healthcare of Washington Incorporated

care plan does not cover this type of service, enter "N/A".

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15d

Resolved grievances related to outpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Coordinated Care of Washington

0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Coordinated Care of Washington

0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

Coordinated Care of Washington

0

Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15g

Resolved grievances related to long-term services and supports (LTSS)

Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15h

Resolved grievances related to dental services

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".

Coordinated Care of Washington

0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

		Wellpoint N/A
D1IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT) Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.15k	Resolved grievances related to durable medical equipment (DME) & supplies Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	Coordinated Care of Washington 0 Community Health Plan of Washington N/A Molina Healthcare of Washington Incorporated N/A United Healthcare Community Plan N/A Wellpoint N/A
D1IV.15l	Resolved grievances related to home health / hospice Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover	Coordinated Care of Washington 0 Community Health Plan of Washington N/A

this type of service, enter “N/A”.

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15m

Resolved grievances related to emergency services / emergency department

Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.

Coordinated Care of Washington
0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15n

Resolved grievances related to therapies

Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.

Coordinated Care of Washington
0

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

D1IV.15o **Resolved grievances related to other service types**

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".

Coordinated Care of Washington
167

Community Health Plan of Washington
N/A

Molina Healthcare of Washington Incorporated
N/A

United Healthcare Community Plan
N/A

Wellpoint
N/A

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	Coordinated Care of Washington 11
		Community Health Plan of Washington 0
		Molina Healthcare of Washington Incorporated 0
		United Healthcare Community Plan 0
		Wellpoint 0
D1IV.16b	Resolved grievances related to plan or provider care management/case management Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	Coordinated Care of Washington 0
		Community Health Plan of Washington 0
		Molina Healthcare of Washington Incorporated 0
		United Healthcare Community Plan 0
		Wellpoint 0
D1IV.16c	Resolved grievances related to network adequacy or access to care/services from plan or provider Enter the total number of grievances resolved by the plan during the reporting year that were related to	Coordinated Care of Washington 3

access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

**Community Health
Plan of Washington**

0

**Molina Healthcare of
Washington
Incorporated**

0

**United Healthcare
Community Plan**

0

Wellpoint

0

**D1IV.16d Resolved grievances related to
quality of care**

Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.

**Coordinated Care of
Washington**

1

**Community Health
Plan of Washington**

0

**Molina Healthcare of
Washington
Incorporated**

0

**United Healthcare
Community Plan**

0

Wellpoint

0

**D1IV.16e Resolved grievances related to plan
communications**

Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

**Coordinated Care of
Washington**

3

**Community Health
Plan of Washington**

0

**Molina Healthcare of
Washington
Incorporated**

0

**United Healthcare
Community Plan**

0

Wellpoint

0

**D1IV.16f Resolved grievances related to
payment or billing issues**

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

**Coordinated Care of
Washington**

146

**Community Health
Plan of Washington**

0

**Molina Healthcare of
Washington
Incorporated**

0

**United Healthcare
Community Plan**

0

Wellpoint

0

**D1IV.16g Resolved grievances related to
suspected fraud**

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

**Coordinated Care of
Washington**

0

**Community Health
Plan of Washington**

0

**Molina Healthcare of
Washington
Incorporated**

0

**United Healthcare
Community Plan**

0

Wellpoint

0

D1IV.16h	Resolved grievances related to abuse, neglect or exploitation Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	Coordinated Care of Washington 0 Community Health Plan of Washington 0 Molina Healthcare of Washington Incorporated 0 United Healthcare Community Plan 0 Wellpoint 0
D1IV.16i	Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals) Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	Coordinated Care of Washington 0 Community Health Plan of Washington 0 Molina Healthcare of Washington Incorporated 0 United Healthcare Community Plan 0 Wellpoint 0
D1IV.16j	Resolved grievances related to plan denial of expedited appeal Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of	Coordinated Care of Washington 0 Community Health Plan of Washington 0

expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.

Molina Healthcare of Washington Incorporated

0

United Healthcare Community Plan

0

Wellpoint

0

D1IV.16k Resolved grievances filed for other reasons

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.

Coordinated Care of Washington

3

Community Health Plan of Washington

0

Molina Healthcare of Washington Incorporated

0

United Healthcare Community Plan

0

Wellpoint

0

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

✓

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visit 1 / 23

(WCV) - 3-11

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and Programs

D2.VII.5

N/A

Program-specific rate

D2.VII.6 Measure Set

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

HEDIS

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

63%

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visit 2 / 23 (WCV) - 12-17

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

52%

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visit 3 / 23 (WCV) - 18-21

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

24%

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

Complete  **D2.VII.1 Measure Name: Well-Child Visits in First 30 Months of life (W30), 0-15 months** 4 / 23

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Coordinated Care of Washington
63.2%

Community Health Plan of Washington
N/A

Molina Healthcare of Washington Incorporated
N/A

United Healthcare Community Plan
N/A

Wellpoint
N/A

✓

Complete

D2.VII.1 Measure Name: Well-Child Visits in First 30 Months of life (W30), 15-30 months

5 / 23

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number	D2.VII.4 Measure Reporting and Programs	D2.VII.5
N/A	Program-specific rate	

D2.VII.6 Measure Set	D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
HEDIS	No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

83%

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) 6 / 23

combo 10

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

47.5

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA)7 / 23

Combo 2

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

46.2

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

D2.VII.1 Measure Name: Lead Screening in Children (LSC)

8 / 23

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set
HEDIS

**D2.VII.7a Reporting Period and
D2.VII.7b Reporting period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

39.6

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



D2.VII.1 Measure Name: Chlamydia Screening (CHL) 16-20

Primary care access and preventative care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

47.3

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



**D2.VII.3 National
Quality Forum
(NQF) number**
N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**
Program-specific rate

D2.VII.6 Measure Set
HEDIS

**D2.VII.7a Reporting Period and
D2.VII.7b Reporting period: Date range**
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Coordinated Care of Washington
62.7

Community Health Plan of Washington
N/A

Molina Healthcare of Washington Incorporated
N/A

United Healthcare Community Plan
N/A

Wellpoint
N/A

 **D2.VII.1 Measure Name: Asthma Medication Ratio (AMR) - 11 / 23**
Complete Total

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set HEDIS
D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description
N/A

Measure results

Coordinated Care of Washington
77.2

Community Health Plan of Washington
N/A

Molina Healthcare of Washington Incorporated
N/A

United Healthcare Community Plan
N/A

Wellpoint
N/A

 **D2.VII.1 Measure Name: Kidney Health Evaluation for Patients with Diabetes (KED)** 2 / 23
Complete

D2.VII.2 Measure Domain
Care of acute and chronic conditions

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

24.3

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

**D2.VII.1 Measure Name: Antidepressant Medication
Management (AMM), Effective Acute Phase**

13 / 23

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

57.5

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

**D2.VII.1 Measure Name: Antidepressant Medication
Management (AMM), Conituation Phase**

14 / 23

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

36.7

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

**D2.VII.1 Measure Name: Follow-up Care for Children
Prescribed ADHD Medciation (ADD), Initiation Phase**

15 / 23

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

45.7

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

**D2.VII.1 Measure Name: Follow-up after Hospitalization for
Mental Illness (FUH), 30-day, Total** 16 / 23

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and

D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

70.7

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

**D2.VII.1 Measure Name: Follow-up after Hospitalization for
Mental Illness (FUH), 7 day, Total** 17 / 23

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National
Quality Forum
(NQF) number**
N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**
Program-specific rate

D2.VII.6 Measure Set
HEDIS

**D2.VII.7a Reporting Period and
D2.VII.7b Reporting period: Date range**
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Coordinated Care of Washington
45.3

Community Health Plan of Washington
N/A

Molina Healthcare of Washington Incorporated
N/A

United Healthcare Community Plan
N/A

Wellpoint
N/A

 **D2.VII.1 Measure Name: Follow-up after Emergency
Complete Department Visit for Substance Use (FUA), 30-day, Total**

18 / 23

D2.VII.2 Measure Domain
Behavioral health care

**D2.VII.3 National
Quality Forum
(NQF) number**
N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**
Program-specific rate

D2.VII.6 Measure Set **D2.VII.7a Reporting Period and**
HEDIS **D2.VII.7b Reporting period: Date range**
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Coordinated Care of Washington
40

Community Health Plan of Washington
N/A

Molina Healthcare of Washington Incorporated
N/A

United Healthcare Community Plan
N/A

Wellpoint
N/A

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set HEDIS
D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Coordinated Care of Washington
27

Community Health Plan of Washington
N/A

Molina Healthcare of Washington Incorporated
N/A

United Healthcare Community Plan
N/A

Wellpoint
N/A

 **D2.VII.1 Measure Name: Getting Needed Care (Composite),** 20 / 23
Complete **Child IFC**

D2.VII.2 Measure Domain
Health plan enrollee experience of care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set
CAHPS

**D2.VII.7a Reporting Period and
D2.VII.7b Reporting period: Date range**

No, 01/01/2025 - 12/31/2025

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

D2.VII.1 Measure Name: Getting Care Quickly (Composite), 21 / 23
Child IFC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set
CAHPS

**D2.VII.7a Reporting Period and
D2.VII.7b Reporting period: Date range**

No, 01/01/2025 - 12/31/2025

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

89.3

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



**D2.VII.1 Measure Name: How Well Doctors Communicate
(Composite), Child IFC**

22 / 23

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set
CAHPS

**D2.VII.7a Reporting Period and
D2.VII.7b Reporting period: Date range**

No, 01/01/2025 - 12/31/2025

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

98.2

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A



Complete

D2.VII.1 Measure Name: Customer Service (Composite), Child

23 / 23

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National
Quality Forum
(NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5
Programs**

Program-specific rate

D2.VII.6 Measure Set
CAHPS

**D2.VII.7a Reporting Period and
D2.VII.7b Reporting period: Date range**

No, 01/01/2025 - 12/31/2025

D2.VII.8 Measure Description

N/A

Measure results

Coordinated Care of Washington

N/A

Community Health Plan of Washington

N/A

Molina Healthcare of Washington Incorporated

N/A

United Healthcare Community Plan

N/A

Wellpoint

N/A

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count:

0 - No sanctions entered

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	Coordinated Care of Washington 4.75
		Community Health Plan of Washington 14
		Molina Healthcare of Washington Incorporated 27
		United Healthcare Community Plan 5
		Wellpoint 6
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	Coordinated Care of Washington 205
		Community Health Plan of Washington 360
		Molina Healthcare of Washington Incorporated 169
		United Healthcare Community Plan 454
		Wellpoint 361
D1X.4	Count of resolved program integrity investigations How many program integrity investigations were resolved by the plan during the reporting year?	Coordinated Care of Washington 206
		Community Health Plan of Washington 303
		Molina Healthcare of Washington Incorporated 176

United Healthcare Community Plan
550

Wellpoint
422

D1X.6 **Referral path for program integrity referrals to the state**

What is the referral path that the plan uses to make program integrity referrals to the state? Select one.

Coordinated Care of Washington

Makes referrals to the SMA and MFCU concurrently

Community Health Plan of Washington

Makes referrals to the SMA and MFCU concurrently

Molina Healthcare of Washington Incorporated

Makes referrals to the SMA and MFCU concurrently

United Healthcare Community Plan

Makes referrals to the SMA and MFCU concurrently

Wellpoint

Makes referrals to the SMA and MFCU concurrently

D1X.7	Count of program integrity referrals to the state Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	Coordinated Care of Washington 1 Community Health Plan of Washington 3 Molina Healthcare of Washington Incorporated 26 United Healthcare Community Plan 10 Wellpoint 12
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D1X.9a:	Plan overpayment reporting to the state: Start Date What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	Coordinated Care of Washington 01/01/2025 Community Health Plan of Washington 01/01/2025 Molina Healthcare of Washington Incorporated 01/01/2025 United Healthcare Community Plan 01/01/2025 Wellpoint 01/01/2025
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D1X.9b:	Plan overpayment reporting to the state: End Date What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	Coordinated Care of Washington 12/31/2025 Community Health Plan of Washington 12/31/2025 Molina Healthcare of Washington Incorporated 12/31/2025 United Healthcare Community Plan
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D1X.9c:	Plan overpayment reporting to the state: Dollar amount From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	Coordinated Care of Washington \$1,654,157.48 Community Health Plan of Washington \$9,766,062.18 Molina Healthcare of Washington Incorporated \$92,099,213.70 United Healthcare Community Plan \$25,461,290.33 Wellpoint \$20,871,866.34
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D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue What is the total amount of premium revenue for the corresponding reporting period (D1X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	Coordinated Care of Washington \$1,100,546,299 Community Health Plan of Washington \$1,425,284,148.10 Molina Healthcare of Washington Incorporated \$2,272,587,797 United Healthcare Community Plan \$1,192,000,000 Wellpoint \$949,874,113.22
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D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	Coordinated Care of Washington Promptly when plan receives information about the change Community Health Plan of Washington
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Promptly when plan receives
information about the change

**Molina Healthcare of Washington
Incorporated**

Promptly when plan receives
information about the change

United Healthcare Community Plan

Promptly when plan receives
information about the change

Wellpoint

Promptly when plan receives
information about the change

Topic XI: ILOS

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	Coordinated Care of Washington Yes, at least 1 ILOS is offered by this plan
		Community Health Plan of Washington Yes, at least 1 ILOS is offered by this plan
		Molina Healthcare of Washington Incorporated Yes, at least 1 ILOS is offered by this plan
		United Healthcare Community Plan Yes, at least 1 ILOS is offered by this plan
		Wellpoint Yes, at least 1 ILOS is offered by this plan

D4XI.2a	ILOSs utilization by plan Select all ILOSs offered by this plan during the contract rating period. For each ILOS offered by the plan, enter the deduplicated number of enrollees that utilized this ILOS during the contract rating period. If the plan offered this ILOS during the contract rating period but there was no utilization, enter "0".	Coordinated Care of Washington Intensive Behavioral Supportive Supervision (IBSS): N/A
		Community Health Plan of Washington Intensive Behavioral Supportive Supervision (IBSS): N/A
		Molina Healthcare of Washington Incorporated Intensive Behavioral Supportive Supervision (IBSS): N/A
		United Healthcare Community Plan Intensive Behavioral Supportive Supervision (IBSS): N/A
		Wellpoint

Topic XIII. Prior Authorization



Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Yes
D1XIII.1	URL for prior authorization data on plan’s website Provide the URL where the plan posts prior authorization data for all items and services excluding drugs, as required in 42 CFR § 438.210(f). If you choose not to respond prior to June 2026, enter “NR” for not reporting.	Coordinated Care of Washington N/A Community Health Plan of Washington https://www.chpw.org/member-center/prior-authorization-and-um/prior-authorization-report/ Molina Healthcare of Washington Incorporated https://www.molinahealthcare.com/providers/wa/medicaid/resource/Utilization-Management.aspx United Healthcare Community Plan https://www.chpw.org/member-center/prior-authorization-and-um/prior-authorization-report/ Wellpoint https://www.wellpoint.com/wa/medicaid
D1XIII.2	URL for list of all items and services subject to prior authorization Provide the URL where the plan posts the list of all items and services, excluding drugs, that are subject to prior authorization, as required in 42 CFR § 438.210(f)(1). If you choose not to respond prior to June 2026, enter “NR” for not reporting.	Coordinated Care of Washington N/A Community Health Plan of Washington https://www.chpw.org/member-center/prior-authorization-and-um/prior-authorization-report/ Molina Healthcare of Washington Incorporated https://www.molinahealthcare.com/providers/wa/medicaid/resource/Utilization-Management.aspx

United Healthcare Community Plan

<https://www.chpw.org/member-center/prior-authorization-and-um/prior-authorization-report/>

Wellpoint

<https://www.wellpoint.com/wa/medicaid>

D1XIII.3

Total standard prior authorization requests received

Enter the total number of standard prior authorization requests received by the plan for all items and services, excluding drugs, during the prior calendar year. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

117265

Molina Healthcare of Washington Incorporated

139980

United Healthcare Community Plan

117265

Wellpoint

97795

D1XIII.4

Total expedited prior authorization requests received

Enter the total number of expedited prior authorization requests received by the plan for all items and services, excluding drugs, during the prior calendar year. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

8240

Molina Healthcare of Washington Incorporated

15716

United Healthcare Community Plan

8240

Wellpoint

4385

D1XIII.5

Total standard and expedited prior

Coordinated Care of Washington

authorization requests received

Enter the total number of standard and expedited prior authorization requests received (D1.XIII.3 plus D1.XIII.4) by the plan during the prior calendar year. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

N/A

Community Health Plan of Washington

125505

Molina Healthcare of Washington Incorporated

155696

United Healthcare Community Plan

125505

Wellpoint

72180

D1XIII.6

Percentage of standard prior authorization requests that were approved

Of the total standard prior authorization requests, as reported in D1.XIII.3, enter the percentage that were fully approved. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

86.7%

Molina Healthcare of Washington Incorporated

84%

United Healthcare Community Plan

86.7%

Wellpoint

89.7%

D1XIII.7

Percentage of standard prior authorization requests that were denied

Of the total standard prior authorization requests, as reported in D1.XIII.3, enter the percentage that were fully or partially denied. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

13.3%

Molina Healthcare of Washington Incorporated

16%

United Healthcare Community Plan

13.3%

Wellpoint

10.3%

D1XIII.8**Percentage of standard prior authorization requests approved after appeal**

Of the total standard prior authorization requests, as reported in D1.XIII.3, enter the percentage that were approved after appeal. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

50.1%

Molina Healthcare of Washington Incorporated

54%

United Healthcare Community Plan

50.1%

Wellpoint

27.9%

D1XIII.9**Average time to decision for standard prior authorizations**

Of the total standard prior authorization requests, as reported in D1.XIII.3, enter the average number of days that elapsed between submission of request and decision by the plan. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

96.67

Molina Healthcare of Washington Incorporated

2

United Healthcare Community Plan

96.97

Wellpoint

2

D1XIII.10**Median time to decision on standard prior authorizations**

Of the total standard prior authorization requests, as reported in D1.XIII.3, enter the median number of days that elapsed between

Coordinated Care of Washington

N/A

Community Health Plan of Washington

45

submission of request and decision by the plan. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Molina Healthcare of Washington Incorporated

1

United Healthcare Community Plan

45

Wellpoint

1

D1XIII.11 Percentage of expedited prior authorization requests that were approved

Of the total expedited prior authorization requests reported in D1.XIII.4, enter the percentage that were approved. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

92.5%

Molina Healthcare of Washington Incorporated

83%

United Healthcare Community Plan

92.5%

Wellpoint

95.7%

D1XIII.12 Percentage of expedited prior authorization requests that were denied

Of the total expedited prior authorization requests, as reported in D1.XIII.4, enter the percentage that were denied. If you choose not to respond prior to June 2026, enter "NR" for not reporting.

Coordinated Care of Washington

N/A

Community Health Plan of Washington

7.7%

Molina Healthcare of Washington Incorporated

17%

United Healthcare Community Plan

7.7%

Wellpoint

4.3%

D1XIII.13	Average time to decision for expedited prior authorizations Of the total expedited prior authorization requests, as reported in D1.XIII.4, enter the average number of hours that elapsed between submission of request and decision by the plan. If you choose not to respond prior to June 2026, enter "NR" for not reporting.	Coordinated Care of Washington N/A Community Health Plan of Washington 27.91 Molina Healthcare of Washington Incorporated 16 United Healthcare Community Plan 27.91 Wellpoint 2
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D1XIII.14	Median time to decision for expedited prior authorizations Of the total expedited prior authorization requests, as reported in D1.XIII.4, enter the median number of hours that elapsed between submission of request and decision by the plan. If you choose not to respond prior to June 2026, enter "NR" for not reporting.	Coordinated Care of Washington N/A Community Health Plan of Washington 4 Molina Healthcare of Washington Incorporated 11 United Healthcare Community Plan 4 Wellpoint 1
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D1XIII.15	Percentage of total prior authorization requests approved with extended timeframe Of the total prior authorization requests, as reported in D1.XIII.5, enter the percentage of requests for which the timeframe for review was extended and the request was approved. If you choose not to respond prior to	Coordinated Care of Washington N/A Community Health Plan of Washington 97% Molina Healthcare of Washington Incorporated 73%
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June 2026, enter "NR" for not reporting.

United Healthcare Community Plan

97%

Wellpoint

0%

Topic XIV. Patient Access API Usage



Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Yes
D1XIV.1	Number of unique beneficiaries with at least one data transfer For the previous calendar year, indicate the total number of unique beneficiaries covered by the plan in this program whose data were transferred via the Patient Access API to a health application designated by the beneficiary. Provide program-specific numbers. If you choose not to respond prior to June 2026, enter “NR” for not reporting.	Coordinated Care of Washington 0 Community Health Plan of Washington 18 Molina Healthcare of Washington Incorporated 4 United Healthcare Community Plan 12 Wellpoint 15
D1XIV.2	Number of unique beneficiaries with multiple data transfers For the previous calendar year, indicate the total number of unique beneficiaries covered by the plan in this program whose data were transferred more than once via the Patient Access API to a health application designated by the beneficiary. Provide program specific numbers. If you choose not to respond prior to June 2026, enter “NR” for not reporting.	Coordinated Care of Washington 0 Community Health Plan of Washington 18 Molina Healthcare of Washington Incorporated 3 United Healthcare Community Plan 10 Wellpoint 10
D1XIV.3	URL for Patient Access API Provide the URL where the plan posts Patient Access	Coordinated Care of Washington https://prod.api.centene.com/iopc/pa/fhir/patientaccess

API.

Community Health Plan of Washington

<https://www.chpw.org/member-center/member-rights/using-third-party-apps/interoperability-faqs/>

Molina Healthcare of Washington Incorporated

<https://api.interop.molinahealthcare.com/patientaccess/Patient>

United Healthcare Community Plan

<https://www.uhc.com/legal/interoperability-apis/patient-access-api>

Wellpoint

<https://www.wellpoint.com/developers>

D1XIV.4 URL for patient educational resources for Patient Access API

Provide the URL where the plan posts patient educational resources for the Patient Access API.

Coordinated Care of Washington

<https://www.coordinatedcarehealth.com/members/medicaid/resources/interoperability-and-patient-access.html>

Community Health Plan of Washington

<https://www.chpw.org/member-center/member-rights/using-third-party-apps/interoperability-faqs/>

Molina Healthcare of Washington Incorporated

<https://www.molinahealthcare.com/members/common/en-us/abtmolina/data-sharing.aspx>

United Healthcare Community Plan

<https://www.uhc.com/legal/interoperability-apis/patient-access-api>

Wellpoint

<https://www.wellpoint.com/developers>

D1XIV.5 Provider Access and Payer-to-Payer API

Coordinated Care of Washington

**patient educational
resources URL**

Provide the URL where the plan posts patient educational resources for the Provider Access and Payer-to-Payer API.

<https://www.coordinatedcarehealth.com/members/medicaid/resources/interoperability-and-patient-access.html>

**Community Health Plan of
Washington**

<https://www.chpw.org/member-center/member-rights/using-third-party-apps/interoperability-faqs/>

**Molina Healthcare of Washington
Incorporated**

<https://www.molinahealthcare.com/members/common/en-us/abtmolina/data-sharing.aspx>

**United Healthcare Community
Plan**

<https://www.uhc.com/legal/interoperability-apis>

Wellpoint

<https://www.wellpoint.com/developers>

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	BSS entity type What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Washington Healthplanfinder State Government Entity
		State Government Entity Enrollment Broker
		Enrollment Broker Other, specify – Coordinated Care, Enrollment Broker for Out of State Alumni
		Other, specify - Coordinated Care, Enrollment Broker for Out of State Alumni Other, specify – Navigator, Tribal Assister, Certified Application Counselor, Certified Volunteer Assister
EIX.2	BSS entity role What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	Washington Healthplanfinder Other, specify – Eligibility and Enrollment
		State Government Entity Other, specify – Enrollment/Choice Counseling
		Enrollment Broker Other, specify – Enrollment/Choice counseling, Care Coordination
		Other, specify - Coordinated Care, Enrollment Broker for Out of State Alumni Other, specify – Enrollment/Care Coordination

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	Notes (optional)	Not answered, optional