2015 External Quality Review Annual Report

Washington Apple Health
Washington Health Care Authority
Division of Behavioral Health and Recovery

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QUALIS HEALTH™

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

This report was prepared by Qualis Health under contract K1324 with the Washington State Health Care Authority and under contract 1534-28375 with the Washington State Department of Social and Health Services Division of Behavioral Health and Recovery to conduct external quality review and quality improvement activities to meet 42 CFR §462 and 42 CFR §438, Managed Care, Subpart E, External Quality Review.

Qualis Health is one of the nation's leading population health management organizations, and a leader in improving care delivery and patient outcomes, working with clients throughout the public and private sectors to advance the quality, efficiency and value of healthcare for millions of Americans every day. We deliver solutions to ensure that our partners transform the care they provide, with a focus on process improvement, care management and effective use of health information technology.

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Executive Summary

Federal law requires every state Medicaid agency that contracts with managed care plans to provide for an external quality review of healthcare services provided to enrollees, specifically, of the timeliness and quality of care they provide and of enrollees' access to care. Washington's Medicaid external quality review organization (EQRO), Qualis Health, conducted this 2015 annual review under contract with the Division of Behavioral Health and Recovery (DBHR) and the Health Care Authority (HCA). This technical report describes the results of the independent review conducted for five managed care organizations (MCOs) and 11 regional support networks (RSNs), which were contracted to provide Medicaid managed care services during the year 2014.

External quality review (EQR) activities are required to include, at a minimum, a review of compliance with Federal regulatory and contractual standards, performance improvement project (PIP) validation, performance measure validation, if applicable, and an assessment of previous-year recommendations.

For managed care organizations (MCOs) providing physical healthcare services under contract with HCA, Qualis Health's EQR activities included performance measure validations, an analysis of performance measure results, a review of prior-year recommendations, and an assessment of compliance review conducted by the interagency TEAMonitor.

Review of regional support networks (RSNs) providing mental healthcare services under contract with DBHR included a compliance review of quality assessment and performance improvement (QAPI), validation of performance improvement projects, an Information Systems Capabilities Assessment (ISCA), encounter data validation (EDV) and review of prior-year recommendations.

This review reflects data that were collected in 2015 measuring the experiences of members in 2014, indicated in this report by reporting year (RY) 2015 and measurement year (MY) 2014, respectively.

The following summary provides an overview of the observations and recommendations resulting from review activities, intended to aid HCA and DBHR, MCOs and RSNs in furthering the access, timeliness and quality of care they furnish to enrollees. These recommendations, as well as additional opportunities for improvement, are also noted in the detailed sections of this report.

Overall Recommendations

As the State prepares to integrate physical and mental health services, collaboration among service networks will be of importance in ensuring continued quality care.

- In preparation for the State's mental and physical health integration, the State needs to foster communication and collaboration between MCOs and RSNs to create transparency and ensure best practices, such as creating an email list through which MCO and RSN staff can communicate.

MCOs and RSNs would benefit from the guidance of an overarching State quality strategy (as required by regulation) that clearly defines statewide managed care program goals and targets for improvement.

- The State needs to complete and distribute the State quality strategy to MCOs and RSNs, and hold RSNs and MCOs accountable for implementing their own quality strategy to align with the State's.

Physical Health

Between January and December 2014, total Apple Health enrollment grew by 42 percent. Medicaid expansion impacted each plan differently. MCOs that experienced significant increases in enrollment may not have had adequate time to expand provider networks enough to accommodate this rapid growth, potentially causing challenges to providing all enrollees with sufficient access to care. This substantial shift may partially explain the disparity in results between TEAMonitor's compliance review of MCOs and the MCOs' reported performance measures. MCOs generally performed very well in the compliance portion of the review, fully meeting nearly all standards related to availability of services and improving in most other areas. Performance measure data, however, shows that some MCOs need to improve in several standards related to access. This comparison suggests that while MCOs have laid the groundwork for a robust healthcare delivery system, work is still needed to improve access to care.

Strengths

- A greater percentage of eligible children received immunizations by Apple Health MCOs in 2015, with the state rate surpassing the national averages for two key immunization combinations (Combo 2 and Combo 3) and significantly higher from the previous year for adolescent immunizations (Combo 1).

- Indicators for diabetes care management were above national averages in 2015, including blood sugar (HbA1c) testing, eye exams and checking for kidney damage.

- TEAMonitor's 2015 compliance review found that MCOs met a high proportion of contractual and regulatory standards.

Recommendations

The review of performance measures for Apple Health MCOs indicated several key areas where the State should focus its efforts in encouraging improvement.

In 2015, all MCOs did not meet contracted goals for well-child visits (0–15 months, 3–6 months and 12–21 years) and childhood immunizations (Combination 2) and performed poorly in other areas, including maternal health visit measures, children's weight assessment and counseling measures, women's health screening measures and rising rates of hospital readmissions.

- HCA needs to continue to review the requirement that MCOs complete performance improvement projects addressing contracted goals the MCOs did not meet.

- HCA needs to note performance standards where MCOs are performing poorly statewide (within the lowest quartile) and determine whether MCOs should conduct performance improvement projects in order to improve performance.

- HCA needs to take steps to address common challenges among MCOs by capitalizing on individual plan best practices and facilitating information-sharing among MCOs, possibly through a group learning forum.

Mental Health

With the expansion of Medicaid enrollment, RSNs face the challenge of providing timely access to high-quality care for the expanded Medicaid population while meeting the demands of both State and Federal expectations. Most of the RSNs met or partially met all the review standards for compliance review (including QAPI), ISCA and PIPs. A few major areas in the EQR that need further attention by the RSNs and the State center around availability and timeliness of services and the RSNs' implementation and evaluation of their own quality management programs.

The following provides a high-level, statewide summary of the conclusions drawn from the review activities with respect to quality, timeliness and access.

Strengths

- Most RSNs actively monitor the provider networks to ensure there is timely access to the full range of Medicaid-covered services across the geographical regions and to ensure contracted providers perform in accordance with contract obligations.

- Most RSNs have a strong, data-driven process for monitoring the timeliness of access to care across provider networks, which includes monitoring access compliance standards by auditing clinical records, reviewing grievance logs and conducting enrollee surveys.

- Many RSNs have implemented the Level of Care Utilization System (LOCUS) and Children and Adolescent Level of Care Utilization System (CALOCUS) to ensure level of care standards are consistently applied across the enrollee network.

- Most RSNs perform monthly exclusion checks to ensure that their staff and the staff of contractors have not been excluded from participation in Federal healthcare programs. Most evaluate exclusion status using both the List of Excluded Individuals and Entities (LEIE) and System for Award Management (SAM) databases.

- Most RSNs conduct a comprehensive annual performance evaluation of each of the contracted provider agencies.

- PIPs revealed many strengths across the state. Themes within the RSNs' chosen topics included reduction in recidivism rates for inpatient psychiatric hospitalization, Wraparound with Intensive Services (WISe) and Intensive Wraparound, and coordination of care.

- Many RSNs have worked to maintain up-to-date provider profile information in provider directories to assist member services staff in helping Medicaid enrollees make informed decisions about access to providers that can meet their special care needs, such as non-English languages or clinical specialties.

Recommendations

Compliance Review/Quality Assessment and Performance Improvement (QAPI)

All of the RSNs have experienced increased enrollment with the enactment of the Patient Protection and Affordable Care Act. Because of the resulting increase in enrollment, several of the RSNs have had difficulties recruiting clinical staff to meet service needs and access standards.

- DBHR needs to encourage and work with the RSNs to explore and implement various options for recruiting clinical staff. RSN options might include paying for relocation expenses, advertising in other states and providing for tuition reimbursements.

Although many of the RSNs can demonstrate that their contracted providers respond to and comply with corrective action plans, several of the RSNs stated that some contracted provider agencies do not respond and/or comply with the conditions of the formal corrective action plans.

- DBHR needs to work with the RSNs to implement procedures and possible incentives/disincentives for the provider agencies, to ensure that the conditions of corrective action plans are being met.

Many of the RSNs have difficulties around ensuring practice guidelines meet the needs of enrollees, that provider agencies are implementing practice guidelines in the care and treatment of the enrollees and that practice guidelines are used in decisions regarding utilization management, enrollee education opportunities and coverage of services.

- DBHR needs to ensure the RSNs' practice guidelines are meeting the needs of the enrollee populations, that the RSNs are implementing the appropriate practice guidelines in the care and treatment of enrollees and that the RSNs have a process in place whereby the practice guidelines are used to help make decisions regarding utilization management, enrollee education opportunities and coverage of services.

Many of the RSNs' policies and procedures have not been reviewed, updated or approved for many years.

- DBHR needs to ensure the RSNs are reviewing, updating and approving policies and procedures, at least yearly, to be certain the policies and procedures are in accordance with current best practices, terminology and references to contract language, WACs and CFRs.

Many of the RSNs continue to have difficulties capturing all grievances and appeals, transfers and requests to change providers.

- DBHR needs to continue to work with the RSNs to develop and implement reliable procedures for capturing all grievances and appeals, transfers and requests to change providers in order to analyze and integrate the information and use it to generate reports for making informed management decisions.

Many of the RSNs do not use performance and quality benchmarks and valid, objective measures to assess their performance against those benchmarks in evaluation of the quality and appropriateness of care and services furnished to enrollees.

- DBHR needs to ensure that all RSNs are evaluating the quality and appropriateness of care and services furnished to enrollees through the use of performance and quality benchmarks with valid, objective measures to assess their performance against those benchmarks.

Many of the quality management program evaluations and work plans do not include results of the year's activities, EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year.

- RSN evaluations and work plans need to include ongoing and short-term quality activities. These work plans should include and be informed by EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations.

Performance Improvement Projects (PIPs)

Several issues arose regarding the PIP process, including a lack of clarity among RSNs about the approval status of many of the PIPs by the State, as well as information regarding RSN resubmissions. At least one of the RSNs' PIPs had not been reviewed by DBHR in time for the RSN's site review. Additionally, the scope of several of the RSNs' PIPs amounted to program evaluation but not performance improvement projects. Thus, it was unclear whether the RSNs were sufficiently knowledgeable regarding performance improvement and the PIP protocol requirements.

- DBHR needs to:
    - Develop a clear and systematic approach for approving PIPs that includes due dates for RSN submission, as well as DBHR's dates of review and approval of PIPs.
    - Ensure all DBHR reviewers have a full understanding of the EQRO PIP protocol so that only true performance improvement projects are approved.
    - Create a communication plan for RSNs regarding timeline submission dates and the status of PIP submissions.

Information Systems Capabilities Assessment (ISCA)

Many RSNs are not able to obtain current disaster recovery plans from their delegated county data centers either because respective county data centers have not updated their disaster recovery plans annually as required, or because delegated entities have declined to release the plans to the RSNs.

- DBHR needs to ensure the RSNs are developing methods to obtain current disaster recovery plans on an annual basis from the delegated county data centers.

During many of the RSN reviews, it was noted that not all of the provider agencies are encrypting PHI data according to DBHR standards.

- DBHR needs to ensure that the RSNs are working with the contracted provider agencies to encrypt agency data according to DBHR standards.

Several RSNs are not able to accept electronic data interchange (EDI) data from contracted provider agencies, resulting in double data entry for those agencies, potentially causing data input errors.

- DBHR needs to ensure that RSNs continue to work with contracted providers to be able to accept EDI data so that the agencies with in-house EHR systems can avoid performing double data entry.

Encounter Data Validation (EDV)

In reviewing the EDV deliverables that the RSNs submitted to the State, it was noted that the RSNs' data collection and analytical procedures for validating encounter data were not standardized.

- In order to improve the reliability of encounter data submitted to the State, DBHR needs to work with the RSNs to standardize data collection and analytical procedures for encounter data validation.

During the onsite clinical record reviews at the provider facilities, Qualis Health discovered numerous encounters in which services were bundled incorrectly. Other errors further suggest that the RSNs and providers need more information or training about how to correctly code encounters prior to submission to the State. Additionally, many of the RSNs and providers were unfamiliar with the terms of EDV in the State contracts and with the specifics of the Service Encounter Reporting Instructions (SERI).

- DBHR needs to provide guidance to the RSNs as to how to bundle services correctly, review the errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians and ensure the RSNs know and understand the content of the State contract and the SERI. DBHR may consider providing further training on both the contract and SERI to the RSNs.

Many RSNs are submitting codes to ProviderOne that have been retired since July 2013, as well as submitting other coding errors. The State reported that ProviderOne does not contain any edits to reject any codes and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to work with ProviderOne to create an algorithm to reject encounters that are submitted incorrectly to the State.

Performance Measures

Performance measure validation did not occur in the review for 2015.

Introduction

Overview

Washington's Medicaid program for physical and mental health services provides benefits for more than 1.3 million low-income residents. The Washington State Health Care Authority (HCA) administers services for physical health through contracts with managed care organizations (MCOs), which facilitate delivery of physical healthcare services. The Washington State Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR) administers services for mental health through contracts with regional support networks (RSNs), which facilitate mental healthcare services.

Federal requirements mandate that every state Medicaid agency that contracts with managed care plans evaluate and report on specific external quality review (EQR) activities. Information in this report was collected from MCOs and RSNs through review activities based on Centers for Medicare & Medicaid Services (CMS) protocols. Additional activities may be included as specified by contract.

Background: The Changing Landscape of Washington's Medicaid Program

This report comes during a time of transformation in Washington's Medicaid program. As a result of the expansion of Medicaid coverage under the Affordable Care Act in January 2014, Apple Health enrollments grew by nearly 42 percent during 2014. This shift put tremendous pressure on provider networks and should be taken into consideration in the context of overall plan performance results.

At the same time, Washington is on a path to transform the way healthcare is furnished in the state through multiple initiatives, including the State Health Care Innovation Plan, Healthier Washington. The changes resulting from these programs will ultimately include integration of behavioral and physical health services, introduction of value-based payments, greater community and consumer empowerment through Accountable Communities of Health and primary practice transformation.

Looking forward, the State will fully integrate the financing and delivery of physical health services, mental health services and chemical dependency services in the Medicaid program through managed healthcare by 2020 to better meet the needs of the whole person, to remove barriers between the disciplines, and to more effectively manage finances.

Regional Service Areas (RSAs) were authorized in 2014 legislation to define new geographical boundaries for the State to purchase behavioral and physical healthcare through managed care contracts. HCA and DSHS jointly designated RSAs in November 2014 (revised in June 2015). HCA will contract with managed care health plans to provide physical healthcare within these regions. DSHS will begin contracting for Behavioral Health Organization (BHO) services starting April 2016, one BHO per RSA, to administer public mental health and substance use disorder services under managed care. BHOs are a county authority or group of county authorities or other entity that contracts for mental health services and substance use disorder treatment services within a defined RSA.

While most of the newly designated RSAs will offer services through BHOs starting in 2016, some may choose to have the State contract with managed care health plans to purchase and administer care for mental health, substance use and physical health in a *combined* benefit. These areas are referred to as "Early Adopters." In these regions there will be no BHO and no RSN. HCA will hold the contracts with the

managed care health plans instead of DSHS. There is currently one area that has chosen to become an Early Adopter, the Southwest Washington RSA.

In its examination of the MCOs' and RSNs' successes in providing enrollees with sufficient access to care, timely delivery of care and quality of care, this 2015 Annual EQR Technical Report explains to what extent the State's managed care plans are meeting Federal and State regulations, contract requirements and statewide goals, and where they need to improve. In subsequent sections, this report offers discussion and recommendations intended to help guide HCA and DBHR in improving the State's overall Medicaid system of care.

Description of External Quality Review Activities

EQR Federal regulations under 42 CFR §438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with protocols of the Centers for Medicare & Medicaid Services (CMS). The 2015 review results in this report include how recommendations from the prior year's findings were addressed, as well as the following:

- **MCOs**
  - audit results of Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures of clinical services provided by MCOs
  - validation of performance measures
  - audit results of HCA's (TEAMonitor's) compliance monitoring
  - evaluation of results of consumer satisfaction surveys

- **RSNs**
  - compliance monitoring of quality assessment and performance improvement (QAPI) through document review, clinical record reviews, onsite interviews and telephone interviews with provider agencies to determine whether regulatory and contractual standards governing managed care were met
  - encounter data validation (EDV) conducted through data analysis and clinical records review
  - validation of an Information Systems Capabilities Assessment (ISCA)
  - validation of PIPs to determine whether the RSN met standards for conducting these required studies

Description of Quality, Access and Timeliness

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

Quality: Quality of care encompasses access and timeliness as well as the process of care delivery and the experience of receiving care. Although enrollee outcomes can also serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as

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

patients' adherence to treatment. The quality components of this year's review center around coordination and continuity of care, patient review and coordination, provider selection, practice guidelines, QAPI, enrollee rights and grievance systems.

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

Timeliness: Timeliness standards by which the MCOs are evaluated include those related to availability of services, claims payment, coverage and authorization, enrollee rights, grievances and appeals. Timeliness of care can influence over- and underutilization and appropriate care.

Physical Health

Qualis Health's contracted review of physical healthcare delivered by Apple Health MCOs included an assessment of the compliance review conducted by the State interagency TEAMonitor, a validation and analysis of performance measures reported by the MCOs, which included HEDIS data and Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) survey results, and a review of prior-year EQR recommendations.

Compliance Review

The State's MCOs are evaluated by TEAMonitor, the interagency unit of the Health Care Authority, the Department of Health and the Department of Social and Health Services, on their compliance with Federal and State regulatory and contractual standards. TEAMonitor's review assesses activities for the previous calendar year and validates MCOs' compliance with the standards set forth in 42 CFR §438, as well as those established in the MCOs' contract with HCA. Qualis Health has provided summaries and observations based on TEAMonitor's results in the Compliance chapter of the Physical Healthcare section of this report.

TEAMonitor also performs assessments of the MCOs' performance improvement projects, in which MCOs are evaluated on study methodology, whether the PIPs' findings are accurate, and the overall validity and reliability of results. At the time of this report's publication, TEAMonitor's validation was still underway, and therefore the results are not included.

Performance Measures

HEDIS is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow MCOs to determine where quality improvement efforts may be needed. For the 2015 reporting year (RY, measuring 2014 data), MCOs submitted data on 31 measures comprising 106 specific indicators.

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

Qualis Health used this data to perform comparisons among MCOs and against national benchmarks. Summary results from this analysis can be found in the Performance Measure Review chapter of the Physical Healthcare section of this report. The full analysis is available in the *2015 Comparative Analysis Report*.[3]

Additionally, Qualis Health conducted a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ of all MCOs to ensure each is accurately collecting, calculating and reporting HEDIS measures.

The CAHPS survey, which assesses consumers' experiences with healthcare services and support, was used by Qualis Health to provide indicators of quality, access and timelines of services for the MCOs. The CAHPS surveys, developed by the U.S. Agency for Healthcare Research and Quality (AHRQ), address such areas as getting care quickly, how well doctors communicate, global ratings of healthcare, access to specialized services and coordination of care. In 2015, the Apple Health MCOs conducted the CAHPS 5.0H Child Medicaid and Child with Chronic Conditions survey, collecting data from parents/guardians of children under the age of 18 enrolled in Apple Health.

Mental Health

Qualis Health's external quality review of the State's 11 RSNs facilitating mental healthcare services consisted of determining the RSNs' level of compliance with State and Federal requirements for quality assessment and performance improvement, validating encounter data submitted to the State, completing an Information Systems Capability Assessment (ISCA), evaluating the RSNs' performance improvement projects (PIPs), and assessing and identifying each RSN's strengths and areas for improvement, as well as following up on the previous year's recommendations. While external quality review generally includes reporting on performance measure results, Washington's RSNs were not required by DBHR to report on performance measures in 2015.

Compliance Review

Qualis Health's compliance review of quality assessment and performance improvement assessed each RSN's compliance with Federal Medicaid managed care regulations and applicable elements of the RSNs' contract with the State.

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

Performance Improvement Project Assessment

RSNs are required to have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas that are designed to assess and improve the processes and outcomes of the healthcare they provide. Performance improvement projects are evaluated each year to ensure they meet State and Federal standards. The performance improvement review methodology used by Qualis

[3] *2015 Comparative Analysis Report* available at http://www.hca.wa.gov/medicaid/healthyoptions/Documents/ComparativeAnalysis_20151215.pdf.

Health (see Appendix D) explains the procedures and scoring used in evaluating performance improvement projects.

Information Systems Capabilities Assessment (ISCA)

The ISCA evaluates the ability of the RSN information systems to accurately and reliably produce performance measure data and reports to assist with management of the care provided to RSN enrollees.

The ISCA review procedures were based on the CMS protocol for this activity, as adapted for the Washington RSNs with DBHR's approval. For each ISCA review area, Qualis Health used the information collected in the ISCA data collection tool, responses to interview questions, and results of the claims/encounter walkthroughs and security walkthroughs to rate the RSNs' performance for seven review areas.

Performance Measure Validation

42 CFR §438.358 requires the annual validation of performance measures for managed care entities that serve Medicaid enrollees. During the review year, DBHR retired the previous performance measures and is now in the process of establishing performance measure targets with new data as it is collected.

Encounter Data Validation (EDV)

EDV is a process used to validate encounter data submitted by RSNs to the State. Encounter data are the electronic records of services provided to RSN enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provide substantially the same type of information that is found on claim forms, but not necessarily in the same format. States use encounter data to assess and improve quality, monitor program integrity and determine capitation payment rates.

DBHR requires each RSN to ensure the accuracy of encounters submitted to DBHR by conducting an annual EDV, per DBHR guidelines. Qualis Health's audit then verifies each RSN's EDV process by conducting an independent check of the RSNs' EDV results. This was accomplished by using the EDV requirements included in contracts with DBHR and the CMS protocol as the standards for validation.

Qualis Health obtained each of the RSNs' encounter data validation reports submitted to DBHR as a contract deliverable for calendar year 2014, and reviewed the RSNs' encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates and fields selected for validation for conformance with the CMS protocol standards and the DBHR contract requirements.

These elements are pursued in fuller detail in subsequent sections of the report.

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Physical Healthcare Provided by Apple Health Managed Care Organizations

Introduction

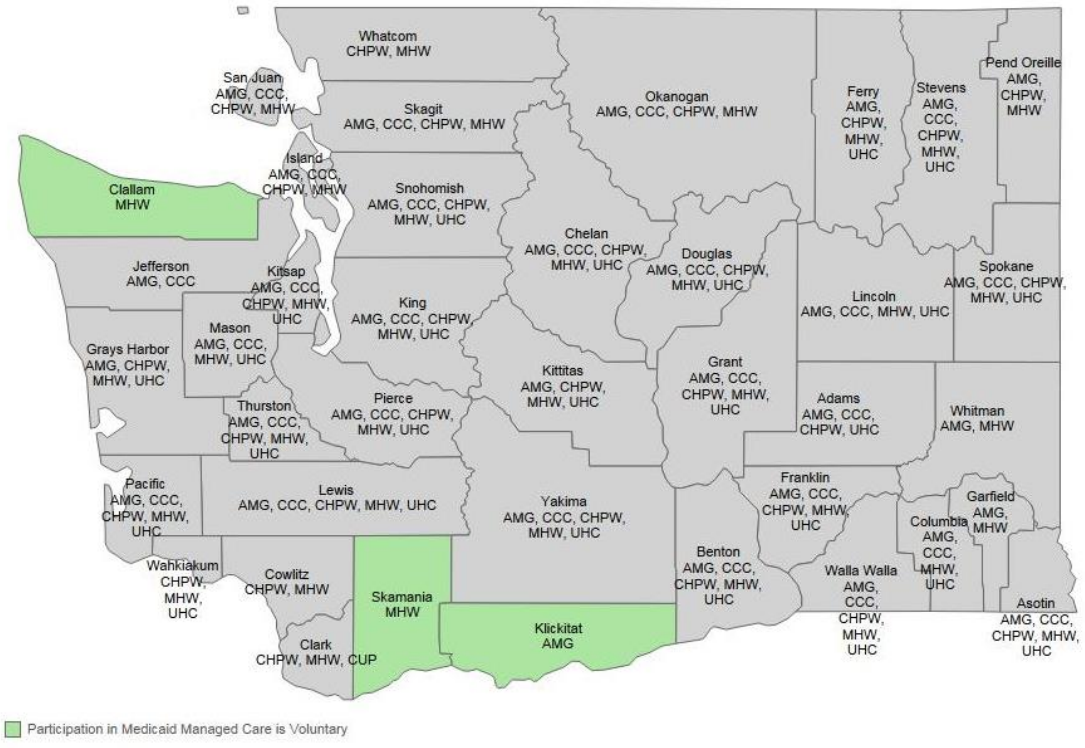
Throughout 2014, five managed care organizations (MCOs) delivered healthcare services to Apple Health managed care (Medicaid) enrollees across the State of Washington:

- Amerigroup Washington, Inc. (AMG)
- Community Health Plan of Washington (CHP)
- Coordinated Care Corporation (CCC)
- Molina Healthcare of Washington (MHW)
- United Healthcare Community Plan (UHC)

A sixth MCO, Columbia United Providers (CUP), began serving Washington enrollees in 2015 and was not included in this review.

Figure 1, below, identifies the MCOs and the counties they serve, as of December 31, 2014. In Clallam, Skamania and Klickitat counties, enrollment was voluntary in 2014 because only one MCO was in operation or because the contracted MCOs did not have sufficient capacity to serve all enrollees.

Figure 1: Washington Apple Health MCO Coverage, By County



As of December 31, 2014, Apple Health enrollment exceeded 1.3 million individuals; the most significant enrollment increase for the year was in the Apple Health Adult Coverage program, due largely to enrollees newly eligible for coverage under Medicaid Expansion. Table A-1, below, identifies Apple Health enrollment numbers for each plan.

Table A-1: Apple Health Enrollment, By Plan

Managed Care Program	AMG	CCC	CHP	MHW	UHC	TOTAL
Apple Health Adult Coverage (AHAC)	74,220	77,813	95,277	101,494	88,562	437,366
Apple Health Family (AHFAM)	43,298	81,749	209,005	341,431	74,910	750,393
Apple Health Blind and Disabled (AHBD)	8,694	12,532	21,212	29,296	12,686	84,420
Healthy Options Foster Care (HOFC)	101	191	579	1,464	263	2,598
Children's Health Insurance Program (CHIP)	2,056	3,068	6,383	12,839	3,804	28,150
Managed Care Enrollment Total	128,369	175,353	332,456	486,524	180,225	1,302,927

Source: Enrollment data provided by Washington State Health Care Authority

Overview of Apple Health Enrollment Trends

A review of enrollment trends provides a background to help better understand how the Medicaid expansion may have impacted performance in 2014. A number of Healthcare Effectiveness Data and Information Set (HEDIS) quality measures require continuous enrollment over one year or more for members to be eligible for the measure. With the current environment of rapid Medicaid enrollment growth, the experience of a large number of new members may not be directly reflected; however, the experience of eligible longstanding members could have been affected in many instances by the influx of new members in 2014, especially with respect to access to care.

Enrollment Growth During 2014

The Medicaid expansion provision of the Affordable Care Act was implemented in January 2014. As a result, Medicaid MCOs in Washington State grew rapidly during 2014 (Table A-2). Overall, the Apple Health-covered population grew by nearly 42 percent during the year. The member populations for two MCOs, AMG and UHC, more than doubled.

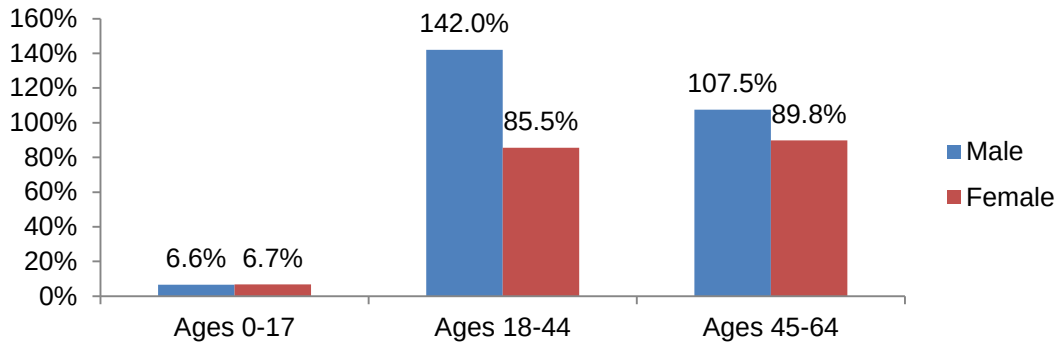
Table A-2: MCO Enrollment Growth During 2014

Medicaid Managed Care Plan	January 2014	December 2014	% Change
Amerigroup Washington (AMG)	55,459	128,369	131.4%
Coordinated Care of Washington (CCC)	105,914	175,353	65.6%
Community Health Plan of Washington (CHP)	267,634	332,456	24.2%
Molina Healthcare of Washington (MHW)	402,942	486,524	20.7%
United Healthcare Community Plan (UHC)	88,199	180,225	104.3%
Total	**920,158**	**1,302,927**	**41.6%**

Source: Enrollment data provided by Washington State Health Care Authority

A majority of the new enrollees in 2014 were male, and many new enrollees were older than traditional (pre-expansion) new enrollees, over the age of 45 (Figure 2). This demographic shift was not likely reflected in many of the performance measures reviewed in this report; however, it may become more apparent in the performance measures collected in 2015 and reported in next year's (2016) edition of this report. An older population will have different healthcare needs and utilization patterns than a traditionally younger population.

Figure 2: Medicaid Enrollment Growth By Age and Gender, January–December 2014



Summary of Recommendations

Qualis Health's review of physical healthcare delivered by Apple Health MCOs included an assessment of the compliance review conducted by the State interagency TEAMonitor, and a validation and analysis of performance measures reported by the MCOs, which included HEDIS data and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results.

This review reflects data that was collected in 2015 measuring the experiences of members in 2014, indicated in this report by reporting year (RY) 2015 and measurement year (MY) 2014, respectively.

Noteworthy in the review of physical healthcare services provided by MCOs was the disparity in results between TEAMonitor's compliance review of MCOs and their reported performance measures, which could be a reflection of the rapid enrollment and subsequent pressure on provider networks that MCOs experienced during 2014. MCOs generally performed very well in the compliance portion of the review, fully meeting nearly all standards related to availability of services and improving in most other areas. Performance measure data, however, show MCOs in marked need for improvement in several areas, including access to services. This comparison suggests that while MCOs have laid the groundwork for a robust healthcare delivery system, work is still needed to deliver consistently high-quality, timely and accessible care to Apple Health's greatly expanded population of enrollees. The following recommendations intend to highlight changes that, when implemented, could impart great improvements in MCO performance statewide.

Performance Measures

The most substantive needs for improvement for MCOs that surfaced during the 2015 EQRO review centered on low-scoring HEDIS performance measures and CAHPS surveys, in which all MCOs either performed inconsistently or poorly. The following recommendations are intended to help identify the barriers causing low performance and take steps to remedy low scores.

- HCA needs to continue to review the requirement that MCOs complete performance improvement projects addressing contracted goals the MCOs did not meet (in RY 2015, for well-child visits (0–15 months, 3–6 months and 12–21 years) and childhood immunizations (Combination 2). All MCOs were below at least one well-child visit goal, and one MCO was below the immunization Combination 2 goal. The State should approve performance improvement projects that seek to address the root cause for the low performance, including examination of provider coding practices, and improve the providers' barriers to either reporting or performing well-child visits that meet HEDIS measurement criteria.

- HCA needs to note performance standards where MCOs are performing poorly statewide (within the lowest quartile) and determine whether MCOs should conduct performance improvement projects in order to improve performance.

- HCA needs to take steps to address common challenges among MCOs by capitalizing on individual plan best practices and facilitating information-sharing among MCOs, possibly through a group learning forum.

Quality Strategy

MCOs and RSNs would benefit from the guidance of an overarching State quality strategy (as required by regulation) that clearly defines statewide managed care program goals and targets for improvement.

- The State needs to complete and distribute the State quality strategy to MCOs and RSNs, and hold RSNs and MCOs accountable for implementing their own quality strategy to align with the State's.

As the State prepares to integrate physical and mental health services, collaboration among service networks will be of importance in ensuring continued quality care.

- In preparation for the State's mental and physical health integration, the State needs to foster communication and collaboration between MCOs and RSNs to create transparency and ensure best practices, such as creating an email list through which MCO and RSN staff can communicate.

Opportunities for Improvement

In addition to the recommendations provided above, HCA may consider the following opportunities as additional tools for improving MCOs' delivery of care.

Performance Measure Improvement

HEDIS measure results indicated that the MCO performance challenges were most prominent in adult access to primary care, well-child visits, maternal health, body mass index (BMI) assessments, cervical cancer screenings and hospital readmissions.

- MCOs should closely monitor and respond to barriers for adult members receiving primary care. Administrative data should be reviewed at least quarterly. To identify excessively low adult access rates and take steps to determine and remove barriers, the data should be appropriately disaggregated at local and regional levels consistent with local provider networks.

- MCOs should increase efforts to get pregnant women and new mothers into provider offices for timely prenatal and postpartum care.

- MCOs should determine why providers are not conducting (or not appropriately recording) BMI assessments and cervical cancer screenings.

- MCOs should conduct a root cause analysis and implement interventions to prevent hospital readmissions within 30 days after discharge.

- Some MCOs are exhibiting clear efforts toward improvement in the access, timeliness and quality of healthcare for enrollees. MCOs being cited for best practices include MHW for high ambulatory access and utilization, which likely relates to a positive trend in decreasing the utilization of emergency use and inpatient admissions, and CCC for achievement of high performance on childhood immunizations.

Data Collection

Collection and application of data relevant to various aspects of care can provide MCOs with the capability of identifying weaknesses in care and streamlining processes for improvement.

- The State should consider collecting more administrative-based information about the timeliness of care.

- Medication management measures are all based on administrative data. The State should encourage MCOs to consider whether there are ways to assist providers with identifying patterns indicating a lack of follow-up for patients who were dispensed medications.

Consumer Experience

Child and adult CAHPS surveys are an optional activity and administered only in alternate years, presenting a less useful dataset.

- HCA should encourage MCOs to administer both adult and child CAHPS surveys each year in order to more frequently track consumer experience.

- MCOs should consider sponsoring real-time patient surveys offered by providers to identify specific barriers or problems with getting care.

Alignment of Statewide Reporting Measures

- In order to fully realize the vision of Healthier Washington, the HCA should work to better align MCO reporting requirements with the program's goals. For example, the Common Measure Set for Healthier Washington includes multiple reported HEDIS measures, including adult and child access to primary care, well-child visits, youth obesity, comprehensive diabetes care, childhood and adolescent immunizations, and avoidance of low-value health services. Making these priority measures for MCOs may encourage improved performance on State goals. Additionally, there are several Healthier Washington goals that align with HEDIS measures that are currently not required reporting measures for MCOs, such as tobacco screening and cessation counseling, follow-up after hospitalization for mental illness, and annual monitoring for patients on persistent medications. Requiring MCOs to report these measures in the future may enable improvement on Healthier Washington goals.

Compliance Review

TEAMonitor, a State interagency, annually evaluates the State's contracted managed care organizations (MCOs) on their compliance with Federal and State regulatory and contractual standards. TEAMonitor evaluates access, timeliness and quality of care of services to determine compliance with the standards set forth in 42 CFR §438, as well as those established in the MCOs' contract with the Health Care Authority (HCA).

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

Methodology

TEAMonitor's assessments consist of desk audits of files submitted electronically by the MCOs, followed by onsite visits in which TEAMonitor staff share results with MCO leadership. For review standards where MCOs are not compliant (receiving a score of partially met or not met), TEAMonitor requests submission of corrective action plans (CAPs) for follow-through during the subsequent year, before the next year's review. The review team also works with MCOs to develop and refine processes that will improve access, timeliness and quality of care for Medicaid enrollees.

Scoring

TEAMonitor scores the MCOs on each compliance standard according to a metric of Met, Partially Met and Not Met, each of which corresponds to a value on a point system of 0–3, 0 and 1 indicating Not Met, 2 indicating Partially Met and 3 indicating Met. Unscored elements are denoted by NS. Final scores for each section are denoted by a fraction indicating the points obtained (the numerator) relative to all possible points (the denominator). For example, in a section consisting of four elements in which the MCO scored a 3, or Met, in three categories and a 1, or Not Met, in one category, the total number of possible points would be 12, and the MCO's total points would be 10, yielding a score of 10/12.

In the following presentation of results, total scores have been converted to percentages, which, for the above score of 10/12, would produce a score of 83 percent.

Summary of Compliance Results

MCOs demonstrated improvement in most compliance standards over the previous year, as discussed in the following sections. Table A-3 provides a summary of all MCO scores by compliance standard and total overall score for each standard.

Bars and percentages reflect total scores for each standard (total scores for all elements combined, converted to percentages). MCOs with elements scored as Partially Met or Not Met were required to submit CAPs to HCA. MCOs were scored on these elements in the first half of the review year. MCOs may have implemented corrective action plans since that time to address specific issues and therefore scores may not be indicative of current performance.

Table A-3: Comparison of MCO Compliance with Regulatory and Contractual Standards, By Plan

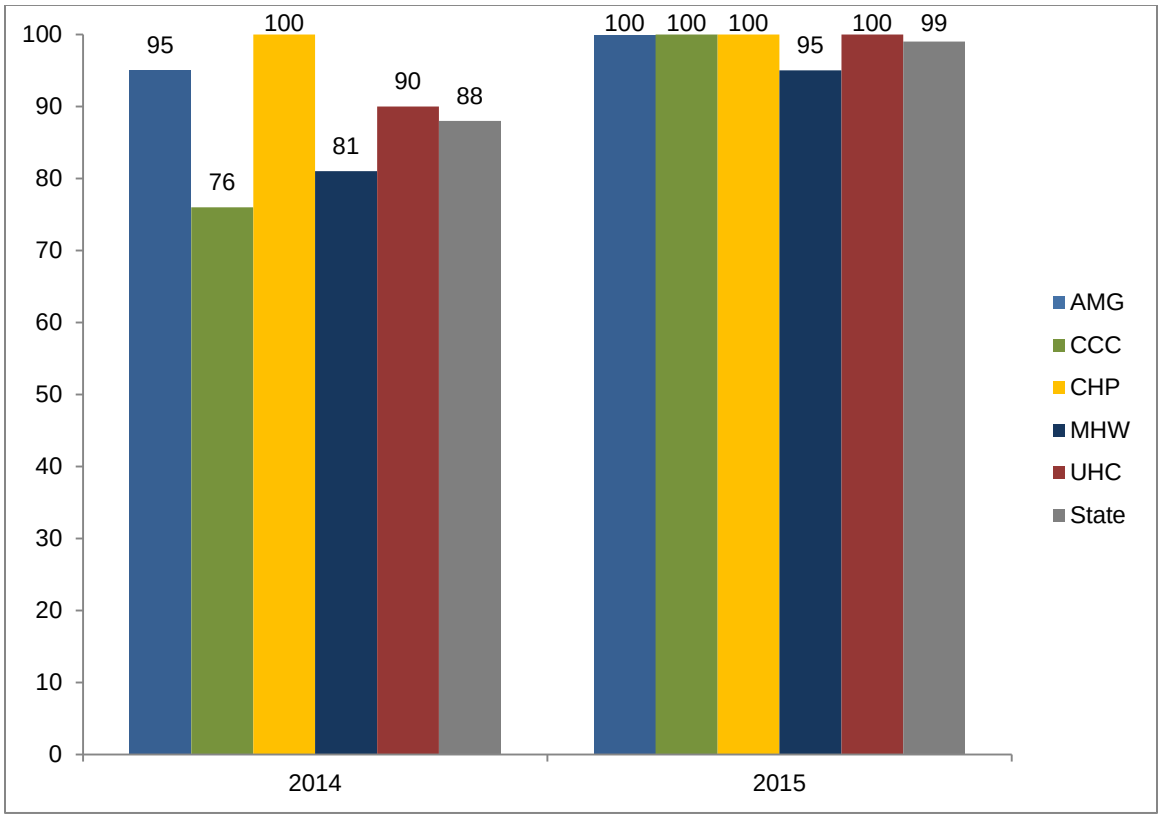
Standard	# of Elements	MCO	# Met 3 points	# Partially Met 2 points	# Not Met 0–1 point	# Not Scored	Total Score (% of points attained)
Availability of Services	7	AMG	7	0	0	0	100
		CCC	7	0	0	0	100
		CHP	7	0	0	0	100
		MHW	6	1	0	0	95
		UHC	7	0	0	0	100
Program Integrity Requirements	5	AMG	4	1	0	0	93
		CCC	4	1	0	0	93
		CHP	3	2	0	0	87
		MHW	3	1	1	0	73
		UHC	5	0	0	0	100
Timely Claims Payment	2	AMG	2	0	0	0	100
		CCC	1	1	0	0	83
		CHP	2	0	0	0	100
		MHW	1	1	0	0	83
		UHC	2	0	0	0	100
Coordination and Continuity of Care	13	AMG	10	2	0	1	94
		CCC	11	0	1	1	92
		CHP	7	3	2	1	75
		MHW	10	2	0	1	94
		UHC	10	1	1	1	92
Patient Review and Restriction	5	AMG	5	0	0	0	100
		CCC	5	0	0	0	100
		CHP	5	0	0	0	100
		MHW	4	1	0	0	93
		UHC	5	0	0	0	100
Coverage and Authorization	7	AMG	4	1	1	0	81
		CCC	4	2	0	0	81
		CHP	4	2	0	0	81
		MHW	6	0	0	0	100
		UHC	5	1	0	0	86
Enrollment/ Disenrollment	2	AMG	2	0	0	0	100
		CCC	2	0	0	0	100
		CHP	2	0	0	0	100
		MHW	2	0	0	0	100
		UHC	2	0	0	0	100

Standard	# of Elements	MCO	# Met 3 points	# Partially Met 2 points	# Not Met 0–1 point	# Not Scored	Total Score (% of points attained)
Enrollee Rights	15	AMG	11	0	3	1	81
		CCC	13	1	0	1	98
		CHP	11	3	0	1	93
		MHW	11	3	0	1	93
		UHC	11	3	0	1	93
Grievance System	18	AMG	17	0	1	0	94
		CCC	15	3	0	0	93
		CHP	10	8	0	0	85
		MHW	17	1	0	0	98
		UHC	16	2	0	0	96
Practice Guidelines	3	AMG	3	0	0	0	100
		CCC	1	2	0	0	78
		CHP	0	3	0	0	67
		MHW	3	0	0	0	100
		UHC	2	1	0	0	89
Provider Selection	4	AMG	2	2	0	0	83
		CCC	4	0	0	0	100
		CHP	4	0	0	0	100
		MHW	4	0	0	0	100
		UHC	3	1	0	0	92
QA/PI Program	5	AMG	3	2	0	0	87
		CCC	5	0	0	0	100
		CHP	3	2	0	0	87
		MHW	5	0	0	0	100
		UHC	4	1	0	0	93
Subcontractual Relationships/ Delegation	4	AMG	4	0	0	0	100
		CCC	4	0	0	0	100
		CHP	2	2	0	0	83
		MHW	4	0	0	0	100
		UHC	4	0	0	0	100
Health Information Systems	3	AMG	3	0	0	0	N/S
		CCC	3	0	0	0	N/S
		CHP	3	0	0	0	N/S
		MHW	3	0	0	0	N/S
		UHC	3	0	0	0	N/S
Healthy Options/ Health Homes	4	AMG	3	2	0	0	92
		CCC	1	3	0	0	75
		CHP	3	1	0	0	92
		MHW	4	0	0	0	100
		UHC	2	1	1	0	67

Access

In 2015, MCOs demonstrated significant improvement in standards grouped under Availability of Services, with four MCOs fully meeting all elements and one plan meeting all but one element. The MCOs also slightly improved in the area of Coverage and Authorization of Services. Some MCOs received recommendations to improve tracking and documentation of utilization of services. Among MCO-specific strengths related to access, Amerigroup's network expansion activities beyond HCA's standard network requirements were cited as a best practice.

Figure 3: MCO Compliance Scores for Availability of Services Standards



Scores reflect percentage of points obtained for standards under Availability of Services section of TEAMonitor compliance review.

Timeliness

MCOs fully met access to care standards for ensuring certain services are available 24 hours a day, appointments are available within designated timeframes, and care for Medicaid patients is available as it would be for non-Medicaid patients. This is a marked improvement from the previous year. In addition, there was slight improvement in complying with timely claims payments and coordination of benefits. MCOs continue to struggle with timeliness under the Coverage and Authorization standard; both CCC and CHP failed to meet the timeliness requirements for authorization decisions. AMG did not consistently resolve grievances and appeals within the specified timeframes, thereby not meeting the standard.

Quality

Among quality standards, MCOs have shown some improvement, as well as some persistent weaknesses.

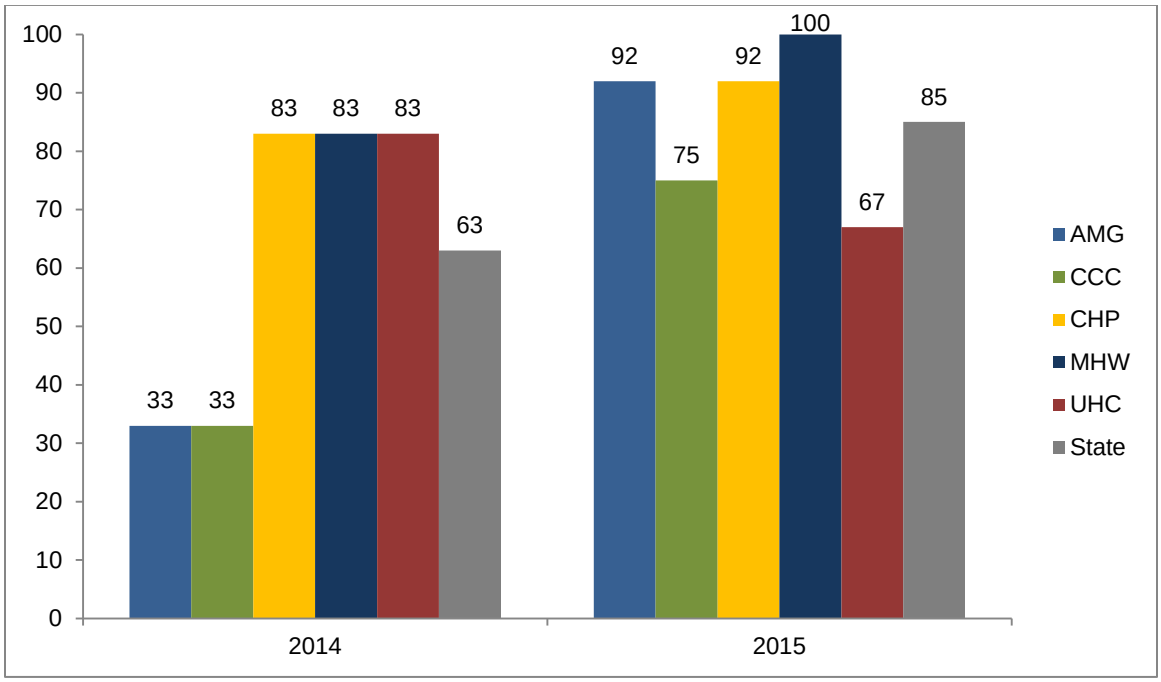
Compliance with Coordination and Continuity of Care standards continues to be an area of difficulty for MCOs. While many of the elements in this category were fully met, none of the MCOs fully met the standard for Assessment and Treatment Plans. In particular, CHP failed to demonstrate timely completion of initial health assessments for enrollees identified as having special health needs, a repeat finding.

Generally, MCOs also showed decreased performance with regard to grievance systems, slightly lowering the overall state score. Handling of grievances and appeals, as well issues related to resolution and notifications, were problematic for some MCOs.

Quality Assessment and Performance Improvement (QAPI), however, was a notable area of improvement for the MCOs, with most MCOs fully meeting standards. Last year, this standard was one of the weakest, with MCOs combined scoring only 75 percent on the QAPI elements; in 2015, combined plan score increased to 93 percent. In its review, TEAMonitor cited CHP and MHW as having robust QAPI program descriptions and practices.

Though the MCOs continue to face challenges, the group showed substantial improvement in the Health Homes standard, increasing the MCO combined score from 63 percent last year to 85 percent in 2015. Implemented in 2013 and first reviewed in 2014, MCOs are assessed on their ability to provide a Health Home program for high-needs enrollees identified as eligible for Health Home services. All but one MCO (MHW) only partially met the requirements associated with Health Action Plans. CHP, however was noted for its development of a Home Health Took Kit for use by care coordinators.

Figure 4: MCO Compliance Scores for Health Homes



Scores reflect percentage of points obtained for standards under Health Homes section of TEAMonitor compliance review.

Corrective Action Plans

All compliance elements scored as Partially Met and Not Met require a corrective action plan (CAP). In addition to scoring current-year compliance efforts, TEAMonitor's assessment includes reviewing the CAPs assigned in the previous review year and determining if CAPs have been completed. During the 2015 review, TEAMonitor found that all five MCOs had at least one incomplete CAP outstanding from 2014. Incomplete CAPs result in newly assigned CAPs. Table A-4 identifies the number of MCOs required to submit CAPs as a result of the 2015 review. The numbers preceding each element below denote the section within the Code of Federal Regulations (CFR) in which the element appears. The numbers that follow each element denote the corresponding Apple Health Managed Care contract requirement.

Table A-4: TEAMonitor Compliance Review Summary of Issues

Compliance Area	42 CFR and Apple Health Contract Citation	Number of Plans with Findings
Availability of Services		
	438.206 (b)(1)(i-v) Delivery network and 438.207(b)(1)(2) Assurances of adequate capacity and services, 6.1 and 6.3	1
Program Integrity		
	Apple Health – Provider payment suspension, 12.5	1
	Apple Health – Reporting, 12.7	3
	438.608(a)(b) Program integrity requirements, 12.4	2
Timely Claims Payment		
	447.46 Timely claims payment, 9.11	2
Coordination & Continuity of Care		
	438.208(c)(26) Assessment and (3) Treatment plans, 14.3	5
	438.240(b)(4) Care coordination oversight, 14.10	1
	Apple Health – Continuity of care, 14.1	1
	Apple Health - Coordination between contractor and external entities, 14.4 (new in 2014)	4
	Apple Health – Transitional care, 14.5	1
Coverage and Authorization		
	438.210(b)(1)(2)(3) Authorization of services, 11.1, 11.3	2
	438.210(c) Notice of adverse action, 11.3.4.2.	1
	438.210(d) Timeframe for decisions (1) (2), 11.3.5	2
	Apple Health - Outpatient mental health, 16.5.13	3
	Apple Health - Second opinion for children prescribed mental health medications, 16.5.14 (new in 2014)	2
Enrollee Rights		
	438.100(a) General rule, 10.1.1	2
	438.10(b) Basic rule, 3.4.2	1
	438.10(d)(1)(ii) and (2) Format, alternative formats, 3.4.1 and 3.4.2	2
	438.10(f) (2-6) General information, 3.2 and 6.15.2	3
	438.100(b)(2)(iv) and (v) Specific rights, 10.1.2	1
	438.106 Liability for payment, 2.13 and 10.5	3
	Apple Health – Customer service, Subsection, 6.6	1
Grievance Systems		
	438.228 Grievance systems, 3.2.5.18.2, and 13.1.1	1
	438.402(b)(1) Filing requirements – Authority to file, 13.3.1	2
	438.404(b) Notice of action – Content of notice,11.3.4.2	1
	438.404(c) Notice of action – Timing of notice,11.3.5 and 13.3.9	2
	438.406(a) Handling of grievances and appeals – General requirements, 13.1.2 and 13.1.5	3

	438.408(a) Resolution and notification: Grievances and appeals – Basic rule, 11.3 and 11.4.1	1
	438.408(b) and (c) Resolution and notification: Grievances and appeals – specific timeframes and extension of timeframes, 13.2.7 and 13.3.9	2
	438.408(d) and (e) Resolution and notification: Grievances and appeals – Format of notice and content of notice of appeal resolution, 13.2.9 and 13.3.10	1
	438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending, 9.4.12.3, 13.5.2.2 and 13.8	1
	438.424 Effectuation of reversed appeal resolutions, 13.9	1
Practice Guidelines		
	438.236(a)(b) Adoption of practice guidelines, 7.8.1	3
	438.236(c) Dissemination of practice guidelines, 7.8.1.5 and 7.8.1.7	2
	438.236(d) Application of practice guidelines, 7.8.1.6	1
Provider Selection		
	438.214(a) General Rules and 438.214(b) Credentialing & re-credentialing requirements, 9.13	2
	438.214 Provider selection (e) State requirements, 9.13.2.5, 9.13.13, and 9.13.17	1
Quality Assessment and Performance Improvement		
	438.240(a)(1) Quality assessment and performance improvement program – General rules, 7.1.1.2.1	1
	438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and under-utilization of services, 7.1.1.2.4.3	3
	438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement – evaluating the program, 7.1.1.2.4 and 7.3.9	1
Sub-contractual Relationships and Delegation		
	438.230(a) General rule (b) Specific conditions (1) Evaluation of subcontractor prior to delegation., 9.1, 9.5, and 8.6	1
	438.230(b)(2) Written agreement with subcontractors, 9.5, 9.6	1
Health Homes		
	Apple Health – Health Action Plan, Exhibit C	2
	Apple Health – Health Action Plan, Exhibit C,3	4
	Apple Health – Health Action Plan, Exhibit C,3.14.1	1

Performance Measure Review

The performance of Apple Health managed care organizations (MCOs) with respect to access, timeliness and quality of care and services furnished to enrollees can be measured quantitatively through two nationally recognized and standardized data sources. The first source is the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA). The NCQA Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow MCOs to determine where quality improvement efforts may be needed[4]. The HEDIS data are derived from provider administrative and clinical data. The second source is the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which was developed under direction of the U.S. Agency for Healthcare Research and Quality (AHRQ). The CAHPS data measure member experience through an annual survey of plan members.

In 2015, 31 HEDIS measures (comprising more than 106 distinct indicators) that pertained to members enrolled during calendar year (CY) 2014 were audited and reported. For many of these measures, enrollees were required to have been continuously enrolled through 2014 to be eligible for inclusion, and several required enrollment prior to 2014. In spring of 2015, Apple Health MCOs administered a CAHPS survey for child members (completed by parents or guardians). The CAHPS child survey included a set of screening questions for identifying children with chronic conditions, allowing results to be reported separately for that subgroup.

In addition to the HEDIS and CAHPS measures, MCOs also reported an All-Cause Readmissions measure, which is not currently adopted by NCQA for Medicaid populations, but was formulated similarly to NCQA's readmissions measures for commercial and Medicare populations.

Performance Measure Data Collection and Validation

In the first half of 2015, Qualis Health conducted an NCQA HEDIS Compliance Audit™ of each Apple Health MCO to ensure that the MCOs accurately collected, calculated and reported HEDIS measures for their member populations[5]. This audit does not analyze HEDIS results; rather, it ensures the integrity of the HEDIS measurements.

Using the NCQA standardized audit methodology, NCQA-certified auditors assessed each MCO's information system capabilities and compliance with HEDIS specifications. HCA and each MCO were provided with an onsite report and a final report that included an Audited Measures List, Summary of Audit Activity, Information Systems Standards Validation, HEDIS Source Code Validation, Survey Sample Frame Validation, HEDIS Supplemental Database Validation, Medical Record Review Validation, Final Audit Statement and Audit Measure Designations. All of Apple Health's MCOs were in compliance with HEDIS technical specifications.

CAHPS survey sample frames and source code were validated. The MCOs then individually contracted with certified CAHPS survey vendors to administer the CAHPS survey. Using the standardized CAHPS questionnaire and survey process, 22,095 Apple Health members were randomly selected and surveyed

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

[5] http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx

via mail, Internet and telephone. Data were gathered from 6,331 selected respondent interviews and analyzed and reported to HCA in August of 2015.

Member-Level Data

HCA required MCOs to submit de-identified member-level data for all administrative and hybrid measures. Member-level data enable HCA and Qualis Health to conduct analyses relating to racial and geographic disparities to identify quality improvement opportunities. Analyses based on member-level data are included in the 2015 *Comparative Analysis Report* and *Regional Analysis Report*. Although Qualis Health took steps to carefully define a member-data reporting template for MCOs, the variation among MCOs in interpreting the template resulted in a great deal of effort to clean the data and make it ready for analysis.

Enrollment Growth Impacts

The implementation of the Affordable Care Act's provisions for expanding Medicaid access to a larger number of lower-income adults in January of 2014 resulted, as intended, in a rapid growth in enrollments during 2014. Apple Health enrollment grew by 42 percent in 2014, with AMG and UHC both more than doubling in size (Table A-5). The impact of this enrollment growth has been to shift the composition further toward an adult population.

Table A-5: MCO Enrollment Growth During 2014

Medicaid Managed Care Plan	January 2014	December 2014	% Change
Amerigroup Washington (AMG)	55,459	128,369	131.4%
Coordinated Care of Washington (CCC)	105,914	175,353	65.6%
Community Health Plan of Washington (CHP)	267,634	332,456	24.2%
Molina Healthcare of Washington (MHW)	402,942	486,524	20.7%
United Healthcare Community Plan (UHC)	88,199	180,225	104.3%
Total	**920,158**	**1,302,927**	**41.6%**

Source: Enrollment data provided by Washington State Health Care Authority

Some performance measures should be interpreted within this context of rapid program growth and changing composition. While most measures do not directly reflect the experiences of new members in 2014 (as they are excluded from the eligible populations for some measures), the increase in membership could have affected access in certain areas where provider networks have not grown as rapidly, impacting services provided to all members. While there is little direct evidence of such impacts, and while it is not possible to determine the impacts from available data, logic suggests that Medicaid expansion should be considered as a factor potentially influencing performance. Root cause analyses conducted by MCOs would help to better determine the role of enrollment expansion in low-performing measures.

The following sections summarize performance at the state level and notable results for specific MCOs. Most HEDIS measures (or scores) reflect percentages of enrollees with the specified numerator event divided by the total number of enrollees eligible for the event, where the denominator may derive from administrative data only, or through the use of a sample drawn from administrative data and verified with medical chart reviews (known as the "hybrid" data collection method). Some HEDIS utilization measures

are expressed in terms of *rates*, which are encounters (e.g., visits or discharges) per 1,000 member months. The CAHPS measures (or scores) express the percentage of respondents who selected a top box response for survey items, with responses aggregated into composites. Readers are encouraged to consult the *Comparative Analysis Report*, including Appendix B of that report, for greater plan-level detail and scoring methodology. Detailed plan-level CAHPS survey results and scoring methodology can be found in the 2015 *CAHPS 5.0H Child Medicaid with Chronic Conditions*[6] report.

Each year, HEDIS measures for all accredited managed care organizations are summarized into national-level averages by the NCQA. In addition to national averages, NCQA provides the percentile distribution of scores for each HEDIS measure indicator. A percentile for a given score is the proportion of MCOs that scored below that score nationwide. For example, if a score were 65.2, and the percentile for that score was the 25th, that would mean that 25 percent of all MCOs nationwide had a score falling below 65.2. In this report, we grouped scores into four equal groups, or *quartiles*. For many measures, a symbol is provided, indicating the national quartile for the given score, based on the percentiles reported in the *2015 NCQA Quality Compass*. The quartile symbols are as follows:

-  below 25th percentile—the score falls within the lowest 25 percent of all MCOs
-  25th to 49th percentile
-  50th to 74th percentile
-  at or above 75th percentile—the score falls within the highest 25 percent of all MCOs

Access to Physical Healthcare

Several HEDIS and CAHPS measures, listed in Table A-6, capture health plans' performance relating to access to care. Overall, the Apple Health HEDIS averages for children's access to care continued to outperform the national average, especially for the 1- to 2-year age group. For all age groups, children's access was higher than in the previous year, and significantly for several age groups. While performance on HEDIS (administrative data)-based measures tended to be above average, surveys of parents and guardians (CAHPS) indicated below-average performance for enrollees getting the care they needed, getting specialized therapy or special medical equipment such as a walker, wheelchair, nebulizer, feeding tubes or oxygen equipment.

Adult access to care state averages were below the national average, with the 45-to-64 age group (84.6 percent) falling in the bottom quartile nationally and the 20-to-44 age group (77.9 percent) into the second quartile. Access measures relating to adults' access to primary care providers were below national averages, and the three maternal health state averages in particular were very low, all three in the bottom quartile nationally.

[6] http://www.hca.wa.gov/medicaid/healthyoptions/Documents/AHMC_CAHPS_2015.pdf

Table A-6: Access to Care Performance Measures

	2014 State Rate	2015 State Rate	2015 National Quartile
Adults' Access to Care (HEDIS)			
20–44 years	--	77.9	
45–64 years	--	84.6	
Children's Access to Care (HEDIS)			
12–24 months	97.3	97.5	
25 months–6 years	87.5	88.8↑	
7–11 years	91.2	91.9↑	
12–19 years	90.8	91.2↑	
Well-Care Visits (HEDIS)			
0–15 months, 6+ visits *(goal: 60%)*	64.0	56.8↓	
3–6 years, annual visit *(goal: 68%)*	65.1	66.6	
12–21 years, annual visit *(goal: 43%)*	42.7	42.6	
Maternal Health (HEDIS)			
Timeliness of Prenatal Care	--	73.7	
Frequency of Prenatal Care (>81%)	--	43.8	
Postpartum Care	--	51.6	
Getting Needed Care (CAHPS)			
Children (2015)	--	55.6	 *
Children With Chronic Conditions	--	54.5	N/A
Q4. Always got care as soon as needed	--	73.3	
Q6. Always got appointments as soon as child needed	--	59.9	
Q15. Always easy to get the care, tests or treatment child needed	--	59.6	
Q46. Always got appointments with specialists as soon as child needed	--	51.7	
Q20. Always easy to get special medical equipment	--	55.7	
Q23. Always easy to get special therapy for child	--	52.4	
Q26. Always easy to get treatment or counseling for child	--	47.1	

-- Not measured in 2014 reporting year
↑↓ 2015 state rate significantly higher or lower than the 2014 state rate
National quartile based on 2015 NCQA *Quality Compass* percentiles
Quartile based on 2015 National CAHPS Benchmarking Database (AHRQ)

The state averages for well-care visits continued to be below the national averages, and despite the State's imposition of contracted goals for these measures in MCO contracts for 2014, the state averages were below these goals and even fell significantly from the previous year for one age group, 0 to 15 months. It is unclear why measures for well-care visits should register so low when access measures appear to be strong. Enrollee survey data, however, indicate that 55.6 percent of parents indicated that getting needed care was not "always" possible, according to the CAHPS Medicaid child survey administered in the spring of 2015. CAHPS scores for all four individual items included in the two Access to Care composites were less than the national median. Both of the items for the Getting Care When Needed composite were more highly correlated with overall satisfaction, indicating that they are important to consumers. Thus, even while general access to care HEDIS measures for children appear to be strong, CAHPS survey data and the lower levels of HEDIS well-care visits suggest difficulties for some child enrollees in getting care.

Part of the difference in performance between the access and well-child visit measures could be related to providers' failing to appropriately enter codes in encounter data or on clinical charts, resulting in an undercount of visits meeting the criteria for a well-child visit.

At the MCO level, best performers for well-child visits were also those that showed improvement between 2014 and 2015, AMG (58.1) and CCC (60.6), with the latter being the only MCO to meet the state goal of 60 percent in 2015. The scores for the two largest MCOs, CHP (57.7) and MHW (55.2), both fell from the previous year, with MHW registering a significant drop. The strongest performers for adults' access to care were CHP and MHW, which may be driven in large part by the longer period of time these MCOs have been operating in Washington and the resiliency of their more firmly established provider networks. The adult access to care measure was not collected by MCOs in RY 2014, so the direction of change in 2015 among the MCOs from the previous year could not be determined.

Perhaps the most concerning result among the access measures was the low performance in maternal health access. For timeliness of prenatal care, CHP was the strongest performer (significantly, when compared with the other MCOs), with a score of 77.9, but which was still significantly below the national average. The weakest performer on prenatal care timeliness was UHC, with a score of 65.2, significantly below the other MCOs. MHW performed significantly below the other MCOs on the frequency of prenatal care (40.2), while all MCOs were uniformly low in postpartum care performance, with no significant plan differences.

Recommendations

- HCA needs to continue to review the requirement that MCOs complete performance improvement projects addressing contracted goals the MCOs did not meet (in RY 2015, for well-child visits (0–15 months, 3–6 months, and 12–21 years) and childhood immunizations (Combination 2). All MCOs were below at least one well-child visit goal, and one MCO was below the immunization Combination 2 goal. The State should approve performance improvement projects that seek to address the root cause for the low performance, including examination of provider coding practices and improve the providers' barriers to either reporting or performing well-child visits that meet HEDIS measurement criteria.

- HCA needs to note performance standards where MCOs are performing poorly statewide (within the lowest quartile) and determine whether MCOs should conduct performance improvement projects in order to improve performance.

Opportunities for Improving Access to Care

- MCOs should closely monitor and respond to barriers for adult members receiving primary care. Administrative data should be reviewed at least quarterly, appropriately disaggregated at local and regional levels consistent with local provider networks, to identify inordinately low adult access rates and take steps to determine and remove barriers.

- MCOs should increase efforts to get pregnant women and new mothers into provider facilities for timely prenatal and postpartum care.

- HCA should require MCOs to submit member-level data relating to enrollee receipt of prenatal care (in terms of both timeliness and frequency) in order to conduct analyses to identify particular subgroups or patterns common to all MCOs that could form a foundation for improvement. This would assist in achieving the State's goals of decreasing disparities in adverse birth outcomes.

Timeliness of Physical Care

The CAHPS Getting Care Quickly composite reflects the degree to which members get appointments or urgent care as soon as they are needed. For children in 2015, Apple Health MCOs overall scored within the second quartile among national Medicaid plans for Getting Care Quickly.

Table A-7: Timeliness of Care Performance Measure

	2014 State Rate	2015 State Rate	2015 National Quartile
Getting Care Quickly (CAHPS)			
Children (2015)	--	66.6	*
Children With Chronic Conditions	--	54.5	NA

-- Not measured in 2014 reporting year
* Quartile based on 2015 National CAHPS Benchmarking Database (AHRQ)

Among MCOs, CHP scored significantly lower than the state average, while MHW was significantly above.

Opportunity for Improving Timeliness of Care

- The State should consider collecting more administrative-based information about the timeliness of care, such as timeliness of authorizations.

Quality of Physical Care

The quality of care, as defined by the MCOs' contract with HCA and CFR §428.320, encompasses a range of process and outcome measures by which MCOs have a positive impact on the health of enrollees and adopt practices consistent with current professional knowledge. In this section, Qualis Health examined several aspects of quality over which MCOs have direct influence, including preventive care, appropriateness of care, avoidance of emergent and inpatient care and members' satisfaction with care.

Preventive Care

Apple Health MCOs overall performed below the national average on assessing adults' and children's weight (body mass index) and providing nutritional and physical activity counseling to children. The rate of BMI assessments for children was particularly low, 36.7, compared to 64.0 percent nationally. Immunization rates for children improved slightly from the previous year but remained below national averages for Combinations 2 (70.9) and 3 (68.7). The Apple Health average surpassed the State contracted goal of 68 percent in 2015. Adolescent immunizations (Combination 1) improved significantly in 2015 from the previous year, surpassing the national average.

State averages for women's health screenings were low compared to the national averages, particularly for cervical cancer screenings. HPV vaccination rates were 29.2 for female adolescents, which is well above the national average rate of 22.2.

Table A-8: Preventive Care Performance Measures

	2014 State Rate	2015 State Rate	2015 National Quartile
Children's Weight Assessment and Counseling for Nutrition and Physical Activity and Adults' BMI Assessment (HEDIS)			
BMI Percentile Assessment	39.7	36.7	
Nutritional Counseling	47.6	51.1	
Physical Activity Counseling	43.1	45.1	
Adult BMI Percentile Assessment	--	82.2	
Children's Combo 2 *(goal: 68%)*	70.7	70.9	
Children's Combo 3	67.2	68.7	
Adolescent Combo 1	67.0	73.7↑	
Breast Cancer Screening	--	54.4	
Cervical Cancer Screening	--	50.4	
Chlamydia Screening	--	51.2	
HPV Vaccination	--	29.2	

-- Not measured in 2014 reporting year
↑↓ 2015 state rate significantly higher or lower than the 2014 state rate
National quartile based on 2015 NCQA *Quality Compass* percentiles

Two MCOs, CCC and UHC, had significantly lower rates than the other MCOs for BMI assessments for both adults and children. CHP, which was a clear leader in 2014 for children's BMI, registered a significant decrease from 53.0 to 37.2 between 2014 and 2015. UHC was significantly lower than its peers for both nutrition and physical activity counseling in 2015.

CCC performed commendably in providing childhood immunizations, outpacing its peers both in terms of its significant improvement between 2014 and 2015 and achievement in 2015, achieving 79.5 for Combo

2 and 78.1 for Combo 3. AMG was significantly below its peers in 2015, with 66.1 for Combo 2 and Combo 3, and was the only MCO to not meet the State contracted goal of 68 percent. In contrast, CCC oversaw significantly lower immunization rates for adolescents (Combination 1) in 2015, being the only plan to see a decline from the previous year, while CHP and MHW posted significantly higher rates than the other MCOs.

Three MCOs had significantly lower rates of breast and/or cervical cancer screenings—AMG, CCC and UHC— all MCOs that are relatively new to Washington Apple Health. CHP and UHC were significantly below peers in chlamydia screenings, while CCC and MHW were significantly above. While Washington overall performed well on HPV vaccinations, AMG was significantly lower than peers.

Recommendations

- The State needs to consider whether AMG should follow through with a performance improvement project after not meeting the State contracted goal of 68 percent for childhood immunizations (Combo 2).
- HCA needs to note performance standards where MCOs are performing poorly statewide (within the lowest quartile) and determine whether MCOs should conduct performance improvement projects in order to improve performance.

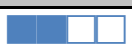
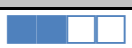
Opportunities for Improving Preventive Care

- MCOs should determine why providers are not conducting (or not appropriately recording) BMI assessments and cervical cancer screenings.
- The State should consider establishing goals to address very low-scoring measures, such as BMI assessments and cervical cancer screenings.
- The State should inquire whether lessons or best practices can be learned from CCC with regard to achieving higher performance on childhood immunizations, and whether the resulting knowledge can be shared among other MCOs.

Diabetes and Chronic Care Measures

Apple Health overall performed relatively well on diabetes care measures, with all process measures (tests, examinations and monitoring) above national averages and significant improvement in two measures (Table A-9). Outcome measures like controlling blood pressure and blood sugar approached the national averages. Measures for other chronic care management were below national averages.

Table A-9: Diabetes and Chronic Care Performance Measures

	2014 State Rate	2015 State Rate	2015 National Quartile
Diabetes Care (HEDIS)			
HbA1c Testing	88.1	90.4	
Eye Examinations	49.6	54.8↑	
Medical Attention for Nephropathy	79.9	83.4↑	
Blood Pressure Control (< 140/90)	59.7	63.7	
Good HbA1c Control (< 8%)	45.7	46.3	
Poor HbA1c Control (> 9%)	46.4	42.6	 †
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	--	85.9	
Diabetes Monitoring for People With Diabetes and Schizophrenia	--	68.6	
Other Chronic Care Management (HEDIS)			
Controlling High Blood Pressure		53.6	
Antidepressant Medication Management		37.0	
Medication Management for People With Asthma (> 75% compliance)		26.1	
Follow-Up Care for Children Prescribed ADHD Medication		37.7	

-- Not measured in 2014 reporting year
† A *lower* score is better for this measure
↑↓ 2015 state rate significantly higher or lower than the 2014 state rate
National quartile based on 2015 NCQA *Quality Compass* percentiles

MHW and UHC performance was below other MCOs' performance and national averages for eye examinations, although UHC significantly improved compared to the prior year. UHC remained below the state average for controlling blood pressure in diabetics, but improved dramatically from the prior year. CHP led the state for all diabetes outcomes performance measures in 2015.

There was wide variation among MCOs in measures pertaining to keeping high blood pressure under control (among members with hypertension), in which CHP and MHW scored significantly higher than other MCOs. MHW was significantly below its peers in managing antidepressant medications, while AMG and UHC were above.

Opportunity for Improving Diabetes and Chronic Care Management

- The medication management measures are all based on administrative data. MCOs should consider whether there are ways to assist providers with identifying patterns indicating a lack of follow-up for patients who were dispensed medications.

Appropriateness of Treatments and Avoidance of Emergency and Inpatient Care

Apple Health overall performed well on providing appropriate treatments, with all scores above the national average. The program also performed well on avoiding emergent and inpatient care, with emergency department (ED) visits below the national average and hospitalizations well below the national average.

Rates of re-hospitalization within 30 days after discharge were significantly higher in 2015 (13.9 percent) compared to 2014 (10.5 percent).

Table A-10: Appropriateness of Care Performance Measures

	2014 State Rate	2015 State Rate	2015 National Quartile
Appropriateness of Treatments (HEDIS)			
Imaging for Low Back Pain	--	77.7	
Antibiotics for Acute Bronchitis (adults)	--	29.3	
Antibiotics for Upper Respiratory Tract Infections (children)	--	92.6	
Avoidance of Emergent and Inpatient Care (HEDIS)			
Emergency Department Visits per 1,000 Member Months	51.6	52.1	†
Inpatient Discharges per 1,000 Member Months	5.8	5.4	†
All-Cause Readmissions Within 30 Days (not a HEDIS measure for Medicaid)	10.5	13.9↑	NA

-- Not measured in 2014 reporting year
† A *lower* score is better for this measure
↑↓ 2015 state rate significantly higher or lower than the 2014 state rate
National quartile based on 2015 NCQA *Quality Compass* percentiles

MHW led the way with the lowest ED visit rate, while AMG, CCC and UHC significantly reduced their rates from the prior year, both for ED visits and hospitalizations. Hospital readmissions increased for four of the five MCOs (AMG, CCC, CHP and MHW) in 2015, significantly for CHP and MHW. Increases in 30-day readmissions were observed for all age groups.

Recommendation

- HCA needs to take steps to address common challenges among MCOs by capitalizing on individual plan best practices and facilitating information-sharing among MCOs, possibly through a group learning forum. For example, MHW's performance in 2015 indicates a successful pattern of low emergent and inpatient utilization coupled with high ambulatory access and utilization, suggesting a successful service model design, elements of which could be shared with other MCOs.

Opportunity for Improving Emergent and Inpatient Care Rates

- MCOs should investigate the reasons for the increases in 30-day readmissions rates.

Consumers' Experience of Care

On measures related to consumers' experience of care, two overall rating items for MCOs were below the national median, including rating of overall healthcare (63.0 percent) and rating of health plan (64.7 percent), shown in Table A-11. Ratings of doctors (73.6 percent), specialists (72.0 percent) and customer service (66.5 percent) were all above the national median.

Table A-11: CAHPS Child Member Experience Measures

	2015 Sample Size	2015 State Rate	2015 National Quartile**
Overall Ratings (CAHPS)			
Overall Rating of Care	4,183	63.0	
Rating of Personal Doctor	4,840	73.6	
Rating of Specialist Seen Most Often	1,165	72.0	
Rating of Health Plan	5,588	64.7	
Customer Service	1,595	66.5	

** Quartile based on 2015 National CAHPS Benchmarking Database (AHRQ), Child Medicaid 5.0

Opportunities for Improving Consumer Experience

- The State and the MCOs should continue monitoring consumers' experience of care.
- Currently, child and adult CAHPS surveys are administered in alternate years. MCOs should consider administering both adult and child CAHPS surveys each year in order to more frequently track consumer experience. Additionally, MCOs should consider sponsoring real-time patient surveys offered by providers to identify specific barriers or problems with getting care.

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Review of Previous-Year EQR Recommendations

Listed below are the EQR recommendations presented in the 2014 EQR report and HCA's responses regarding consideration or implementation. Qualis Health has determined that HCA is taking adequate steps to address these issues.

Table A-12: Review of HCA Responses to 2013–2014 EQR Recommendations

Prior-Year Recommendations	HCA Response
Clinical Performance Measures	
HCA should designate incentive measures for which MCOs can receive quality incentive payments for top performance.	HCA will take this recommendation under consideration as time and resources allow.
HCA should continue to provide supplemental data on Early and Periodic Screening, Diagnosis and Treatment to assist the MCOs in calculating HEDIS well-child measures.	HCA currently provides supplemental data on Early and Periodic Screening, Diagnosis and Treatment to assist the MCOs in calculating HEDIS well-child measures.
HCA should seek to align performance measures with other State and Federal reporting requirements to reduce burden on providers and promote efficient use of healthcare resources.	HCA has aligned contractual performance measures with other State and Federal reporting requirements to reduce burden on providers and promote efficient use of healthcare resources.
HCA should consider adding a contract requirement for the MCOs to provide HEDIS-specific performance feedback to clinics and providers on a frequent and regular schedule.	HCA has taken this recommendation under advisement and shared it with the MCOs. Many of the MCOs already provide performance measure feedback to clinics and providers.
Consumer Satisfaction	
MCOs need to assist providers in examining and improving their abilities to manage patient demand. As an example, MCOs can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine or group visits for certain types of healthcare services and appointments to increase physician availability.	HCA has shared this recommendation with the MCOs for their consideration.
MCOs need to identify and eliminate access barriers that prevent patients from obtaining necessary and timely care, locating a personal doctor and receiving adequate assistance when calling a physician office.	HCA has shared this recommendation with the MCOs for their consideration.
MCOs should explore additional methods for obtaining direct patient feedback on services, such as by developing comment cards for enrollees to fill out after a physician office visit.	HCA has shared this recommendation with the MCOs for their consideration.
Technical Assistance	

During 2015, HCA should sponsor formal training for all MCOs on care transitions and coordination, program integrity and access issues, to assist the MCOs in meeting related contractual and regulatory requirements.	HCA has ongoing meetings with the MCOs to offer technical assistance to address these areas of concern.
HCA should encourage MCOs with emerging best practices to share those practices at the regularly scheduled joint MCO/RSN quality meetings, in order to reduce performance gaps among MCOs for specific measures.	HCA has shared this recommendation with the MCOs for their consideration.
Data Quality and Completeness	
HCA should help MCOs overcome barriers to collecting complete member-level encounter data, including race/ethnicity data, so that the MCOs can use these data to assess resources for improving the quality of care and establish appropriate interventions to address healthcare disparities.	HCA has ongoing meetings with the MCOs to offer technical assistance to address these areas of concern.

Washington EQRO Performance Improvement Project

Reducing Disparities in Birth Outcomes Learning Collaborative—Phase 1

In 2015, Qualis Health began implementing a performance improvement project (PIP) to improve birth outcomes among American Indian/Alaska Native (AI/AN) or African American female Medicaid enrollees of childbearing age. The project structure was based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series Learning Collaborative model, with Phase One, program development, slated to occur in 2015 and Phase Two, a test of the framework, to occur among physician practices that serve the targeted population in 2016.

This pilot project was approved to utilize and expand upon the recommendations for addressing disparities in adverse birth outcomes identified by the Governor's Interagency Council on Healthcare Disparities' Birth Outcomes Workgroup. The project's goal was to develop a shortlist of promising, actionable changes that the healthcare system, the managed care organizations (MCOs) and communities could test and implement, with the aim of decreasing adverse outcomes. In order to fully develop the framework for this project, Qualis Health convened a technical expert panel (TEP) representing members of the AI/AN and African American communities, clinicians and Health Care Authority (HCA) leaders. The TEP met three times during the summer and fall of 2015 to provide recommendations, review draft documents, suggest project metrics and help define the overall effort. During these meetings, the TEP also discussed community stakeholders, content and faculty for future learning sessions and potential practices for testing the proposed change package.

Technical Expert Panel

- Josie Amory, MD, Swedish Medical Center *(content review)*
- Rebecca Benko, MD, MultiCare
- Vazaskia Crockrell, Health Equity and CLAS Manager, Health Care Authority
- Beverly Court, Washington Department of Social and Health Services
- Jessie Dean, Administrator, Tribal Affairs, Health Care Authority
- Charissa Fotinos, MD, Health Care Authority—Collaborative Chair
- Neva Gerke, Centering Pregnancy/Laoch Midwifery
- Gina Legaz, March of Dimes
- Devon Love, Center for MultiCultural Health
- Shelley Means, Native American Women's Dialog on Infant Mortality (NAWDIM)
- Dale Reisner, MD, Swedish Medical Center
- State Rep. June Robinson, 38th District
- Casey Zimmer, Health Care Authority

Technical Expert Panel Recommendations

Developing the Change Package and Project Metrics

Qualis Health provided the TEP with an initial draft of a proposed Collaborative Handbook (project framework), based on the Governor's Interagency Council on Health Disparities Birth Outcomes Workgroup recommendations, a literature review and a demographic analysis for review and discussion. At each meeting, the TEP discussed evidence-based change concepts and strategies/considerations that

could be implemented by providers in support of achieving the goal of improving birth outcomes for the populations of focus. The TEP determined that cultural competency/cultural humility should serve as the overall framework for this effort and be considered in all aspects of care, beginning with preconception health and following throughout prenatal, intrapartum and postpartum care.

The TEP members also provided input for outcomes and process metrics, and offered assistance in understanding potential data sources.

Determining Geographical Area for Testing the Change Package

The panel recommended that it would be optimal for this work to be shared with practices across the state; however, after understanding time and scope limitations, it was determined that initial pilot testing should occur in King and Pierce counties, and that project results would be reported to HCA and the State at project's end, with possible recommendations for implementing efforts on a broader, statewide scale.

TEP Observations

Throughout the course of the meetings, the TEP discussed a number of issues, and the panel's contributions pointed to three specific concerns: the "fit" of this work with the Collaborative model, addressing the needs of multiple target populations with one project, and a need for wider cultural input.

- Review of the Collaborative Handbook generated significant dialogue among the group, leading many to question whether the IHI Collaborative model and its relatively traditional framework—improving processes conducted by healthcare providers—would be successful with the populations served.
- The TEP also expressed concern that in order to develop and implement this work successfully, the voices of the target populations must be better represented, and that communities (in addition to the representative nature of the TEP) needed to have the opportunity to provide substantive feedback to the proposed change concepts. It was recommended that forums or focus groups be conducted among communities, including community gatekeepers, members and trusted providers (including non-medical providers) to determine what initiatives were already in place and what efforts would work. These forums would replace the proposed clinic-based test component of the project, and the issues addressed at these events would be used to focus on initiatives for improving health. This recommendation was incorporated into a revised project plan and submitted to and approved by the HCA.

Phase Two

The results and recommendations of the TEP were provided to the HCA for review and consideration. Qualis Health also submitted a proposed alternative project plan for using data and engaging Apple Health managed care organizations (MCOs) in performance improvement efforts designed to address maternal care of AI/AN and African American female Medicaid enrollees. Proposed activities could include, for example, additional analysis of member-level data, delivery of findings to the State and learning sessions related to using the birth outcomes data to develop efforts that will help close gaps in healthcare disparities

Mental Healthcare Provided by Regional Support Networks

Introduction

In 2014, the Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) contracted with 11 regional support networks (RSNs) throughout the State of Washington to provide comprehensive and culturally appropriate mental health services for adults, children and their families. Table B-1, below, lists the RSNs and their service areas.

DBHR currently contracts with the RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs administer services by contracting with provider groups, including community mental health programs and private nonprofit agencies, to provide mental health treatment. The RSNs are accountable for ensuring that mental health services are delivered in a manner that complies with legal, contractual and regulatory standards for effective care.

In fulfillment of Federal requirements under 42 CFR §438.350, DBHR contracts with Qualis Health to perform an annual external quality review (EQR) of managed mental health services provided by the RSNs to Medicaid enrollees, assessing, specifically, the quality and timeliness of the care they provide and enrollees' access to care.

Table B-1: Regional Support Network Service Areas

Regional Support Network	Counties Served
Chelan-Douglas RSN (CDRSN)	Chelan, Douglas
Grays Harbor RSN (GHRSN)	Cowlitz, Grays Harbor
Greater Columbia Behavioral Health RSN (GCBH)	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Wala, Whitman, Yakima
King County RSN (KCRSN)	King
North Sound Mental Health Administration RSN (NSMHA)	Island, San Juan, Skagit, Snohomish, Whatcom
Optum Pierce RSN (OPRSN)	Pierce
Peninsula RSN (PRSN)	Clallam, Jefferson, Kitsap
Southwest Washington Behavioral Health RSN (SWBH)	Clark, Skamania
Spokane County RSN (SCRSN)	Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens
Thurston-Mason RSN (TMRSN)	Mason, Thurston
Timberlands RSN (TRSN)	Lewis, Pacific, Wahkiakum

Qualis Health's review of mental healthcare delivered by RSNs included a compliance review, a validation of the RSNs' performance improvement projects (PIPs), an information systems capabilities assessment (ISCA) and an encounter data validation (EDV), as well as a review of progress on the previous year's external quality review recommendations.

Summary of Recommendations

With the expansion of the Medicaid enrollment, RSNs face the challenge of providing timely access to high-quality care for the expanded Medicaid population while meeting the demands of both State and Federal expectations. Most of the RSNs met or partially met all the review standards for quality assessment and performance improvement (QAPI), ISCA and PIPs. A few major areas in the EQR that need further attention by the RSNs and the State center around availability and timeliness of services and the RSNs' implementation and evaluation of their own quality management programs.

The following provides a high-level, statewide summary of the conclusions drawn from the findings of the activities regarding the RSNs' strengths and recommendations to DBHR with respect to quality, timeliness and access.

Compliance Review/QAPI

All of the RSNs have experienced increased enrollment with the enactment of the Patient Protection and Affordable Care Act. Because of the resulting increase in enrollment, several of the RSNs have had difficulties recruiting clinical staff to meet service needs and access standards.

- DBHR needs to encourage and work with the RSNs to explore and implement various options for recruiting clinical staff. RSN options might include paying for relocation expenses, advertising in other states and providing for tuition reimbursements.

Although many of the RSNs can demonstrate that their contracted providers respond to and comply with corrective action plans, several of the RSNs stated that some contracted provider agencies do not respond and/or comply with the conditions of the formal corrective action plans.

- DBHR needs to work with the RSNs to implement procedures and possible incentives/disincentives to the provider agencies, to ensure that the conditions of corrective action plans are being met.

Many of the RSNs have difficulties around ensuring practice guidelines meet the needs of enrollees, that provider agencies are implementing practice guidelines in the care and treatment of the enrollees and that practice guidelines are used in decisions regarding utilization management, enrollee education opportunities and coverage of services.

- DBHR needs to ensure the RSNs' practice guidelines are meeting the needs of the enrollee populations, that the RSNs are implementing the appropriate practice guidelines in the care and treatment of enrollees and that the RSNs have a process in place whereby the practice guidelines are used to help make decisions regarding utilization management, enrollee education opportunities, and coverage of services.

Many of the RSN's policies and procedures have not been reviewed, updated or approved for many years.

- DBHR needs to ensure the RSNs are reviewing, updating and approving policies and procedures at least yearly to be certain the policies and procedures are in accordance with current best practices, terminology and references to contract language, WACs and CFRs.

Many of the RSNs continue to have difficulties capturing all grievances and appeals, transfers and requests to change providers.

- DBHR needs to continue to work with the RSNs to develop and implement reliable procedures for capturing all grievances and appeals, transfers and requests to change providers in order to analyze and integrate the information and use it to generate reports for making informed management decisions.

Many of the RSNs do not use performance and quality benchmarks and valid, objective measures to assess their performance against these benchmarks in evaluation of the quality and appropriateness of care and services furnished to enrollees.

- DBHR needs to ensure that all RSNs are evaluating the quality and appropriateness of care and services furnished to enrollees through the use of performance and quality benchmarks with valid, objective measures to assess their performance against those benchmarks.

Many of the quality management program evaluations and work plans do not include results of the year's activities, EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year.

- RSN evaluations and work plans should include ongoing and short-term quality activities. These work plans should include and be informed by EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations.

ISCA

Many RSNs are not able to obtain current disaster recovery plans from their delegated county data centers either because respective county data centers have not updated their disaster recovery plans annually as required, or because delegated entities have declined to release the plans to the RSNs.

- DBHR needs to ensure the RSNs are developing methods to obtain current disaster recovery plans on an annual basis from the delegated county data centers.

During many of the RSN reviews, it was noted that not all of the provider agencies are encrypting protected health information (PHI) data according to DBHR standards.

- DBHR needs to ensure the RSNs are working with the contracted provider agencies to ensure that agencies are encrypting agency data according to DBHR standards.

Several RSNs are not able to accept electronic data interchange (EDI) data from contracted provider agencies, resulting in double data entry for those agencies, potentially causing data input errors.

- DBHR needs to ensure that RSNs continue to work with contracted providers to be able to accept EDI data so that the agencies with in-house EHR systems can avoid performing double data entry.

EDV

In reviewing the EDV deliverables that the RSNs submitted to the State, it was noted that the RSNs' data collection and analytical procedures for validating encounter data were not standardized.

- In order to improve the reliability of encounter data submitted to the State, DBHR needs to work with the RSNs to standardize data collection and analytical procedures for encounter data validation.

During the onsite clinical record reviews at the provider facilities, Qualis Health discovered numerous encounters in which services were bundled incorrectly. Other numerous errors further suggest that the RSNs and providers need more information or training about how to correctly code encounters prior to

submission to the State. Additionally, many of the RSNs and providers were unfamiliar with the terms of EDV in the State contracts and with the specifics of the Service Encounter Reporting Instructions (SERI).

- DBHR needs to provide guidance to the RSNs as to how to bundle services correctly, review the numerous errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians and ensure the RSNs know and understand the content of the State contract and the SERI. DBHR may consider providing further training on both the contract and SERI to the RSNs.

Many RSNs are submitting codes to ProviderOne that have been retired since July 2013, as well as submitting other coding errors. The State reported that ProviderOne does not contain any edits to reject any codes and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to work with ProviderOne to create an algorithm to reject encounters that are submitted incorrectly to the State.

PIPs

Several issues arose regarding the PIP process, including a lack of clarity among RSNs about the approval status of many of the PIPs by the State, as well as information regarding RSN resubmissions. At least one of the RSNs' PIPs had not been reviewed by DBHR in time for the RSN's site review. Additionally, the scope of several of the RSNs' PIPs amounted to program evaluation but not performance improvement projects. Thus, it was unclear whether the RSNs were sufficiently knowledgeable regarding performance improvement and the PIP protocol requirements.

- DBHR needs to:
    - Develop a clear and systematic approach for approving PIPs that includes due dates for RSN submission, as well as DBHR's dates of review and approval of PIPs.
    - Ensure all DBHR reviewers have a full understanding of the EQRO PIP protocol so that only true performance improvement projects are approved.
    - Create a communication plan for RSNs regarding timeline submission dates and the status of PIP submissions.

Performance Measures

Performance measure validation did not occur in the review for 2015 as the State was in the process of retiring the previous performance measures and defining new performance measurements.

Compliance Review

Objectives

The compliance portion of Qualis Health's external quality review of RSNs assesses overall performance, identifies strengths, and notes opportunities for improvement or recommendations requiring corrective action plans (CAPs) in areas where the RSN did not clearly or comprehensively meet Federal and/or State requirements for quality assessment and performance improvement.

Methodology

Qualis Health evaluated the RSNs' performance on each element of the protocol by reviewing and performing desk audits on documentation submitted by the RSNs, conducting telephone interviews with the RSNs' contracted provider agencies, and conducting onsite interviews with the RSN staff.
The procedures for conducting the review included the following:

- All interview questions and documentation were given to the RSNs prior to onsite interviews.
- Requested documentation was submitted by the RSNs to Qualis Health for review.
- Qualis Health staff conducted telephone interviews with two provider agencies for each RSN prior to the onsite interviews.
- Qualis Health conducted onsite interviews with each RSN and provided each RSN with an exit interview summarizing the preliminary results of the review.
- Qualis Health staff met for consensus and scored the oral and written responses to each question and compiled the results for the individual RSN reports.

Scoring

For the compliance section of the review, Qualis Health applied the three-point scoring metric using the following criteria, adapted from CMS guidelines:

Fully Met: ● All documentation listed under a regulatory provision, or component thereof, is present and RSN staff provides responses to reviewers that are consistent with each other and with the documentation.

Partially Met: ◉ All documentation listed under a regulatory provision, or component thereof, is present, but RSN staff is unable to consistently articulate evidence of compliance, or RSN staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.

Not Met: ○ No documentation is present and RSN staff has little to no knowledge of processes or issues that comply with regulatory provisions, or no documentation is present and RSN staff have little to no knowledge of processes or issues that comply with key components of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

Summary of Compliance Results

Table B-2: Summary Results of Compliance Monitoring Review

CMS EQR Protocol	CFR	Chelan-Douglas	Grays Harbor	Greater Columbia	King County	North Sound	Optum Pierce	Peninsula	Southwest	Spokane	Thurston-Mason	Timberlands
Availability of Services	**438.206**	◉	●	◉	◉	◉	◉	◉	●	●	◉	●
Coordination and Continuity of Care	**438.208**	◉	◉	◉	●	◉	●	●	◉	●	◉	◉
Coverage and Authorization of Services	**438.210**	●	◉	◉	●	◉	●	◉	◉	◉	◉	◉
Provider Selection	**438.214**	◉	◉	◉	◉	◉	●	●	●	●	●	●
Subcontractual Relationships and Delegation	**438.230**	●	◉	◉	●	●	●	●	●	●	◉	◉
Practice Guidelines	**438.236**	◉	○	◉	◉	●	●	◉	◉	◉	◉	◉
QAPI	**438.240**	◉	◉	◉	●	◉	◉	●	◉	◉	◉	◉
Health Information Systems	**438.242**	●	◉	◉	◉	●	◉	●	●	●	◉	◉

Table B-3, next page, summarizes the areas within the compliance review where RSNs experienced the most issues.

Table B-3: Summary of Issues Found in RSN Compliance Review

Compliance Area	42 CFR Citation	Number of RSNs with Issues
Availability of Services—Second Opinion	438.206(b)(3)	1
Availability of Services—Out-of-Network Provider Credentials	438.206(b)(6)	3
Coordination and Continuity of Care—Primary Care and Coordination of Services	438.208(b)	4
Coordination and Continuity of Care—Additional Services for Enrollees with Special Healthcare Needs	438.208(c)(1)(2)	1
Coordination and Continuity of Care—Treatment Plans	438.208(c)(3)	1
Coverage and authorization—Basic rule	438.210(a)	2
Coverage and Authorization of Services—Authorization of Services	438.210(b)	2
Coverage and Authorization of Services—Timeframe for Decisions	438.210 d	1
Coverage and Authorization of Services—Compensation for Utilization of Services	438.210(e)	1
Provider Selection—General Rules	438.214(a)(b)	1
Provider Selection—Excluded Providers	438.214(d)	2
Subcontractual Relationships and Delegation	438.230	3
Practice Guidelines—Clinical Evidence and Adoption	438.236(a–b)	3
Practice Guidelines—Application of Guidelines	438.236	3
Quality Assessment and Performance Improvement Program—Rules, Evaluation, Measurement, Improvement, Program Review by State	438.240(a)(b)(1)(d)(e)	7
Quality Assessment and Performance Improvement—Mechanisms to Detect Under- and Overutilization of Services	438.240(b)(3)	3
Quality Assessment and Performance Improvement—Mechanisms to Assess the Quality and Appropriateness of Care	438.240(b)4	4

Availability of Services

Strengths: Access

- Many RSNs use geo-mapping as a resource for identifying where the RSNs' enrollee populations are located, what the ratio of the populations are to the number of providers in the identified location and the service needs of the populations.

- Most RSNs actively monitor the provider networks to ensure there is timely access to the full range of Medicaid-covered services across the geographical regions and to ensure that their providers perform in accordance with contract obligations.

- Most RSNs have a strong, data-driven process for monitoring the timeliness of access to care across provider networks, which includes monitoring access compliance standards by auditing clinical records, reviewing grievance logs and conducting enrollee surveys.

- One of CDRSN's 2014 quality work plan goals was 90 percent compliant across the network: "Services provided throughout the RSN are monitored for network sufficiency, under/over utilization, and accuracy/consistency of authorization decisions."

- KCRSN annually reviews its specialist mix and geographic distribution of practitioners to ensure there are adequate services to meet its enrollee network population.

- PRSN generates a monthly Provider Performance Summary Report, which calculates, by agency and for the region as a whole, the number of services and hours for each state plan modality, utilization rates for inpatient services, crisis services, penetration rates and other performance statistics.

- SWBH utilizes TeleMed services to help meet the needs of its enrollees and to ensure adequate access to care.

- TMRSN has an out-of-network service contract in place with several of the neighboring RSNs in the event an enrollee requires specialized treatment unavailable within the TMRSN network.

Opportunity for Improvement: Access

The State Mental Health Statistics Improvement Program (MHSIP) consumer survey, which measures enrollee satisfaction with services including access, is performed yearly. Several RSNs' survey results have trended below the state's average for satisfaction on access to care and services.

- DBHR should consider methods to discover the issues causing the low rate of satisfaction on access to care and services, and implement methods to meet the needs of its enrollees.

Strength: Timeliness

- Many RSNs experienced an increase in enrollment since the implementation of the Patient Protection and Affordable Care Act. Several of the RSNs supported their provider agencies in initiating same-day walk-in intakes and assessments in order to meet the increase in enrollment and service requests.

Strengths: Quality

- Most RSNs have a robust policy and procedure to address enrollees with limited English proficiency and diverse cultural and ethnic backgrounds and to ensure the delivery of services is in a culturally competent manner for all enrollees.

- GHRSN's policy on culturally competent services incorporates diversity, non-English languages, age, disability and self-disclosed sexual orientation.

- KCRSN ensures that services are provided in an amount, duration and scope sufficient to achieve adequate care through several mechanisms, including the work of its Hospital and Residential Services Utilization Management Work Group. The work group develops effective strategies to address under- or overutilization of resources and makes recommendations to management for system quality improvements.

- PRSN has a variety of mechanisms in place to detect both under- and overutilization of services. These include reviewing and analyzing reports describing utilization trends, quality indicator tracking logs, administrative reviews, admission and reauthorization-focused chart reviews and other quality assurance monitoring results.

- OPRSN sponsors community conversations regarding cultural competency; participants include law enforcement, mental health, physical health and substance abuse providers, other health systems staff, lawyers and peers.

Coordination and Continuity of Care

Strengths: Access

- Most RSNs have a robust process in place to monitor for care coordination.

- GHRSN monitors the use of services among high utilizers, specifically enrollees who are frequent users of the emergency department (ED) and crisis services. GHRSN states that the emergency room is overutilized in Grays Harbor, and in 2014 the RSN attended monthly meetings with representatives from the ED to develop and implement interventions.

- The PRSN Crisis Response Team consults with and assists the local hospital emergency room medical providers and staff with the development of integrated medical and/or mental health treatment plans that provide a coordinated and effective course of treatment for the enrollees.

- In addition to tracking crisis services, OPRSN's care managers review individuals who have had four or more crisis service encounters during the previous month to explore the reasons for the encounters and what routine and outpatient services have or have not been utilized.

Strengths: Quality

- Several of the RSNs regularly work with county partners such as the local jails, juvenile justice departments and inpatient psychiatric departments to promote integrated and coordinated care for individuals involved in multiple systems.

Recommendation: Coordination of Care—Quality

Although most RSNs monitor network providers through onsite clinical record reviews to ensure that documentation of coordination of activities is evident in the enrollee's clinical records, the documentation in the clinical records, especially for children, needs to support the communication between the coordination of services which occurs within the scope of the consent and release(s) given by the enrollee.

- DBHR needs to work with the RSNs to ensure the provider agencies are providing coordination of services and documenting the coordination of services in the clinical records.

Coverage and Authorization of Services

Strengths: Access

- Many RSNs have implemented the Level of Care Utilization System (LOCUS) and Children and Adolescent Level of Care Utilization System (CALOCUS) to ensure level of care standards are consistently applied across the enrollee network.

- GHRSN has worked with crisis services to hire two stabilization peers to work in the community to help decrease the use of ED and crisis services.

Strength: Timeliness

- Many of the RSNs are able to authorize requests for service within a 24-hour timeframe from first receipt of the request.

Strengths: Quality

- Several of the RSNs perform records reviews to determine if the appropriate level of care is being utilized.

- For monitoring purposes, during the authorization process GCBH documents and tracks the use of services delivered to enrollees with both limited English proficiency and diverse cultural and ethnic backgrounds.

- OPRSN uses the following mechanisms to monitor the inter-rater reliability of clinical staff when making authorizations:
    - intensive mentoring of every care manager during his/her first six months of employment
    - routine auditing of samples of completed inpatient and outpatient authorizations to ensure that care managers consistently comply with access to care standards
    - weekly case consultations with OPRSN's medical director

Recommendation: Coverage and Authorization of Services—Quality

Many RSNs were unable to demonstrate the use of mechanisms for monitoring the inter-rater reliability of clinical staff who make authorization decisions.

- DBHR needs to ensure that RSNs are able to demonstrate the use of mechanisms for monitoring the inter-rater reliability of clinical staff who make authorization decisions.

Provider Selection

Strengths: Quality

- Many of the RSNs have robust credentialing and re-credentialing processes in place and perform detailed credentialing reviews of contracted provider clinicians.

- Most RSNs perform monthly checks to ensure that their staff and the staff of contractors have not been excluded from participation in Federal healthcare programs. Most evaluate exclusion status using both the List of Excluded Individuals and Entities (LEIE) and System for Award Management (SAM) databases.

Recommendation: Provider Selection—Quality

All of the RSNs have experienced increased enrollment with the enactment of the Patient Protection and Affordable Care Act. Because of the resulting increase in enrollment, several of the RSNs have had difficulties recruiting clinical staff to meet service needs and access standards.

- DBHR needs to encourage and work with the RSNs to explore and implement various options for recruiting clinical staff. RSN options might include paying for relocation expenses, advertising in other states and providing for tuition reimbursements.

Subcontractual Relationships and Delegation

Strength: Quality

- Most RSNs conduct a comprehensive annual performance evaluation of each of the contracted provider agencies. Review areas include policies/procedures, credentialing files, financial reports, compliance program, QI plan and activities, grievance and crisis logs, staff training and, when applicable, subcontractor agreements and business associate agreements.

Recommendations: Subcontractual Relationships and Delegation—Quality

Although most of the RSNs include corrective action plans in the evaluation of provider agencies, several RSNs still need to fully articulate the specific nature of the action that is needed, and include specific CFR, WAC or contract citations related to the issue.

- DBHR needs to ensure all the RSNs are fully identifying the specific nature and conditions of corrective action plans and that the corrective action plans include references to the specific related CFR, WAC or contract citations.

Although many of the RSNs can demonstrate that their contracted providers respond to and comply with corrective action plans, several of the RSNs stated that some contracted provider agencies do not respond and/or comply with the conditions of the formal corrective action plans.

- DBHR needs to work with the RSNs to implement procedures and possible incentives/disincentives to the provider agencies, to ensure that the conditions of corrective action plans are being met.

Practice Guidelines

Strengths: Quality

- Interviews with CDRSN's provider network indicated that practice guidelines are discussed at monthly RSN clinical meetings and that the RSN routinely reviews for adherence to the guidelines during the clinical record reviews.

- NSMHA has a broad array of diagnosis-oriented practice guidelines to address the needs of its enrollees. The practice guidelines were developed through a collaborative process that included input from providers, the NSMHA Advisory Board and the Board of Directors.

- PRSN consulted with the network's clinical directors to identify the elements to monitor within each adopted practice guideline. To ensure that the appropriate elements are included in the services provided to each enrollee with a diagnosis of schizophrenia or bipolar disorder, the RSN reviews, at least once a year, a sample of charts for adherence to the appropriate guideline. The results are given to the provider agencies.

- OPRSN's care managers review level of care guidelines and access to care standards, and apply clinical practice guidelines and evidence-based practice guidelines for authorizing requests for authorization.

Recommendation: Practice Guidelines—Quality

Many of the RSNs have difficulties around ensuring practice guidelines meet the needs of enrollees, that provider agencies are implementing practice guidelines in the care and treatment of the enrollees and that practice guidelines are used in decisions regarding utilization management, enrollee education opportunities and coverage of services.

- DBHR needs to ensure the RSNs' practice guidelines are meeting the needs of the enrollee populations, that the RSNs are implementing the appropriate practice guidelines in the care and treatment of enrollees and that the RSNs have a process in place whereby the practice guidelines are used to help make decisions regarding utilization management, enrollee education opportunities and coverage of services.

Quality Assessment and Program Improvement (QAPI)

Strengths: Quality

- Most RSNs collect, analyze and track quality of care to ensure compliance with Federally mandated standards.

- NSMHA has a thorough 2012–2014 Quality Management Work Plan. The document defines the quality program, explains the scope of services, discusses its accountability to DSHS and describes its quality management processes, including specific review and clinical audit activities. The document further discusses its administrative processes, enrollee/advocate involvement, provider expectations, delegation and delegated functions, recommendations, remedial action and sanctions, and the structure of the Quality Management Program.

- PRSN has several committees responsible for reviewing, analyzing and making recommendations for improvement for both internal processes as well as for contracted agencies. PRSN's Quality Improvement Committee (QUIC) provides oversight of the quality improvement process and activities for the RSN. The committee is composed of at least six consumers in the community who have received or are receiving services in a publicly funded mental health system, representatives from each of the provider agencies and PRSN staff to facilitate.

- TRSN has a very robust quality management (QM) program that clearly defines the process the RSN uses to conduct its QM program.

Recommendations: QAPI—Quality

Several RSNs lack both policies and procedures and level of care criteria for identifying, monitoring and detecting underutilization and overutilization of services. Several of the RSNs' current levels of care systems do not support an expected service level intensity within each level of care.

- DBHR needs to ensure RSNs develop appropriate policies and procedures and level of care criteria for identifying, monitoring and detecting underutilization and overutilization of services. In addition, DBHR needs to ensure RSN current levels of care systems support an expected service level intensity within each level of care.

Many of the RSNs' policies and procedures have not been reviewed, updated or approved for many years.

- DBHR needs to ensure the RSNs are reviewing, updating and approving policies and procedures at least yearly to be certain the policies and procedures are in accordance with current best practices, terminology and references to contract language, WACs and CFRs.

All of the RSNs are not in compliance with the State's quality strategy plan as the State has not completed or implemented a quality strategy plan for several years.

- To be in compliance with the CFR, the State must develop, implement and distribute to the RSNs a quality plan.

Many of the RSNs continue to have difficulties capturing all grievances and appeals, transfers and requests to change providers, which information they would analyze and integrate and use to generate reports for making informed management decisions.

- DBHR needs to continue to work with the RSNs to develop and implement reliable procedures for capturing all grievances and appeals, transfers and requests to change providers in order to analyze and integrate the information and use it to generate reports for making informed management decisions.

Many of the RSNs do not use performance and quality benchmarks and valid, objective measures to assess their performance against those benchmarks in the evaluation of the quality and appropriateness

of care and services furnished to enrollees.

- DBHR needs to ensure that all RSNs are evaluating the quality and appropriateness of care and services furnished to enrollees through the use of performance and quality benchmarks with valid, objective measures to assess their performance against those benchmarks.

Although many RSNs' 2014 quality assessment and performance improvement (QAPI) work plans are quite informative and summarize both ongoing activities as well as short-term activities, several work plans do not include results of the year's activities, EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year.

- DBHR needs to work with the RSNs to ensure the RSNs' work plans are informative and summarize both ongoing activities as well as short-term activities and include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year.

Health Information Systems

Strengths: Quality

- Many RSNs have a health information system that collects and integrates data pertaining to transfers, requests to change providers, and grievances and appeals.

- SCRSN demonstrated an effective system of edit checks and business rules to ensure that data received from contracted providers is accurate, complete and timely. SCRSN has robust monitoring processes to ensure compliance with data quality standards.

- TRSN and its provider agencies use the same health information system, Avatar. This allows the RSN to receive data from all agencies in the same format and also allows all data to be integrated and reported.

- KCRSN encourages small provider agencies to coordinate data services with larger agencies for the transfer of data to the RSN.

Performance Improvement Project Validation

Objectives

Performance improvement projects (PIPs) are designed to assess and improve the processes and outcomes of the healthcare system. They represent a focused effort to address a particular issue or process identified by an organization. As prepaid inpatient health plans (PIHPs), RSNs are required to have an ongoing program of PIPs that focus on clinical and non-clinical areas that involve:

- measurement of performance using objective quality indicators
- implementation of systems interventions to achieve improvement in quality
- evaluation of the effectiveness of the interventions
- planning and initiation of activities for increasing or sustaining improvement

Following PIP evaluations, RSNs are offered technical assistance to assist them with improving their PIP study methodology and outcomes. RSNs may resubmit their PIPs up to two weeks following the initial evaluation. PIPs are assigned a final score following the final submission.

Methodology

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

- the study topic was appropriately selected
- the study question is clear, simple and answerable
- the study population is appropriate and clearly defined
- the study indicator is clearly defined and is adequate to answer the study question
- the PIP's sampling methods are appropriate and valid
- the procedures the RSN used to collect the data to be analyzed for the PIP measurement(s) are valid
- the RSN's plan for analyzing and interpreting PIP results is accurate
- the RSN's strategy for achieving real, sustained improvement(s) is appropriate
- it is likely that the results of the PIP are accurate and that improvement is "real"
- improvement is sustained over time

Full description of Qualis Health's PIP evaluation methodology is included in Appendix D.

Scoring

Qualis Health assigns a score of Met, Partially Met or Not Met to each element that is applicable to the PIP being evaluated. Elements may be Not Applicable if the PIP is at an early stage of design or implementation. If a PIP has advanced only to the first measurement of the study indicator (baseline), elements 1–6 are reviewed. If a PIP has advanced to the first re-measurement, elements 1–9 are reviewed. Elements 1–10 are reviewed for PIPs that have advanced to repeated re-measurement.

Summary of PIP Validation Results

In 2015, each Washington State RSN was required to complete a clinical PIP and a non-clinical PIP. Clinical PIPs can focus on areas such as prevention and care of acute and chronic conditions and high-risk, high-volume or high-need services. Non-clinical PIP areas can address coordination or continuity of care, access to care and availability of services as well as enrollee appeals, grievances and satisfaction. Additionally, RSNs were required to incorporate a children-focused topic into either the clinical or non-clinical PIP, with the intention of addressing some facet of high-cost, high-need and/or high-utilizer children and youth enrollment.

Qualis Health's review of the RSNs' PIPs revealed many areas of strength as well as some opportunities for improvement throughout the state. Themes within the RSNs' chosen topics included reduction in recidivism rates for inpatient psychiatric hospitalization, WISe and Intensive Wraparound, and coordination of care. Many PIPs were still in the early phases of study, and in those cases Qualis was unable to assess for success related to real or sustained improvement.

Table B-4, below, summarizes the RSNs' scores for PIP validation.

Table B-4: Summary of PIP Validation Results

RSN	Study Topic		Validation Result
Chelan-Douglas	**Clinical PIP**	Improving the penetration rate of child and family team participation for Medicaid children	● Fully Met
	Non-clinical PIP	Implementation of a standardized discharge protocol to increase the percentage of Medicaid enrollees receiving a crisis service who receive clinically indicated follow-up services	● Fully Met
Grays Harbor	**Clinical PIP**	Collaboration and coordination of care with physical health and behavioral health services providers and monitoring the medication side effects for persons with developmental disabilities/intellectual developmental disorders	○ Not Met
	Non-clinical PIP	Coordination of physical health and behavioral healthcare as a measure of quality of mental health service	○ Not Met
Greater Columbia	**Non-clinical/Children's PIP**	Lowered inpatient readmission rates in a high-risk population through the development of enhanced communication with inpatient providers	● Fully Met
	Non-clinical PIP	Increasing inclusion of healthcare information and PCP involvement into outpatient mental health treatment through provider training and shared PRISM health information	◉ Partially Met

King County	**Clinical PIP**	Effectiveness of the transitional support program	○ Not Met
	Non-clinical PIP	Improved care coordination with managed care organizations (MCOs) for children and youth	◉ Partially Met
North Sound	**Clinical PIP**	WRAP + MAP: Integrating care coordination and clinical practice models for Medicaid children and youth enrolled in WISe – year 2 (2015)	○ Not Met
	Non-clinical PIP	Improving the quality of care coordination for high-risk transition-age youth	◉ Partially Met
Optum Pierce	**Clinical PIP**	Effects of the WISe model on caregiver strain	○ Not Met
	Non-clinical PIP	Reduction of RTF average length of stay	N/A
Peninsula	**Clinical PIP**	Tobacco use cessation: Ask and record	● Fully Met
	Non-clinical PIP	Improving identification of intensive-needs children and youth	● Fully Met
Southwest Behavioral Health	**Clinical PIP**	Improving outcomes for youth with intensive mental health needs	● Fully Met
	Non-clinical PIP	Reduction of psychiatric readmissions for adult Medicaid beneficiaries	● Fully Met
Spokane	**Clinical PIP**	Evaluating the outcome of implementing Enhanced Care Management to promote stabilization and recovery for individuals discharging from the Eastern State Hospital population	● Fully Met
	Non-clinical PIP	Evaluating the outcome of school-based mental health services as an intervention to optimize access to care for mentally ill children and adolescents in targeted rural communities	● Fully Met
Thurston-Mason	**Clinical PIP**	Implementation of high-fidelity Wraparound to achieve better outcomes for children and youth	● Fully Met
	Non-clinical PIP	Improving TMRSN utilization management of core outpatient services	● Fully Met
Timberlands	**Clinical PIP**	Improving identification and clinical outcomes for children in need of intensive home- and community-based mental health services	● Fully Met
	Non-clinical PIP	Improving coordination of care outcomes for individuals with major or severe physical health co-occurring disorder	● Fully Met

PIP Summaries and Analysis

Chelan-Douglas (CDRSN)

Clinical/Children's: Improving the Penetration Rate of Child and Family Team Participation for Medicaid Children (Fully Met)

In an effort to increase the number of youth, 0–20 years old, enrolled in Child and Family Teams (CFTs), CDRSN's PIP focuses on implementing the State's Children's Mental Health System Principles and the Core Practice Model as a practice guideline by its provider network. Clinical teams at provider facilities were trained on practice guidelines and process as well as proper service coding. Results from the first re-measurement period were not statistically significant, and the PIP has not progressed to the completion of the second re-measurement period. An assessment of the second re-measurement period should occur to further assess for statistically significant change.

Non-clinical: Crisis Intervention Follow-up: Does the Implementation of a Standardized Discharge Protocol Increase the Percentage of Medicaid Enrollees Receiving a Crisis Service Who Receive Clinically Indicated Follow-up Services? (Fully Met)

CDRSN chose a nonclinical PIP focused on increasing the percentage of clinically indicated follow-up services for Medicaid enrollees who received mental health crisis services. The discharge protocol consists of case management components to improve continuity of care within the crisis episode, including clinically indicated follow-up services. At the time of the review, the first re-measurement period had not ended and no preliminary data had been reviewed. CDRSN should review data in a timely manner so that the RSN can assess the success of the intervention and make any necessary changes.

Grays Harbor (GHRSN)

Clinical: Collaboration and Coordination of Care with Physical Health and Behavioral Health Services Providers and Monitoring of the Medication Side Effects for Persons Who Have Developmental Disabilities/Intellectual Developmental Disorders (Not Met)

GHRSN initiated a PIP that seeks to implement the Monitoring of Side Effects Scale (MOSES) as part of the services provided to enrollees with developmental/intellectual disabilities. GHRSN attempts to use the information from the MOSES as a vehicle to coordinate behavioral and physical health services for the study population. GHRSN also plans to administer consumer satisfaction surveys to enrollees participating in this PIP to determine whether care coordination positively impacts satisfaction rates. GHRSN needs to fully define its study topic by clearly specifying whether it is focused on consumer satisfaction, implementation of MOSES or care coordination.

Non-Clinical & Children's: Coordination of Physical Health and Behavioral Healthcare As a Measure of Quality of Mental Health Service (Not Met)

GHRSN's non-clinical PIP addresses provider documentation regarding physical healthcare coordination as a predictor of quality care. The study population is identified as the GHRSN Medicaid enrollees placed in foster care requesting outpatient mental health services from GHRSN contracted providers. At the time of review, this project was still in its early stages and

was not completely designed. GHRSN still needs to clarify its study question and explain how it will set the framework for data collection, analysis and interpretation, as well as link it to its target population. GHRSN has not yet and needs to define its study population, fully explain its study indicator, sampling methods, data collection procedures and plan for analysis.

Greater Columbia Behavioral Health (GCBH)

Note: At the time of this review, GCBH's PIPs had not been reviewed or approved by the Division of Behavioral Health and Recovery. GCBH reported to the external quality review team that it was given permission to have two non-clinical PIPs.

Non-clinical/Children's: Lowered Inpatient Readmission Rates in a High-Risk Population Through the Development of Enhanced Communication with Inpatient Providers (Not Met)

GCBH's non-clinical/children's PIP was designed to enhance communication, empower youth and their families, build on strengths and identify resources previously unused or not considered within the community with a goal of decreasing readmission rates to inpatient psychiatric services within 90 days of discharge. Calculation and data collection logic errors were discovered that impacted the baseline calculation for the intervention. Initially, the readmission rate for the baseline period was calculated as 28 percent, but the correct rate was 14 percent. As GCBH had used an incorrect percentage to create its goal of 15 percent, statistically significant improvement was not achieved for either the re-measurement period or an extended re-measurement period implemented in response to a four-to-six-week breach in the data collection process. GCBH needs to consider ending this PIP or modifying the study question and topic to address a facet of the study topic in need of true improvement. GCBH reported that it received more than 500 completed questionnaires during the study. The RSN should analyze and utilize the data it has collected from these questionnaires to inform the selection of its new or adjusted PIP.

Non-Clinical: Increasing Inclusion of Healthcare Information and PCP Involvement Into Outpatient Mental Health Treatment Through Provider Training and Shared PRISM Health Information (Partially Met)

GCBH's second non-clinical PIP focuses on the integration of primary care and mental health services by increasing the inclusion of PRISM summary information in the clinical record and primary care provider (PCP) involvement in outpatient mental health treatment planning. GCBH reported quantitative improvement, although there was not statistically significant improvement. GCBH reported that it could not conclude that changes in direction or significance were the result of the study intervention. Washington Administrative Code (WAC) 388-877-620 requires that initial intake assessments include documentation of the individual's medical provider names, medical concerns and medications taken, and the DBHR-RSN contract requires, if an enrollee has a suspected or identified healthcare problem, that appropriate referrals be made to healthcare providers and the enrollee's service plans identify the medical concerns and plan to address them. If GCBH chooses to continue using this study topic, it should consider modifications to the PIP that would less closely tie it to current WAC and contract requirements.

King County (KCRSN)

Clinical: Effectiveness of the Transitional Support Program (Not Met)

KCRSN chose a clinical PIP that focuses on the reduction of psychiatric hospitalizations of Medicaid enrollees by improving connections to outpatient behavioral health services and supports through services from the transitional support program (TSP). This PIP has not progressed to the point at which a continuous cycle of measurement and performance analysis has been conducted. KCRSN has not reported any results. KCRSN needs to reevaluate its current study topic, study question and intervention to ensure that it is assessing program improvement.

Non-clinical/Children's: Improved Care Coordination with Managed Care Organizations (MCOs) for Children and Youth (Partially Met)

For its non-clinical PIP, KCRSN designed a program intended to reduce psychiatrically related emergency department (ED) use among youth through the intervention of coordinated care. The foundation for this PIP fully meets all of the required CMS elements, and the intent of the PIP is appropriate. However, in its current state, the PIP is not fully formulated. Several key aspects, including the study design, implementation and strategies related to outcomes and improvement, need to be clearly stated in order for the PIP to continue.

North Sound Mental Health Administration (NSMHA)

Clinical/Children's: WRAP + MAP: Integrating Care Coordination and Clinical Practice Models for Medicaid Children and Youth Enrolled in WISe—Year 2 (2015) (Not Met)

NSMHA did not submit a PIP in the required format; instead, an outcome study, not written by the RSN, was submitted in its place. Without following the approved PIP format, required CMS scoring elements are not sufficiently addressed; therefore, no standards could be passed. When selecting future PIPs, NMSHA should be thoughtful about choosing study topics and questions to ensure that all aspects of the proposals, with special attention paid to implementation and data collection, are realistic from the onset of the projects.

Non-clinical: Improving the Quality of Care Coordination for High-Risk Transition-Age Youth (Partially Met)

NSMHA's non-clinical PIP seeks to improve the quality of care coordination for high-risk transition-age youth by developing a comprehensive array of services and supports related to practice guidelines. NSMHA's goal is to improve clinician perception of competency in providing services and measured success by administering the Transition Service Provider Competency Scale. NSMHA had intended to implement a second portion of the PIP related to youth perception of quality of care, but it was abandoned due to lack of resources. The PIP showed sustained statistically significant improvement through repeated measurements over time. However, although NSMHA conducted a thorough barrier analysis and articulated several areas for potential improvement, the RSN did not act on any of the noted strategies. NSMHA should ensure that when possible resolutions are proposed, the rationale for whether or not to implement them should be documented. In addition, while this PIP did show success for providers, it did not demonstrate a direct impact on enrollees. When choosing future PIPs, NSMHA should consider topics that include measurable indicators clearly related to enrollee outcomes.

Optum Pierce (OPRSN)

Clinical/Children's: Effects of the WISe Model on Caregiver Strain (Not Met)

OPRSN's clinical PIP focuses on reducing the stress that can be experienced by caregivers of children and youth in high-intensity mental health services. The PIP seeks to discover if the implementation of the WISe model would decrease caregiver strain. OPRSN intended to administer a pre- and post-enrollment questionnaire on caregiver strain to caregivers of WISe-authorized youth; however, the response rate was too low to be considered meaningful. Additionally, without comparison data it cannot be fully asserted that the WISe model would be the true cause for any reduction in caregiver strain vs. another type of intervention. Last, the scope of the study design, to monitor the effectiveness of the WISe program on caregiver strain, amounts only to program evaluation, not a performance improvement project. A PIP should implement changes or interventions to a program or processes with the intent of improving the processes or programs outcomes. OPRSN should reconsider its study design and intent.

Non-clinical: Reduction of RTF Length of Stay (N/A)

The focus of OPRSN's non-clinical PIP is to reduce lengths of stay at residential treatment facilities (RTF) by creating clear contract terms and revising level of care guidelines, with a specific focus on a particular RTF. OPRSN's goal is to reduce the average length of stay at all RTFs to fewer than 18 months. Marked improvement toward this goal was noted before the initiation of this PIP. It is recommended that given the RSN's prior success related to this topic, the small scope of the PIP and the study question not being fully answerable due to the contract terms not being finalized at the time of the PIP submission, OPRSN consider whether the PIP is worthy of continuation.

Peninsula (PRSN)

Clinical: Tobacco Use Cessation: Ask and Record (Fully Met)

PRSN has initiated a PIP aimed to improve its ability to apply tobacco cessation and prevention interventions among Medicaid enrollees served by PRSN providers and measure the effectiveness of the interventions through the use of outcome data. The PIP is broken into three phases: 1) improving assessment of tobacco use and documenting the information in the enrollee's electronic medical record; 2) utilizing the Public Health Service clinical practice guideline "Treating Tobacco Use and Dependence" (2008) as an intervention; and 3) measuring tobacco use outcomes before and after the implementation of interventions. PRSN completed its baseline measurement at the time of the review; the first re-measurement was still in progress. A second re-measurement period is scheduled from September 1, 2015 through February 28, 2016. The PIP had not progressed to the stage of analysis and comparison for interpretation.

Non-clinical/Children's: Improving Identification of Intensive-Needs Children and Youth (Fully Met)

For its non-clinical PIP, PRSN seeks to develop a reliable means of identifying the high-risk, high-cost children and youth population in order to ensure appropriate levels of care and accurate data measurement, and track outcomes for this population. Provider clinicians were trained to a standardized method of identifying children and youth in need of intensive services. PRSN has completed a baseline and two re-measurement periods. At the end of the first re-measurement period, PRSN demonstrated a decline in performance, most likely due to the narrow parameters of the inclusion criteria. For the second re-measurement period, the inclusion criteria were modified to contain expanded, more inclusive criteria. At the time of the review, the second re-

measurement period had not been completed, but a preliminary analysis of the data did show improvement. PRSN added an additional measurement period to the PIP to ensure sustained improvement is achieved. PRSN should continue to closely monitor its outcomes and refine aspects of the study if needed.

Southwest Behavioral Health (SWBH)

Clinical & Children's: Improving Outcomes for Youth with Intensive Mental Health Needs (Fully Met)

SWBH implemented High-fidelity Wraparound as its clinical PIP to achieve better outcomes for children and youth, ages 0–21, through the recognition of the intensive service needs of this vulnerable population. This PIP is in its second year, and at the time of the review SWBH had no available data to report. SWBH might consider changing the study question and intervention to include other methods by which the RSN can measure the outcome of mental healthcare needs of its enrollees, as at the time of the review the Behavioral Health Assessment System (BHAS) outputs did not include the raw data needed for analysis of the study indicator.

Non-clinical: Reduction of Psychiatric Readmissions for Adult Medicaid Beneficiaries (Fully Met)

The goal of SWBH's non-clinical PIP is to evaluate the effectiveness of engaging individuals in outpatient treatment appointments within seven days of discharge from an inpatient psychiatric facility, thereby reducing readmission rates within 30 days of discharge. This PIP concentrates on a specific program design at an evaluation and treatment (E&T) facility within the SWBH region. The first measurement of the intervention had not occurred at the time of evaluation, so the PIP had not progressed to the point of being assessed for implementation and outcomes.

Spokane County (SCRSN)

Clinical: Reduction in Spokane County Hospital Readmissions for Individuals Discharged from State Hospitals As a Result of Enhanced Case Management (Fully Met)

SCRSN's clinical PIP, which began in 2013, focuses on improving the outcomes of individuals hospitalized at state hospitals by seeking to decrease the percentage of readmission rates within 30 days of discharge. SCRSN implemented the evidence-based practice of Enhanced Case Management, which focuses on care coordination during hospitalization and discharge preparation as well as facilitation and monitoring of engagement in services post discharge. The PIP showed statistical significance in the trend toward a decrease in readmission to Eastern State Hospital from baseline to second re-measurement. SCRSN should continue this PIP with an updated intervention.

Non-Clinical & Children's: Increase in Access to Treatment for Children Residing in Rural Underserved Areas As a Result of School-Based Outpatient Services (Fully Met)

This PIP seeks to improve the health and functional status of Medicaid-enrolled youth with serious mental health issues. SCRSN's goal is to optimize access to mental health services by providing eligible youth, ages 6–19, with the opportunity to meet with mental health professionals at school or after school in their homes. Analysis of the baseline and first re-measurement period data did not show statistically significant improvement. SCRSN should explore the reasons why

youth did not return to treatment. If the reasons for the low return rate can be addressed, SCRSN should continue this PIP.

Thurston-Mason (TMRSN)

Clinical & Children's: Implementation of High-fidelity Wraparound to Achieve Better Outcomes for Children and Youth (Fully Met)

TMRSN is in the fourth year of a five-year clinical PIP regarding the implementation of High-fidelity Wraparound. TMRSN chose the intervention of a family-centered, strength-based, facilitated planning process to help at-risk children and youth achieve improvements in functional, educational and independence-related outcomes. Concurrently, the RSN seeks to significantly improve the average scores for overall emotional and behavioral functioning as rated on the Strengths and Total Difficulties Questionnaire (SDQ) Scale for Medicaid-enrolled youth ages 5–20 compared to a control group of Medicaid-enrolled youth who received support through other Thurston-Mason Wraparound initiatives. The RSN's analysis demonstrated statistically significant improvement from the baseline to the second re-measurement. TMRSN was selected as an early adoption location for the implementation of WISe in July 2014 and as such is required to use the Child and Adolescent Needs and Strengths (CANS) tool for WISe screening and then every three months for treatment and discharge planning. TMRSN should continue this PIP by incorporating the use of the CANS data, modifying the study question, adding new indicators, and comparing data from the CANS and the SDQ Scale.

Non-Clinical: Improving TMRSN's Utilization Management of Core Outpatient Services (Fully Met)

TMRSN's non-clinical PIP concentrates on the implementation of the Level of Care Utilization System (LOCUS) as a means to increase the average number of core outpatient service hours received by Medicaid-enrolled adult clients within the first 90 days following an intake. TMRSN has completed its baseline measurement, but has not completed a re-measurement period. Preliminary results have not demonstrated increase in service hours. However, TMRSN reported that due to difficulties with data transmission, data are incomplete. At this point, it is not known whether the additional data will show an increase in services. TMRSN should continue this PIP and work to improve the data transfer process to ensure all data is captured.

Timberlands (TRSN)

Clinical/Children's: Improving Identification and Clinical Outcomes for Children in Need of Intensive Home- and Community-based Mental Health Services (Fully Met)

For its clinical PIP, TRSN chose a study topic related to the implementation of the Child and Adolescent Level of Care Utilization System (CALOCUS) in an effort to increase the percentage of youth identified as needing intensive home- and community-based services. TRSN has completed a baseline measurement and two re-measurement periods. The re-measurements indicated that statistical significance for the intervention was sustained, and the second re-measurement period was ended earlier than anticipated when it became clear that the goals of the PIP had been achieved. TRSN intends to continue to utilize the CALOCUS and move to a second phase of this PIP with the goal of reducing CALOCUS scores for youth assessed at a level of care (LOC) 3 or higher.

Non-clinical: Improving Coordination of Care Outcomes for Individuals with Major or Severe Physical Health Co-Occurring Disorder (Fully Met)

TRSN's non-clinical PIP was designed to improve adherence to the Coordination of Care (COC) protocol by 10 percent each year. The study population for the PIP is Medicaid enrollees with major or severe physical health issues identified by the CA/LOCUS. The intervention for the PIP was re-training providers on the revised COC protocol. The TRSN has completed the baseline and first re-measurement period. Results did not show statistically significant improvement; however, there was an increase in the identification of enrollees with comorbid issues during the re-measurement period. TRSN noted several potential threats to the validity of this PIP including a lack of inter-rater reliability among provider staff in scoring the CALOCUS and LOCUS, increased medical attention and medical health home and integrated services advertising having potentially impacted results, some enrollees' health having improved after initial assessment and requiring less coordination, and the small size of the study population. PRISM reports were not provided in a timely manner, not all providers had access to Avatar to enter the necessary codes, the measurement periods were unequal, and during the measurement period Medicaid expansion created an increased demand for services, which impacted clinicians' ability to provide coordination of care services. TRSN should conduct a root-cause analysis to better understand barriers and risks as well as explore what further interventions can be implemented to improve performance.

Strengths

- The majority of RSNs developed thoughtfully formulated PIP study designs.
- Most RSNs chose study topics that were well researched and clearly defined. Almost all study topics focused on areas that combined national, state and local mental health initiatives.
- Many study topics addressed issues that have the potential to, or did, create significant impact on the areas of focus.
- Most RSNs received an overall score of passing for the PIPs, with more than half of the PIPs receiving confidence levels of reported results of high or moderate.
- Many RSNs incorporated evidence-based practices and evidence-based tools into the PIPs.

Recommendations

Several issues arose regarding the PIP process, including a lack of clarity among RSNs about the approval status of many of the PIPs by the State, as well as information regarding RSN resubmissions. At least one of the RSNs' PIPs had not been reviewed by DBHR in time for the RSN's site review. Additionally, the scope of several of the RSNs' PIPs amounted to program evaluation but not performance improvement projects. Thus, it was unclear whether the RSNs were sufficiently knowledgeable regarding performance improvement and the PIP protocol requirements.

- DBHR needs to:
    - Develop a clear and systematic approach for approving PIPs that includes due dates for RSN submission, as well as DBHR's dates of review and approval of PIPs.

o Ensure all DBHR reviewers have a full understanding of the EQRO PIP protocol so that only true performance improvement projects are approved. o Create a communication plan for RSNs regarding timeline submission dates and the status of PIP submissions.

Opportunities for Improvement

Conducting interim evaluations of data in addition to end-of-measurement-period data analysis could assist RSNs in detecting and removing barriers that could negatively impact the PIP. A few of the RSNs waited until the end of the measurement period to review and analyze data.

- RSNs should proactively review data to help identify issues in data collection as well as other issues that could impede improvement.

Improvement strategies are key to bringing about improved outcomes.

- When barriers to the success of the PIP are detected, RSNs need to conduct a quality improvement process such as a Plan, Do, Study, Act (PDSA) cycle. This process should be fully documented, and changes to the PIP should be clearly noted and justified. Many RSNs did not perform any kind of barrier analysis or implement any improvements to their PIPs. RSNs should be mindful to follow the PIP format, and to answer all responses clearly and concisely.

Some RSNs have not conducted true baseline measurements, have not conducted two full re-measurement periods, or have conducted more than two re-measurement periods even after significant improvement has been shown.

- In order to show sustained improvement with statistical significance, RSNs should ensure PIPs have a baseline and two re-measurement periods that are at least six months to one year in length. Once a PIP has shown repeated measurements of sustained improvement, a PIP should be retired.

When choosing PIP topics, it is important to ensure that the study is truly a performance improvement project and not program evaluation. Many RSNs implemented PIPs that merely monitored a current practice or program.

- Within the PIP design, RSNs need to implement a targeted intervention with the intent to create and measure change.

Several RSNs submitted PIPs that were not fully formulated. Missing details included the full nature of the intervention, clearly stated study questions and fully defined indicators or study populations. Other RSNs did not have clear plans or were unable to access data. Some PIPs had not progressed since their last review in 2014.

- When submitting PIP proposals, RSNs need to fully articulate the study design and ensure it is ready for initial phase of implementation. RSNs need to document continued development of the PIPs at each annual review. PIPs need to be ready for initiation within six months of submission to DBHR.

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Information Systems Capabilities Assessment (ISCA)

Objectives

Qualis Health examined each of the RSNs' information systems and data processing and reporting procedures to determine the extent to which data processing and reporting procedures support the production of valid and reliable State performance measures and the capacity to manage the care and services of RSN enrollees.

The ISCA procedures were based on CMS protocol for this activity, as adapted for the Washington RSNs with DBHR's approval. For each of seven ISCA review areas, the following data was used to rate RSN performance:

- information collected in the ISCA data collection tool
- responses to interview questions
- results of the claims/encounter analysis walkthroughs and security walkthroughs

Methodology

The ISCA review process for each RSN consisted of four phases:

Phase 1: Standard information about the RSN's information systems was collected. Each RSN and two of its delegated provider agencies completed the ISCA data collection tool before the onsite review.

Phase 2: The completed ISCA data collection tools and accompanying documents were thoroughly reviewed. Wherever an answer seemed incomplete or indicated an inadequate process, it was marked for follow-up. If the desktop review indicated that further accompanying documents were needed, those documents were requested.

Phase 3: Onsite visits and walkthroughs with the RSN and two delegated provider agencies were conducted. Claims/encounter walkthroughs and data center security walkthroughs were conducted. In-depth interviews with knowledgeable RSN staff and delegated provider agency staff were conducted. Additional documents were requested if needed, based upon interviews and walkthroughs completed at the RSN and at two delegated provider agencies.

Phase 4: Findings from the RSN's information system onsite review were analyzed. In this phase, the material and findings from the first three phases were reviewed with the RSN and selected delegate provider agencies to close out any open review questions. The RSN-specific ISCA evaluation report was then finalized.

The following sections discuss the specific criteria used for assessing compliance for each of the eight ISCA review areas.

Section A: Information Systems
This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical data by member, practitioner and vendor. Information systems that facilitate valid and reliable performance measurement have the following characteristics:

- flexible data structures
- no degradation of processing with increased data volume

- adequate programming staff
- reasonable processing and coding time
- ease of interoperability with other database systems
- data security via user authentication and permission levels
- data locking capability
- proactive response to changes in encounter and enrollment criteria
- adherence to the Federally required format for electronic submission of claims/encounter data

To ensure accurate and complete performance measure calculation, appropriate practices in computer programming should include:

- good documentation
- clear, continuous communication between the client and the programmers on client information needs
- a quality assurance process version control
- continuous professional development of programming staff

Section B: Hardware Systems

This section assesses the RSN's hardware systems and network infrastructure. Appropriate protocol for sustaining quality hardware systems include:

- infrastructural support that includes maintenance and timely replacement of computer equipment and software, disaster recovery procedures, adequate training of support staff and a secure computing environment
- redundancy or duplication of critical components of a hardware system with the intention of increasing reliability of the system, usually in the form of a backup or fail-safe

Section C: Information Security

This section assesses the security of the RSN's information systems. Appropriate practices for securing data include:

- maintaining a well-run security management program that includes IT governance, risk assessment, policy development, policy dissemination and monitoring. Each of these activities should flow into the next to ensure that policies remain current and that important risks are addressed
- protecting computer systems and terminals from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates
- securing paper-based claims and encounters in locked storage facilities when not in use. Data transferred between systems/locations should be encrypted.
- utilizing a comprehensive backup plan that includes scheduling, rotation, verification, retention and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.
- verifying integrity of backups periodically by performing a "restore" and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite climate-controlled facility.

- ensuring databases and database updates include transaction management, commits and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
- employing formal controls in the form of batch control sheets or assignment of a batch control number to ensure a full accounting of all claims received.

DBHR's RSN contract presents requirements related to business continuity and disaster recovery (BC/DR). The contractor must certify annually that a BC/DR plan is in place for both the contractor and subcontractors. The certification must indicate that the plans are up to date and that the system and data backup and recovery procedures have been tested. The plan must address these criteria:

- a mission or scope statement
- an appointed IS disaster recovery staff
- provisions for backup of key personnel, identified emergency procedures and visibly listed emergency telephone numbers
- procedures for allowing effective communication with hardware and software vendors
- confirmation of updated system and operations documentation, as well as process for frequent backup of systems and data
- offsite storage of system and data backups, ability to recover data and systems from backup files, and designated recovery options that may include use of a hot or cold site
- evidence that disaster recovery tests or drills have been performed

Exhibit C of the RSN contract presents detailed requirements for data security, including:

- data protection during electronic transport, including via email and the public Internet
- safeguarding access to data stored on hard media (hard disk drives, network server disks and optical discs), on paper or on portable devices or media, and access to data used interactively over the State Governmental Network
- segregation of DSHS data from non-DSHS data to ensure that all DSHS data can be identified for return or destruction, and to aid in determining whether DSHS data has or may have been compromised in the event of a security breach
- data disposition (return to DSHS or destruction) when the contracted work has been completed or when data is no longer needed
- notification of DSHS in the event of compromise or potential compromise of DSHS shared data
- sharing of DSHS data with subcontractors

Section D: Medical Services Data

This section assesses the RSN's ability to capture and report accurate medical services data. To ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, it is important to have documented standards, a formal quality assurance of input data sources and transactional systems, and readily available historical data. Appropriate practices include:

- automated edit and validity checks of procedure and diagnosis code fields, timely filing, eligibility verification, authorization, referral management and a process to remove duplicate claims and encounters

- a documented formal procedure for rectifying encounter data submitted with one or more required fields missing, incomplete or invalid; ideally, the data processor would not alter the data until receiving written notification via a paper claim or from the provider
- audits of randomly selected records conducted internally and externally by an outside vendor to ensure data integrity and validity; audits are critical after major system upgrades or code changes
- maintenance of multiple diagnosis codes and procedure codes for each encounter record, which distinguish clearly between primary and secondary diagnoses
- efficient data transfer (frequent batch processing) to minimize processing lags that can affect data completeness

Section E: Enrollment Data

This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data. Timely and accurate eligibility data are paramount in providing high-quality care and for monitoring services reported in utilization reports. Appropriate enrollment data management practices include:

- ensuring access to up-to-date eligibility data is easy and fast; enrollment data should be updated daily or in real time
- ensuring the enrollment system is capable of tracking an enrollee's entire history with the RSN, further enhancing the accuracy of the data

Section F: Practitioner Data

This section assesses the RSN's ability to capture and report accurate practitioner information. RSNs need to ensure accuracy in capturing rendering practitioner type as well as practitioner service location. RSNs also need to be able to uniquely identify each of their practitioners. RSNs must also present accurate practitioner information within the RSN provider directory.

Section G: Vendor Data

This section assesses the quality and completeness of the vendor data captured by the RSN. The majority of each RSN's claims/encounter data is contracted provider agency data. RSNs must perform encounter data validation audits at least annually for each of their contracted provider agencies. RSNs must also evaluate the timeliness of the claims/encounter data submitted to their agency by their vendors.

Section H: Meaningful Use of Electronic Health Records (EHR)

This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not rated. This review section evaluates the following:

- any planning and/or development efforts the RSN has taken toward adopting and using a certified EHR system
- number of providers in the RSN network currently using EHRs
- whether any EHR technology in use by the RSN has been verified as certified by the appropriate Federal body
- any training, education or outreach the RSN has delivered to network providers on the meaningful use of certified EHR technology
- whether the RSN uses data from EHRs as part of its quality improvement program (i.e., to improve the quality of services delivered or to develop PIPs)
- strategies or policies the RSN has developed to encourage the adoption of EHR by providers

Scoring

For each ISCA review area, the information collected in the ISCA data collection tool, responses to interview questions and results of the claims/encounter walkthroughs, as well as security walkthroughs, were used to rate the RSN's performance. The rating was applied to the review areas specified in this chapter and ranked as fully meeting, partially meeting or not meeting standards. The RSN's meaningful use of electronic health records (EHR) systems was reviewed but is not rated.

Qualis Health used CMS's three-point scoring system in evaluating the RSNs. The three-point scale allows for credit when a requirement is partially met and the level of performance is determined to be acceptable. The three-point scoring system includes the following levels:

● Fully Met

◉ Partially Met

○ Not Met

Summary of ISCA Results

Table B-5: Summary Results of ISCA Review

ISCA Section	Description	Chelan-Douglas	Grays Harbor	Greater Columbia	King County	North Sound	Optum Pierce	Peninsula	Southwest	Spokane	Thurston-Mason	Timberlands
A. Information Systems	This section assesses the RSN's information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.	●	●	●	●	●	●	●	●	●	◉	●
B. Hardware Systems	This section assesses the RSN's hardware systems and network infrastructure.	●	●	●	●	●	●	●	●	●	●	●
C. Information Security	This section assesses the security of the RSN's information systems.	●	◉	●	●	◉	◉	●	●	●	◉	●
D. Medical Services Data	This section assesses the RSN's ability to capture and report accurate medical	●	●	●	●	●	●	●	●	●	●	●

	services data.											
E. Enrollment Data	This section assesses the RSN's ability to capture and report accurate Medicaid enrollment data.	●	●	●	●	●	●	●	●	●	●	●
F. Practitioner Data	This section assesses the RSN's ability to capture and report accurate practitioner information.	●	●	●	●	●	●	●	●	●	●	●
G. Vendor Data	This section assesses the quality and completeness of the vendor data captured by the RSN.	●	●	●	●	●	●	●	●	●	●	●
H. Meaningful Use of EHR	This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not scored.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strengths

The 2015 ISCA review revealed the following strengths among the RSNs' overall information systems and data processing and reporting procedures:

- Most RSNs have multiple policies and procedures related to information security.
- Many RSNs' information security policies and procedures are fully compliant.
- Most RSNs' data center facilities and hardware systems are robust and well maintained.
- Many RSNs are ensuring accurate and proper storage of medical services, enrollment, provider and vendor data.
- Several RSNs perform monthly reconciliation activities to verify the authorization status of each encounter service, provider credentials, member month eligibility files, member ID codes and income source and program codes.
- Many RSNs have worked to maintain up-to-date provider profile information in provider directories to assist member services staff in helping Medicaid enrollees make informed decisions about access to providers that can meet their special care needs, such as non-English languages or clinical specialties.
- Most RSNs have multiple policies and procedures in place for information security and backup and recovery, ensuring information security systems are relatively strong.

- Many RSNs are working proactively with their respective provider agencies toward EHR implementation, including providing data testing, monitoring, technical assistance and financial support.

- Many RSNs maintain current premium-level hardware, software and network vendor service contracts, ensuring data center facilities and hardware systems are well designed and maintained.

- Several RSNs have developed policies and procedures for contracted provider agency EHR implementation, specifying the RSN's role in EHR adoption, expectations during implementation, and plans for transition periods when data may not be available.

- Several RSNs have a process for testing with provider data systems during provider agency EHR implementation. Throughout the process they are monitoring data for quality, completeness and accuracy, including a post-implementation review.

Recommendations

Many RSNs are not able to obtain current disaster recovery plans from their delegated county data centers either because respective county data centers have not updated their disaster recovery plans annually as required, or because delegated entities have declined to release the plans to the RSNs.

- DBHR needs to ensure the RSNs are developing methods to obtain current disaster recovery plans on an annual basis from the delegated county data centers.

During many of the RSN reviews, it was noted that not all of the provider agencies are encrypting PHI data according to DBHR standards.

- DBHR needs to ensure that the RSNs are working with the contracted provider agencies to encrypt agency data according to DBHR standards.

Several RSNs are not able accept electronic data interchange (EDI) data from contracted provider agencies, resulting in double data entry for those agencies, which could cause data input errors.

- DBHR needs to ensure that RSNs continue to work with contracted providers to be able to accept EDI data so that the agencies with in-house EHR systems can avoid performing double data entry.

Opportunity for Improvement

Many RSNs do not cross-check 834s to 837s before submitting 837s to remove services for members who weren't Medicaid eligible at the time of the encounter. However, this is not a State requirement. Many RSNs follow the DBHR's Service Encounter Reporting Instructions (SERI) v201411.2, on p. 4, which specifies that all services that meet the following criteria should be reported to the State:

- State plan services provided to Medicaid-eligible individuals
- non-covered/non-State plan services to Medicaid-eligible individuals (e.g., IMD facilities, State-Only or Federal block grant services)
- all services to non-Medicaid individuals who are funded in whole or part by the RSN

- DBHR should encourage the RSNs to cross-check 834s to 837s before submitting 837s to remove the services for members who weren't Medicaid eligible at the time of the encounter.

Encounter Data Validation

Objectives

Encounter data validation (EDV) is a process used to validate encounter data submitted by the RSNs to the State. Encounter data are electronic records of the services provided to Medicaid enrollees by providers under contract with an RSN. Encounter data are used by RSNs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the RSNs.

Methodology

Prior to performing the data validation for encounters, Qualis Health reviewed the State's standards for collecting, processing and submitting encounter data to develop an understanding of State encounter data processes and standards. Documentation reviewed included:

- the Service Encounter Reporting Instructions (SERI) that were in in effect during the range of dates for the encounters reviewed
- the Consumer Information System (CIS) Data Dictionary for RSNs
- Health Care Authority Encounter Data Reporting Guide for Managed Care Organizations, Qualified Health Home Lead Entities and Regional Support Networks
- the 837 Encounter Data Companion Guide ANSI ASC X12N (Version 5010) Professional and Institutional, State of Washington
- the prior year's EQR report(s) results and recommendations on validating encounter data

Qualis Health then reviewed the RSNs' capacity to produce accurate and complete encounter data, including a review of the most recent Information Systems Capabilities Assessment (ISCA). Three activities were performed supporting a complete encounter data validation: a State-level encounter validation of encounter data received by the State from the RSNs, a validation of the RSNs' EDV procedures and results of the RSNs' internal EDV required under the RSNs' contract with the State, and a clinical record validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of each RSN's internal EDV.

State-level Encounter Data Validation

Qualis Health analyzed encounter data submitted by the RSNs to the State to determine the general magnitude of missing encounter data, types of potentially missing encounter data and overall data quality of the data files submitted to the State. Specific tasks included:

- a basic integrity check on the encounter data files to determine whether expected data exist, whether the encounter data fit with expectations and whether the data are of sufficient quality to proceed with more complex analysis
- application of consistency checks, including verification that critical fields contain values in the correct format and that the values are consistent across fields
- inspection of data fields for general validity
- analyzing and interpreting data on submitted fields, the volume and consistency of encounter data and utilization rates, in aggregate and by time dimensions, including service date and encounter processing data, provider type, service type and diagnostic codes

Validating RSN EDV Procedures

Qualis Health performed independent validation of the procedures used by the RSNs to perform encounter data validation. The EDV requirements, included in the RSNs' contract with DBHR, were the standards for validation.

Qualis Health obtained and reviewed each RSN's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2014. Qualis Health reviewed the RSNs' encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates and fields selected for validation for conformance with DBHR contract requirements. The RSNs' encounter and enrollee sampling procedures were reviewed to ensure conformance with accepted statistical methods for random selection.

Each RSN submitted to Qualis Health a copy of its data entry system (spreadsheet, database or other application) used to conduct encounter data validation, along with any supporting documentation, policies and procedures, and/or user guides. Qualis Health's analytics staff then evaluated the data system to determine whether its functionality was adequate for the intended program.

Additionally, each RSN submitted documentation of its data analysis methods from which summary statistics of the encounter data validation results were drawn. The data analysis methods were then reviewed by Qualis Health analytics staff to determine validity.

Clinical Record Reviews

Qualis Health performed clinical record reviews onsite at provider agencies that had contracts with the RSNs. The process included the following:

- selecting a statistically valid sample of enrollee encounters from the file provided by the State
- loading data from the encounter sample into Qualis Health's custom database to record the scores for each encounter data field
- providing the RSN with a list of the enrollees whose clinical charts were selected for review to assist in the coordination with contracted provider agencies pursuant to the onsite review

Encounter documentation included in the clinical record was reviewed to validate data submitted to the State and to confirm the findings of the analysis of State-level data. Upon completion of the clinical record reviews, error rates were calculated for each encounter field. The error rates were then compared to error rates reported by the RSN to DBHR for encounters for which dates of service fell within the same time period.

Scoring

Qualis Health used CMS's three-point scoring system in evaluating the RSNs. The three-point scale allows for credit when a requirement is partially met and the level of performance is determined to be acceptable. The three-point scoring system includes the following levels:

● Fully Met

◉ Partially Met

○ Not Met

Summary of EDV Review

Table B-6: Summary Results of External Review of Encounter Data Validation Procedures

EDV Standard	Description	Chelan-Douglas	Grays Harbor	Greater Columbia	King County	North Sound	Optum Pierce	Peninsula	Southwest	Spokane	Thurston-Mason	Timberlands
Sampling procedure	Sampling was conducted using an appropriate random selection process and was of adequate size.	◉	◉	●	●	●	◉	●	●	◉	●	◉
Review tools	Review and analysis tools are appropriate for the task and used correctly.	●	●	●	◉	●	○	●	●	●	●	●
Methodology and analytic procedures	The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.	●	●	◉	●	○	○	●	●	●	●	●

Table B-7: Summary Results of Qualis Health Encounter Data Validation

EDV Standard	Description	Chelan-Douglas	Grays Harbor	Greater Columbia	King County	North Sound	Optum Pierce	Peninsula	Southwest	Spokane	Thurston-Mason	Timberlands
Electronic Data Checks	Full review of encounter data submitted to the state indicates no (or minimal) logic problems or out-of-range values.	●	●	●	●	●	●	●	●	●	●	●
Onsite Clinical Record Review	State encounter data is substantiated through audit of patient charts at individual provider locations. Audited fields include demographics (name, date of birth, ethnicity, and language) and encounters (procedure codes, provider type, duration of service, service date and service location).	○	○	○	○	○	○	○	○	◉	○	○

EDV Procedures

Results of the review of the RSN EDV report summaries submitted to the State indicated numerous issues, including the following:

- Many of the RSNs' summary reports submitted as contract deliverables to the State lacked all of the information required by the State contract, such as adequate descriptions of the methodology, sampling procedures, data analysis results and summary of findings that would determine whether or not items met criteria for adequacy.
- Several of the RSNs' encounter data fields did not include all the required elements.
- Three of the RSNs did not document that they reviewed all the contracted required elements of the EDV.
- All but two RSNs used their internal data for comparison with the provider data rather than using data downloaded from ProviderOne.
- Many RSNs reported that while encounter data had been accepted by ProviderOne, there had been issues using it. The State confirmed that ProviderOne accepts all encounters and stated that the ProviderOne system does not reject encounters with incorrect information.

RSN Sampling Procedures

- Five of the RSNs submitted inadequate documentation describing the sampling procedure and methodology.
- Nine RSNs used their own data to compare to the clinical records. Two RSNs used the State data from ProviderOne.

Data Entry Tools

- Six of the 11 RSNs used MS Access databases to record and document the results of the encounter reviews.
- Three RSNs used Excel spreadsheets.
- One RSN used a combination paper and MS Access database, using the paper tool onsite and completing data entry with the tool later.
- One RSN did not submit enough information to determine whether or not its tool was adequate for the EDV process.

Methodology

- Nine of the 11 RSNs adequately described their EDV methodology. Of the two that did not pass this standard, both had not included all the required elements required for the encounter review. One RSN failed to review provider name and whether the service code agreed with the treatment described. The other RSN did not report the date of service. All other RSNs reviewed all the required elements and adequately described the process in which they conducted the EDV.

- Most RSNs reported information about the staff who conducted the encounter reviews, including their positions at the RSNs and their attendance records for prior EQRO EDV training.
- Staff who conducted the reviews included IS managers, operations managers, quality managers and contract monitors.
- Of the 11 RSNs, only five documented a process for, or mentioned, inter-rater reliability.

Electronic Data Checks

- Qualis Health analyzed the required demographic data submitted to the State by the RSNs and found that most had submitted 100 percent of the required demographic data.
- The optional data element, Social Security number, was not submitted by most of the RSNs, although one RSN had a 58 percent rate of submission for the element.
- For two data elements, preferred language and sexual orientation, the response “unknown, patient refused” was unusually high for many RSNs.

Onsite Clinical Record Review

Qualis Health reviewed both demographic and encounter data for slightly more than 411 encounters in approximately 100 unique client clinical records for each of the RSNs. The demographic data included the enrollee’s last name, first name, Social Security number, date of birth, ethnicity, Hispanic origin, gender, language and sexual orientation. Results for demographic validations varied between RSNs, because not all RSNs reviewed demographic data, as it is not required in the RSNs’ contract with the State. Three RSNs were above 95 percent in all demographic areas. One RSN was below 95 percent in all areas. The remaining RSNs typically reached 95 percent on first name, last name, gender and date of birth. The most common elements that did not reach 95 percent were ethnicity, Hispanic origin, preferred language, Social Security number and sexual orientation.

For each of the encounters, the following data fields were reviewed: procedure code, service date, service minutes, service location, agency, provider type and whether the service code agreed with the treatment described. The fields for procedure code and service code agrees with treatment described

received the highest rate of mismatches within the Qualis Health review. Nine of the 11 RSNs did not reach the 95 percent standard for encounter elements. One RSN reached 95 percent in all areas except procedure code, duration, provider type and service code agrees with treatment described. The remaining RSNs reached the 95 percent standard in all areas except procedure code and service code agrees with treatment described.

In reviewing Qualis Health's results of the RSN encounter review, there were a variety of issues with encounters found within the clinical onsite review. The most frequent error concerned procedure code and service code not agreeing with the treatment described. Others examples of errors included:

Coding errors

- submitting codes no longer in the SERI
- submitting the improper codes for the length of service
- submitting codes that do not meet SERI requirements
- submitting improper codes for inpatient, outpatient and rehab case management
- submitting the wrong codes for the services provided
- submitting codes for services not allowed
- submitting codes for the wrong service provider
- submitting an encounter for services that were rendered by a community member

Documentation concerns

- submitting encounters without clinical documentation, supporting documentation and/or medical necessity
- submitting encounters without the required elements
- shredding all requests for service documentation after 12 months if the individual did not show up for an intake assessment (all documentation must be retained for 7 years)

Provider type errors

- submitting the incorrect provider type for the staff that provided the service
- submitting codes with a provider type not allowable per the SERI (example: provider type 5 submitted as 96372)

Duration errors

- submitting units for codes that should be submitted as minutes
- submitting multiple units for codes that have a unit of one
- submitting services that are incorrectly bundled

Services that should not have been submitted to the State

- submitting nursing assessments codes at the same time as evaluation and management codes
- submitting services prior to an intake assessment
- submitting two services at the same time with two clinicians, such as attending a medical appointment with the client at the same clinic with both the prescriber and the clinician encountering
- submitting encounters for no-shows, no-contacts or enrollees not at home
- submitting encounters for internal consultations and staffing
- submitting encounters for administrative tasks: listening to and leaving voicemails, reading and sending e-mails, texting, faxing, writing letters, researching games for clients, coordinating care for a client's children, calling in prescriptions, rescheduling appointments, making reminder calls

- submitting encounters for social events, with no therapeutic intervention documented, including bowling, sports, hiking, transportation, going to lunch, going for ice cream or pizza, going to the skate park or park, playing board games, teaching games, standing in line, facial groups, nature park outings, fishing, going to the park, going to the library and shopping

Overall, the RSNs have described protocols that would be appropriate and adequate for validating providers' encounter data. The sampling procedures appear to result in random oversamples; however, five of the 11 RSNs only partially passed this area.

The majority of the reason for the partial pass was lack of documentation explaining the RSNs' sampling procedures. The data entry tools developed by nine of the 11 RSNs appeared to be adequately functioning and appropriate for the reviews.

Qualis Health's onsite demographic and encounter review yielded a large variance compared to the RSNs' reviews. There was a high variance in all encounter elements for five of the RSNs. For the remaining RSNs, the most common elements that resulted in a high variance were procedure code, service code matched treatment described and duration. Other areas that resulted in high variance were RSN specific. One discrepancy could be a result of Qualis Health using the State data whereas all but two RSNs used their own. Qualis Health also did not review the same encounters as the RSN, which could account for some of differences in results.

Recommendations

In reviewing the EDV deliverables that the RSNs submitted to the State, it was noted that the RSNs' data collection and analytical procedures for validating encounter data were not standardized.

- In order to improve the reliability of encounter data submitted to the State, DBHR needs to work with the RSNs to standardize data collection and analytical procedures for encounter data validation.

During the onsite clinical record reviews at the provider facilities, Qualis Health discovered numerous encounters in which services were bundled incorrectly. Other numerous errors further suggest that the RSNs and providers need more information or training about how to correctly code encounters prior to submission to the State. Additionally, many of the RSNs and providers were unfamiliar with the terms of EDV in the State contracts and with the specifics of the SERI.

- DBHR needs to provide guidance to the RSNs as to how to bundle services correctly, review the numerous errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians and ensure the RSNs know and understand the content of the State contract and the SERI. DBHR may consider providing further training on both the contract and SERI to the RSNs.

Many RSNs are submitting codes to ProviderOne that have been retired since July 2013, as well as submitting other coding errors. The State reported that ProviderOne does not contain any edits to reject any codes and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to work with ProviderOne to create an algorithm to reject encounters that are submitted incorrectly to the State.

RSNs report different internal protocols for handling encounter errors that are discovered. The RSNs have not received any identified protocol from the State for how to address encounter errors that are

identified.

- DBHR needs to create expectations or protocols for RSNs on how to address errors identified in encounters.

Opportunities for Improvement

Within the EDV reports submitted as a contract deliverable by the RSNs to DBHR, many of the RSNs report a wide variety of information within the deliverable. Some of the reports were missing crucial information, such as adequate descriptions of the methodology, sampling procedures, data analysis results and summary of findings that would determine whether or not items met criteria for adequacy.

- DBHR should work with the RSNs to create a standardized template for the EDV contract deliverable to ensure that all RSNs are consistent in reporting the same information.

There is not a known position within DBHR staff assigned to monitor encounters and work directly with the RSNs to ensure accuracy.

- DBHR should develop a process for monitoring encounters and actively work with the RSNs on encounter accuracy.

Most of the RSNs perform EDV using their own internal data from clinical encounters for comparison with provider data rather than using data downloaded from ProviderOne.

- DBHR should consider requiring the RSNs to use the State's data rather than the RSNs' internal data to ensure that data transmissions are submitting accurate encounter information from the RSN to ProviderOne.

Review of Previous-Year EQR Recommendations

Listed below are the EQR recommendations presented in the 2014 EQR report, DBHR's responses to those recommendations, and Qualis Health's comments on those responses.

Table B-8: Review of DBHR Responses to 2013–2014 EQR Recommendations

Prior-Year Recommendations	DBHR Response	EQRO Response
Quality Strategy		
DBHR needs to develop, adopt and implement a quality strategy that the RSNs understand and support.	Kara Panek has been appointed the new DBHR Quality Administrator. Her primary focus regarding the EQR activities for 2016 will be the development of the shared DBHR/HCA Quality Strategy.	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.
Access to Care		
DBHR needs to explore ways to facilitate training and recruitment of mental health clinicians to meet Medicaid enrollees' access needs.	DBHR is currently participating in the SAMHSA multi-state workgroup focusing on workforce training and development for mental health and SUD.	The EQRO considers this response appropriate.
Children's Mental Health		
DBHR needs to provide clear direction and technical assistance for the RSNs as they implement the Children's Mental Health System Principles.	DBHR has included implementation of the Children's Mental Health Principles as a core component within the WISe training.	The EQRO considers this action responsive.
DBHR needs to continue to update the WISe manual and program expectations.	In FY 2015, the manual was updated on a quarterly basis. It will continue to be updated on an annual basis using an inclusive stakeholder process.	The EQRO considers this response appropriate.
DBHR needs to work with RSNs to • develop strategies to strengthen participation of allied partners in implementing the WISe program • continue community education and training for allied partners and their direct staff regarding the WISe program and in-home community placement with service options • ensure that the RSNs have developed the necessary	• DBHR has contracted with the Workforce Collaborative to provide technical assistance to our interagency governance structure, including the engagement of our system partners, youth and families. • DBHR developed WISe information sheets specific to system partners (internal/external) as to their role and involvement in WISe. We have also provided local trainings to system partners in person	The EQRO considers this response appropriate.

infrastructure to implement WISe successfully	and via online formats. Community trainings have been provided as new communities begin implementing WISe and as requested. • DBHR asked that WISe capacity be addressed in the BHO Detailed Plan Process. • DBHR has inserted language into the RSN contract and upcoming BHO contracts that set capacity building expectations. In conjunction, the RSN/BHO is required to report quarterly on progress and action steps in meeting the capacity expectations and reporting requirements.	
Compliance		
DBHR needs to ensure that all RSNs and their contracted providers maintain and observe policies and procedures on the use of seclusion and restraint, as well as de-escalation practices.	DBHR will review BHO policies and procedures on seclusion and restraint. Note: Evaluation and Treatment (E&T) providers are required via licensure and certification to have policies and procedures on seclusion and restraint. DBHR reviews these procedures prior to issuing E&T certifications.	The EQRO considers this action responsive.
DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.	DBHR will ensure that the BHO contracts include language that the BHO monitors requests for translation services.	The EQRO considers this action responsive.
EDV		
DBHR needs to require the RSNs to report only units of service, or DSHS needs to modify ProviderOne to accept minutes of service.	DBHR is currently analyzing a data set that has been exported from ProviderOne. DBHR is examining which CPT and CPC codes create significant conversion errors.	The EQRO considers this action responsive and recommends DBHR continue to examine which CPT and CPC codes create significant conversion errors.

Table B-9: Review of ISCA Recommendations for DBHR Identified in 2013.

2013 EQR Recommendations	2014 DBHR Response	2015 DBHR response	2015 EQR Response
Information Systems			
DBHR still lacks robust documentation of IT systems, staffing and data processing and reporting procedures. Insufficient documentation can create problems related to data recovery, staff turnover and overall system supportability. DBHR needs to fully document its IT systems, staffing responsibilities and data processing and reporting procedures.	DBHR reported that it has made some progress in documenting process and procedures. In anticipation of changing its IT systems in the near future, DBHR has decided not to allocate resources to documenting all systems. DBHR agrees that as new IT systems are established, appropriate documentation must be developed to support those processes. **Status of recommendation: In progress.**	DBHR has had progress documenting processes and procedures. DBHR has contracted with TeamFoundation Server to support applications development. This product forces developers to document steps in the development effort and gives traceability. DBHR has not yet begun reporting procedure documentation, but the structural pieces are now in place. **Status of recommendation: In progress.**	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.
DBHR has no budget for training to keep programmers abreast of rapid changes in information technology. DBHR needs to develop a plan for programmer training during this period of budget austerity.	DBHR has subscribed to online training services for each member of its programming staff. Staff will use this resource until the budget allows more focused, hands-on training to resume. **Status of recommendation: In progress.**	DBHR is utilizing the online training Lynda.com, which has been made available to all staff. This training platform includes numerous classes that staff can take as needed and when time is available. DBHR is also maximizing an existing contract with Washington Technology Services (WA Tech) to train developers. **Status of recommendation: Resolved.**	The EQRO considers this response appropriate. Resolved.
CNSI has not upgraded its	DBHR reported that CNSI issues	2013–2014 software has been	The EQRO considers this

ProviderOne software since implementation in 2010. DBHR should develop a planned upgrade schedule to ensure continuing support for critical software.	regular updates to ProviderOne coding to address fixes, updates and changes. **Status of recommendation: In progress.**	updated as needed. This is an ongoing process. **Status of recommendation: Resolved.**	response appropriate. Resolved.
Staffing			
DBHR employs limited staff to analyze mental health data and oversee the flow of encounter data throughout the process. DBHR should consider allocating more resources for staff to analyze and oversee the flow of mental health data.	DBHR remains short-staffed for key IT positions, but is pursuing more staff to support all system changes. DBHR holds weekly and bi-weekly meetings integrating IT, decision support and evaluation staff, along with those processing and reviewing encounter data. **Status of recommendation: In progress.**	Decision Support & Evaluation (DSE) staff have ongoing meetings with IT staff, during which time they discuss issues and anomalies. IT does the front-end data intake, extracts and transforms data and sends to DSE, which does the back-end activities of analyzing data. Both sections are still understaffed but are in the process of hiring new staff. **Status of recommendation: In progress (improvement has been made in the past year).**	The EQRO considers this response appropriate.
Hardware Systems			
DBHR lacks a formal policy and plan for replacing hardware to avoid disruption of services caused by hardware failures. DBHR should formalize its hardware replacement policy to ensure that current equipment does not reach end of life and fall out of warranty while in production.	DBHR reported that it has formalized its hardware replacement policy, which addresses critical hardware, but DBHR did not submit this policy for review. **Status of recommendation: In progress.**	DBHR is in the process of establishing contracts for centralized IT providers. Plans have been made for implementing infrastructure as a service contracts to provide server and storage capacity. These services will be provided by WA Tech and DSHS Enterprise Technology (formerly DSHS ISSD).	The EQRO considers this response appropriate. Resolved.

		Status of recommendation: Resolved.	
Security			
DBHR has a policy to remove access within five days for an employee or contractor who no longer requires access to Medicaid data systems. This practice does not align with industry standards. DBHR needs to revise its access policy to ensure immediate removal of access when a previously authorized person no longer requires access.	DBHR agrees that it needs to update this policy. DBHR has an informal practice to remove access immediately, but only on a case-by-case basis. **Status of recommendation: In progress.**	DSHS as an agency does not require immediate removal—DBHR's practice is more restrictive than agency requirements. DBHR immediately removes previously authorized people who no longer require access when informed by the program that such an action is needed. **Status of recommendation: In progress. Needs additional development.**	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.
Administrative Data			
DBHR has a process for screening encounters upon receipt. However, several issues noted during the ISCA review call into question the accuracy and completeness of the State's encounter data. DBHR needs to ensure that encounter data submitted electronically by the RSNs pass through a stringent screening process to ensure accuracy and validity.	DBHR has made some progress regarding cleaning the data entered into its CIS. However, data do not pass through validity or accuracy checks in ProviderOne to reject invalid or incomplete data upon receipt. As a result, ProviderOne continues to receive and house invalid and inaccurate data. A special request was granted in November 2014 to allow some limited encounter data cleanup that is currently not allowed in ProviderOne. DBHR is working with several RSNs to identify a time in December to submit and process these fixed or missing	When revised rates are configured by DBHR's contracted actuary, the RSNs usually request that data be re-run and do a large data dump to "fix" old encounters. When the new Behavioral Health Consolidated Database (BHCD) is completed, fixed dates will be set to close the opportunities for updates to past encounter data. BHCD development is still in progress and it is anticipated that the current CIS (client information system) will close out edits in the beginning of July 2016, at which time the BHCD will be in place.	The EQRO considers this response appropriate. Resolved.

	encounter records. **Status of recommendation: In progress.**	**Status of recommendation: Resolved.**	
DBHR uses the 837 electronic formats, which accepts multiple diagnoses. However, some RSNs report that they submit only the primary diagnosis or do not submit diagnoses on the 837. DBHR has no method in place to ensure that the diagnosis being treated at the time of service is reported on the 837. DBHR needs to implement a method to ensure that the diagnosis being treated at the time of service is reported on the 837.	DBHR issued a SERI update in November 2014, effective 1/1/2015, that addresses how RSNs should report diagnoses for mental health encounters. **Status of recommendation: In progress.**	This fix has been in place since November 2014. **Status of recommendation: Resolved.**	The EQRO considers this response appropriate. Resolved
Enrollment Systems			
Although DBHR developed a process that RSNs can use to update eligibility data (e.g., change of address or name), RSNs are not sufficiently aware of this new process to use it effectively. DBHR needs to clearly communicate to RSNs the process by which they can update eligibility data.	DBHR has a formal process for RSNs to contact the MMIS help desk for correcting eligibility data. DBHR agrees that RSNs still struggle with the process of updating eligibility information. DBHR will continue to work with RSNs and direct them on an as-needed basis. **Status of recommendation: In progress.**	DBHR continues to work with RSNs as needed. **Status of recommendation: Resolved.**	The EQRO considers this response appropriate. Resolved.
RSNs submit all encounters paid for with RSN funds. Many RSNs are not tracking which services are being paid for with Medicaid funds, since all encounters are included in the same	DBHR disagrees with Acumentra Health that it is necessary for DBHR to require RSNs to identify services paid for by Medicaid funds versus Medicare, State funds or other sources, either	DBHR is now requiring all encounters to be submitted regardless of funding source. DBHR is able to determine whether an encounter is	The EQRO considers this response appropriate. Resolved.

file. DBHR provides no specifications for RSNs to distinguish services paid by Medicaid from those paid by other sources. Some services for a Medicaid-eligible person may not be covered by Medicaid (e.g., jail services). ProviderOne accepts all encounters regardless of funding source. DBHR uses internal processes to determine if a person was Medicaid-eligible at the time of a service, and attaches a revenue code to the encounter. This practice does not replicate RSN processing rules, such as ensuring that non-Medicaid-eligible services are excluded. DBHR needs to work with the RSNs to develop and/or clarify reporting rules to identify services and encounters that RSNs pay for with Medicaid funds. DBHR needs to develop internal practices for tracking services paid for by Medicaid.	within the 837 or by other reporting means. DBHR continues to use the eligibility file to assign revenue codes at the state level and does not verify the accuracy of this process with the RSNs. Acumentra Health disagrees with the practice of relying solely on the eligibility file. Although a client may be eligible for Medicaid services, the funding source may not automatically be Medicaid. **Status: Recommendation stands**	Medicaid/non-Medicaid by the information received from the RSNs. **Status of recommendation: Resolved.**	
Performance Measure Reporting			
DBHR does not keep a frozen data set for the calculated performance measures. ProviderOne data are dynamic, preventing replication of the performance measure reports if they are lost. In the absence of a frozen data set, DBHR needs to develop procedures to validate the integrity of data	Looking Glass Analytics can freeze the data for performance measure calculations, but DBHR needs to initiate this process. At the time of review, DBHR had not initiated this process for the 2013 measures. **Status: Recommendation stands**	DBHR is implementing new performance measures, and will start measuring for baseline targets throughout 2016. **Status: N/A**	N/A

undergoing formatting changes in transition from ProviderOne to Looking Glass Analytics.			
The ProviderOne/CIS file consolidation project is complete, but documentation was not available at the time of the ISCA review. DBHR needs to fully document the process by which source data are extracted from CIS, aggregated and uploaded to DBHR's SAS server, and made available for Looking Glass Analytics to use.	DBHR agrees that the data pass through approximately six conversions before being made available to Looking Glass Analytics, and that these processes lack documentation that clearly describes the data flow. **Status: Recommendation stands**	DBHR is implementing new performance measures, and will start measuring for baseline targets throughout 2016. **Status: N/A**	N/A

Appendix

Amerigroup Washington (AMG)

Access to Care

Primary care visits

Adult access (20-44 yrs)	68.7%	
Adult access (45-64 yrs)	79.5%	▼
Adult access (total)	73.3%	

Maternal health visits

Prenatal timeliness	68.6%	
Frequency of prenatal care	45.8%	
Postpartum care	56.3%	▲

Children's access (12-24 mths)	96.2%	▼
Children's access (25 mths - 6 yrs)	83.5%	▼
Children's access (7-11 yrs)	88.6%	▼
Children's access (12-19 yrs)	85.5%	▼

Well child visits

6+ visits in the first 15 months	58.1%	
Annual visit, 3-5 yrs	68.2%	
Annual visit, adolescent	40.3%	

Preventive Care

Womens health screenings

Breast cancer	39.2%	▼
Cervical cancer	35.5%	▼
Chlamydia	49.7%	
HPV vaccination before 13 yrs	17.3%	▼

Weight assessment and counseling

BMI percentile	42.6%	▲
Nutrition counseling	55.8%	▲
Physical activity counseling	52.3%	▲
Adult BMI assessments	81.4%	▲

Children's immunizations

Combo 2	66.1%	▼
Combo 3	60.1%	▼

Adolescents' immunizations

Combo 1	64.0%	
Meningococcal	66.0%	▼
Tdap	81.6%	

Quality of Medical Care

Diabetes management

HbA1c testing	91.2%
Eye exam	56.8%
Attention to nephropathy	84.5%
Good HbA1c control	43.9%
Poor HbA1c control *	43.2%
Bood pressure < 140/90 mm Hg	58.0%
Screening - Schiz/Bipolar	86.0%
Monitoring - Schiz/Bipolar	57.9%

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	311.54
Hospital all cause readmisssions *	15.4%
ED visits per 1,000/MM *	53.65
Hosp. rate - medical, disch./1,000 MM*	2.45
Hosp. ALOS - medical *	3.89
Hosp. rate - surgical, disch./1,000 MM *	1.74
Hosp. ALOS - surgical *	7.92

Other disease management

Asthma medication - 75% compliance	34.2%	▲
COPD medication - systemic corticosteroid	75.1%	
COPD medication - bronchodialator	89.0%	
Antidepressant medication - acute	58.0%	▲
Antidepressant medication - continuation	44.4%	▲
ADHD medication follow up - initial	36.4%	
ADHD medication follow up - continuing	35.5%	
Medication adherence - schizophrenia	71.3%	
Control of high blood pressure	53.5%	

Appropriateness of treatments

Antibiotics for children with colds (URI)	92.5%	
Antibiotics for adults with bronchitis	37.4%	▲
Children pharyngitis	71.5%	▲
Use of imaging for lower back pain	71.3%	▼

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

Amerigroup Washington (AMG), continued

Performance Measure Strengths & Opportunities

Strengths

- Sig. improved from previous year and outperformed peers in all **weight assessment and counseling** measures
- Sig. above peers in **postpartum care visits**
- Sig. above peers and national average in **antidepressant medication management**

Opportunities for Improvement

- Sig. below peers in all **children's access to primary care** measures
- Sig. below peers in **breast and cervical cancer screenings** and HPV vaccinations
- Sig. below peers in **childhood immunizations** (combos 2 and 3) and **adolescent Meningococcal immunizations**

Consumer Experience

Measure	Score	Quartile
Rating of personal doctor	70.2	
Rating of specialist	76.1	
Rating of all health care	60.4	
Rating of health plan	59.9	
Getting needed care	56.2	
Getting care quickly	65.5	
Customer service	70.6	

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance Systems	94.0%
Program Integrity	93.0%	Performance Improvement Projects	
Timely Claims Payment	100.0%	Practice Guidelines	100.0%
Coordination and Continuity of Care	94.0%	Provider Selection (Credentialing)	83.0%
Patient Review and Restriction (PRR)	100.0%	QA/PI Program	87.0%
Coverage and Authorization of Services	81.0%	Sub-contractual Relationships/Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Homes	92.0%
Enrollee Rights	81.0%		

Amerigroup (AMG), a subsidiary of Anthem, utilizes an approach to healthcare that centers on a strong local presence, community-based expertise and relationships, and national resources. In 2014 in Washington, AMG served 128,369 enrollees in 33 counties.

Coordinated Care Washington (CCC)

Access to Care

Primary care visits

Adult access (20-44 yrs)	71.5%	
Adult access (45-64 yrs)	80.9%	▼
Adult access (total)	75.2%	

Maternal health visits

Prenatal timeliness	74.1%	
Frequency of prenatal care	48.4%	
Postpartum care	49.3%	

Children's access (12-24 mths)	97.7%	
Children's access (25 mths - 6 yrs)	89.2%	
Children's access (7-11 yrs)	91.6%	
Children's access (12-19 yrs)	90.9%	

Well child visits

6+ visits in the first 15 months	60.6%	
Annual visit, 3-5 yrs	66.8%	
Annual visit, adolescent	38.0%	

Preventive Care

Womens health screenings

Breast cancer	43.6%	▼
Cervical cancer	43.1%	
Chlamydia	54.5%	▲
HPV vaccination before 13 yrs	31.4%	

Children's immunizations

Combo 2	79.5%	▲
Combo 3	78.1%	▲

Weight assessment and counseling

BMI percentile	24.5%	▼
Nutrition counseling	50.7%	
Physical activity counseling	52.4%	▲
Adult BMI assessments	70.5%	▼

Adolescents' immunizations

Combo 1	61.3%	▼
Meningococcal	74.0%	
Tdap	76.4%	▼

Quality of Medical Care

Diabetes management

HbA1c testing	90.7%	
Eye exam	54.6%	
Attention to nephropathy	85.2%	
Good HbA1c control	39.4%	▼
Poor HbA1c control *	44.7%	
Bood pressure < 140/90 mm Hg	60.4%	
Screening - Schiz/Bipolar	87.2%	
Monitoring - Schiz/Bipolar	60.0%	

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	313.83	
Hospital all cause readmisssions *	14.4%	
ED visits per 1,000/MM *	57.12	
Hosp. rate - medical, disch./1,000 MM*	2.24	
Hosp. ALOS - medical *	3.71	
Hosp. rate - surgical, disch./1,000 MM *	1.52	
Hosp. ALOS - surgical *	7.21	

Other disease management

Asthma medication - 75% compliance	30.7%	▲
COPD medication - systemic corticosteroid	75.5%	
COPD medication - bronchodialator	86.1%	
Antidepressant medication - acute	52.6%	
Antidepressant medication - continuation	38.5%	
ADHD medication follow up - initial	42.4%	
ADHD medication follow up - continuing	40.6%	
Medication adherence - schizophrenia	72.4%	
Control of high blood pressure	43.6%	▼

Appropriateness of treatments

Antibiotics for children with colds (URI)	91.7%	▼
Antibiotics for adults with bronchitis	26.9%	
Children pharyngitis	46.4%	▼
Use of imaging for lower back pain	79.3%	

▼▲Plan score significantly different from peers (p<.05)

* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges

MM: member months

ALOS: average length of stay (days)

Coordinated Care Washington (CCC), continued

Performance Measure Strengths & Opportunities

Strengths

- Sig. above peers in children's **physical activity counseling**
- Sig. improved from previous year and outperformed peers in **childhood immunizations** (combos 2 and 3)
- Sig. above peers in **chlamydia screenings**

Opportunities for Improvement

- Sig. below peers in children's and adults' **body mass index assessments**
- Sig. below peers in **breast cancer screenings**
- Sig. decline from previous year and below peers in **adolescent immunizations** (combo 1)
- Sig. below peers and national average in **blood sugar control** for diabetic patients
- Sig. below peers and national average for **controlling high blood pressure** in patients with hypertension

Consumer Experience

Measure	Score	Quartile
Rating of personal doctor	76.0	
Rating of specialist	73.9	
Rating of all health care	63.4	
Rating of health plan	70.7	
Getting needed care	54.4	
Getting care quickly	65.8	
Customer service	65.2	

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance Systems	93.0%
Program Integrity	93.0%	Performance Improvement Projects	
Timely Claims Payment	83.0%	Practice Guidelines	78.0%
Coordination and Continuity of Care	92.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Restriction (PRR)	100.0%	QA/PI Program	100.0%
Coverage and Authorization of Services	81.0%	Sub-contractual Relationships/Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Homes	75.0%
Enrollee Rights	98.0%		

Coordinated Care (CCC), a subsidiary of Centene Corporation, works under the core mission that quality healthcare is best delivered locally. CCC provided Medicaid benefits to 175,353 beneficiaries in 26 counties across Washington in 2014.

Community Health Plan of Washington (CHP)

Access to Care

Primary care visits

Adult access (20-44 yrs)	81.4%	▲
Adult access (45-64 yrs)	87.5%	▲
Adult access (total)	83.9%	

Maternal health visits

Prenatal timeliness	77.9%	▲
Frequency of prenatal care	46.7%	
Postpartum care	52.6%	

Children's access (12-24 mths)	97.4%	
Children's access (25 mths - 6 yrs)	87.9%	▼
Children's access (7-11 yrs)	91.1%	▼
Children's access (12-19 yrs)	89.5%	▼

Well child visits

6+ visits in the first 15 months	57.7%	
Annual visit, 3-5 yrs	65.0%	
Annual visit, adolescent	40.9%	

Preventive Care

Womens health screenings

Breast cancer	56.1%	▲
Cervical cancer	56.2%	▲
Chlamydia	49.7%	▼
HPV vaccination before 13 yrs	28.5%	

Children's immunizations

Combo 2	72.5%	
Combo 3	70.3%	

Weight assessment and counseling

BMI percentile	37.2%	
Nutrition counseling	56.9%	▲
Physical activity counseling	49.9%	
Adult BMI assessments	86.0%	▲

Adolescents' immunizations

Combo 1	75.1%	▲
Meningococcal	75.7%	
Tdap	91.8%	▲

Quality of Medical Care

Diabetes management

HbA1c testing	91.5%	
Eye exam	63.7%	▲
Attention to nephropathy	81.5%	
Good HbA1c control	52.3%	▲
Poor HbA1c control *	33.3%	▼
Bood pressure < 140/90 mm Hg	72.5%	▲
Screening - Schiz/Bipolar	87.3%	
Monitoring - Schiz/Bipolar	60.4%	▼

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	323.20	
Hospital all cause readmisssions *	14.5%	▲
ED visits per 1,000/MM *	52.91	
Hosp. rate - medical, disch./1,000 MM*	2.30	
Hosp. ALOS - medical *	3.52	
Hosp. rate - surgical, disch./1,000 MM *	1.41	
Hosp. ALOS - surgical *	6.50	

Other disease management

Asthma medication - 75% compliance	27.7%	▲
COPD medication - systemic corticosteroid	75.2%	
COPD medication - bronchodialator	87.2%	
Antidepressant medication - acute	52.3%	
Antidepressant medication - continuation	38.0%	
ADHD medication follow up - initial	30.5%	▼
ADHD medication follow up - continuing	30.0%	▼
Medication adherence - schizophrenia	64.4%	▼
Control of high blood pressure	64.3%	▲

Appropriateness of treatments

Antibiotics for children with colds (URI)	93.0%	
Antibiotics for adults with bronchitis	32.5%	▲
Children pharyngitis	65.8%	
Use of imaging for lower back pain	78.0%	

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

Community Health Plan of Washington (CHP), continued

Performance Measure Strengths & Opportunities

Strengths

- Sig. above peers in **adults' access to primary care**
- Sig. above peers in **timeliness of prenatal care**
- Sig. above peers in **breast and cervical cancer screenings**
- Sig. above peers and the national average in adult **body mass index assessments**
- Sig. above peers in **children's nutrition counseling**
- Sig. above peers in **adolescent immunizations**
- Sig. above peers in **diabetes care** (eye exams, blood sugar control, and blood pressure control)

Opportunities for Improvement

- Sig. below peers in **managing ADHD medication**
- Sig. below peers in **managing medications for people with schizophrenia**

Consumer Experience

Measure	Score	Quartile
Rating of personal doctor	73.5	
Rating of specialist	67.7	
Rating of all health care	60.9	
Rating of health plan	61.3	
Getting needed care	51.7	
Getting care quickly	62.2	
Customer service	65.6	

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance Systems	85.0%
Program Integrity	87.0%	Performance Improvement Projects	
Timely Claims Payment	100.0%	Practice Guidelines	67.0%
Coordination and Continuity of Care	75.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Restriction (PRR)	100.0%	QA/PI Program	87.0%
Coverage and Authorization of Services	81.0%	Sub-contractual Relationships/Delegation	83.0%
Enrollment and Disenrollment	100.0%	Health Homes	92.0%
Enrollee Rights	93.0%		

Community Health Plan of Washington (CHP), headquartered in Seattle, was founded over 20 years ago by Washington community health centers and is the state's only local nonprofit health plan. In 2014, CHP provided Medicaid services to 332,456 enrollees in 30 counties.

Molina Healthcare of Washington (MHW)

Access to Care

Primary care visits

Adult access (20-44 yrs)	83.8%	▲
Adult access (45-64 yrs)	88.6%	▲
Adult access (total)	85.3%	▲

Maternal health visits

Prenatal timeliness	74.7%	
Frequency of prenatal care	40.2%	▼
Postpartum care	52.0%	

Children's access (12-24 mths)	97.9%	▲
Children's access (25 mths - 6 yrs)	89.5%	▲
Children's access (7-11 yrs)	92.6%	▲
Children's access (12-19 yrs)	92.6%	▲

Well child visits

6+ visits in the first 15 months	55.2%	
Annual visit, 3-5 yrs	67.5%	
Annual visit, adolescent	44.4%	

Preventive Care

Womens health screenings

Breast cancer	58.4%	▲
Cervical cancer	58.7%	▲
Chlamydia	52.8%	▲
HPV vaccination before 13 yrs	30.0%	

Weight assessment and counseling

BMI percentile	39.1%	▲
Nutrition counseling	48.8%	
Physical activity counseling	41.5%	▼
Adult BMI assessments	84.5%	▲

Children's immunizations

Combo 2	69.1%	
Combo 3	66.9%	

Adolescents' immunizations

Combo 1	75.5%	▲
Meningococcal	75.9%	
Tdap	92.5%	▲

Quality of Medical Care

Diabetes management

HbA1c testing	89.6%	
Eye exam	48.3%	▼
Attention to nephropathy	82.6%	
Good HbA1c control	45.9%	
Poor HbA1c control *	46.6%	
Bood pressure < 140/90 mm Hg	65.8%	▲
Screening - Schiz/Bipolar	84.2%	
Monitoring - Schiz/Bipolar	75.5%	▲

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	345.81	
Hospital all cause readmisssions *	12.8%	▼
ED visits per 1,000/MM *	49.55	
Hosp. rate - medical, disch./1,000 MM*	1.56	
Hosp. ALOS - medical *	3.64	
Hosp. rate - surgical, disch./1,000 MM *	1.07	
Hosp. ALOS - surgical *	6.95	

Other disease management

Asthma medication - 75% compliance	23.4%	▼
COPD medication - systemic corticosteroid	77.0%	
COPD medication - bronchodialator	87.1%	
Antidepressant medication - acute	48.4%	▼
Antidepressant medication - continuation	32.8%	▼
ADHD medication follow up - initial	41.3%	▲
ADHD medication follow up - continuing	44.0%	▲
Medication adherence - schizophrenia	76.8%	▲
Control of high blood pressure	58.8%	▲

Appropriateness of treatments

Antibiotics for children with colds (URI)	92.8%	
Antibiotics for adults with bronchitis	27.7%	▼
Children pharyngitis	67.9%	▲
Use of imaging for lower back pain	79.1%	▲

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

Molina Healthcare of Washington (MHW), continued

Performance Measure Strengths & Opportunities

Strengths

- Sig. above peers in **adults' access to primary care**
- Sig. above peers and the national average in adults' and children's **body mass index assessments**
- Sig. above peers in **breast and cervical cancer screenings**
- Sig. above peers in **adolescent immunizations** (combo 1)
- Sig. above peers in **managing medications for people with schizophrenia**
- Sig. below peers in **all cause hospital readmissions**

Opportunities for Improvement

- Sig. below peers in **physical activity counseling**
- Sig. below peers in **frequency of prenatal care**
- Sig. above peers in **adolescent immunizations** (combo 1)
- Sig. below peers in **diabetes eye exams**
- Sig. below peers in **antidepressant medication management** and **asthma medication management**

Consumer Experience

Measure	Score	Quartile
Rating of personal doctor	74.5	
Rating of specialist	72.8	
Rating of all health care	64.2	
Rating of health plan	66.8	
Getting needed care	59.8	
Getting care quickly	69.7	
Customer service	67.0	

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	95.0%	Grievance Systems	98.0%
Program Integrity	73.0%	Performance Improvement Projects	
Timely Claims Payment	83.0%	Practice Guidelines	100.0%
Coordination and Continuity of Care	94.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Restriction (PRR)	93.0%	QA/PI Program	100.0%
Coverage and Authorization of Services	100.0%	Sub-contractual Relationships/Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Homes	100.0%
Enrollee Rights	93.0%		

Molina Healthcare of Washington (MHW), established in 1995, offers health plans, medical clinics and health information management services. In 2014 MHW provided coverage for 486,524 Medicaid enrollees in 37 counties across Washington.

United Healthcare Community Plan (UHC)

Access to Care

Primary care visits

Adult access (20-44 yrs)	71.8%	
Adult access (45-64 yrs)	81.3%	▼
Adult access (total)	75.7%	

Maternal health visits

Prenatal timeliness	65.2%	▼
Frequency of prenatal care	43.1%	
Postpartum care	48.2%	

Children's access (12-24 mths)	96.2%	▼
Children's access (25 mths - 6 yrs)	88.3%	
Children's access (7-11 yrs)	91.2%	
Children's access (12-19 yrs)	88.9%	▼

Well child visits

6+ visits in the first 15 months	57.4%	
Annual visit, 3-5 yrs	65.2%	
Annual visit, adolescent	45.7%	

Preventive Care

Womens health screenings

Breast cancer	41.2%	▼
Cervical cancer	35.8%	▼
Chlamydia	45.0%	▼
HPV vaccination before 13 yrs	25.5%	

Children's immunizations

Combo 2	68.6%	
Combo 3	65.9%	

Weight assessment and counseling

BMI percentile	30.4%	▼
Nutrition counseling	39.2%	▼
Physical activity counseling	37.7%	▼
Adult BMI assessments	68.1%	▼

Adolescents' immunizations

Combo 1	66.1%	
Meningococcal	68.6%	
Tdap	80.6%	

Quality of Medical Care

Diabetes management

HbA1c testing	88.8%	
Eye exam	49.1%	▼
Attention to nephropathy	86.6%	
Good HbA1c control	43.6%	
Poor HbA1c control *	49.9%	▲
Bood pressure < 140/90 mm Hg	48.4%	▼
Screening - Schiz/Bipolar	85.6%	
Monitoring - Schiz/Bipolar	79.4%	▲

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	326.91
Hospital all cause readmisssions *	12.6%
ED visits per 1,000/MM *	51.89
Hosp. rate - medical, disch./1,000 MM*	1.99
Hosp. ALOS - medical *	3.95
Hosp. rate - surgical, disch./1,000 MM *	1.42
Hosp. ALOS - surgical *	7.04

Other disease management

Asthma medication - 75% compliance	35.8%	▲
COPD medication - systemic corticosteroid	75.8%	
COPD medication - bronchodialator	85.5%	
Antidepressant medication - acute	57.2%	▲
Antidepressant medication - continuation	43.0%	▲
ADHD medication follow up - initial	29.6%	▼
ADHD medication follow up - continuing	32.8%	
Medication adherence - schizophrenia	73.5%	
Control of high blood pressure	34.5%	▼

Appropriateness of treatments

Antibiotics for children with colds (URI)	90.8%	▼
Antibiotics for adults with bronchitis	26.5%	
Children pharyngitis	65.8%	
Use of imaging for lower back pain	74.8%	▼

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

United Healthcare Community Plan (UHC), continued

Performance Measure Strengths & Opportunities

Strengths

- Dramatic (sig.) improvement from previous year in **blood sugar control** for diabetic patients
- Sig. above peers in **asthma medication management**
- Sig. above peers in **antidepressant medication management**

Opportunities for Improvement

- Sig. below peers in all **weight assessment and counseling** measures
- Sig. below peers in **prenatal timeliness**
- Sig. below peers in **breast and cervical cancer and chlamydia screenings**
- Despite improvement from prior year, continued sig. below peers in **diabetes care** (eye exams, and blood pressure and blood sugar control)
- Sig. below national average for **controlling high blood pressure** in patients with hypertension

Consumer Experience

Measure	Score	Quartile
Rating of personal doctor	72.3	
Rating of specialist	70.4	
Rating of all health care	65.1	
Rating of health plan	62.9	
Getting needed care	55.9	
Getting care quickly	69.0	
Customer service	65.7	

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance Systems	96.0%
Program Integrity	100.0%	Performance Improvement Projects	
Timely Claims Payment	100.0%	Practice Guidelines	89.0%
Coordination and Continuity of Care	92.0%	Provider Selection (Credentialing)	92.0%
Patient Review and Restriction (PRR)	100.0%	QA/PI Program	93.0%
Coverage and Authorization of Services	86.0%	Sub-contractual Relationships/Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Homes	67.0%
Enrollee Rights	93.0%		

UnitedHealthcare Community Plan (UHC) is a program of UnitedHealth Group, one of the largest health insurers in the United States. In 2014, UHC provided Medicaid coverage to 180,225 enrollees in 24 Washington counties, helping low-income adults and children and people with disabilities get access to personalized healthcare benefits and services.

Chelan-Douglas Regional Support Network (CDRSN)

CDRSN is responsible for contracting and oversight of all outpatient and inpatient managed mental health services delivered by contracted providers to enrollees in Chelan and Douglas counties. CDRSN is headquartered in East Wenatchee, Washington, and is governed by a board comprising elected officials from each county and four elected city officials.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	Subcontractual Relationships	●
Coordination and Continuity of Care	⦿	Practice Guidelines	⦿
Coverage/Authorization of Services	●	Quality Assessment	⦿
Provider Selection	⦿	Health Information Systems	●

Strengths	Recommendations
• CDRSN has provided specific trainings to the provider agencies managers, supervisors and clinicians on coordinating care with other providers and services. • CDRSN, annually, monitors the treatment plans for enrollees with specialized healthcare needs to ensure the client's participation and voice are present in the treatment plan, services are appropriately provided, and consultations with specialists are included.	• CDRSN needs to consolidate the information it gathers from the IS, clinical, compliance and quality work plans into a single annual summary and incorporate the information into the RSN's ongoing quality management program. This was a finding in the 2012 EQRO report. • CDRSN needs to continue to develop its improvement process by implementing the LOCUS and CALOCUS in late 2015, work toward improving stabilization of care with a triage center rather than a mobile crisis outreach service, review the strengths and gaps in its delivery system, and review strategies to improve residential treatment.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Improving the Penetration Rate of Child and Family Team Participation for Medicaid Children	●	• CDRSN chose a study topic that is in line with the current State initiatives related to high risk/high needs children and youth. The data collection sources are well defined and include mechanisms to guard against unreliable results.	• CDRSN should continue this PIP through the second re-measurement period and monitor for any possible impact related to the implementation of WISe.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Does the Implementation of a Standardized Discharge Protocol Increase the Percentage of Medicaid Enrollees Receiving a Crisis Service Who Receive Clinically Indicated Follow-up Services?	●	• CDRSN included the RSN Advisory Board and the QMOC in choosing to focus on increasing the percentage of clinically indicated follow-up services for enrollees who received mental health services.	• CDRSN needs to analyze re-measurement data and compare results to baseline data to determine whether improvement has been achieved or if modification should be made to the PIP.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	In 2014, one of the three CDRSN provider agencies was not encrypting its backup data. • CDRSN needs to ensure that its provider agencies' backup data is encrypted in adherence with DBHR requirements. CDRSN's next Agency Annual Data Security Audits will again address this topic and will be performed in October 2015.
Hardware Systems	●	
Information Security	⦿	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Chelan-Douglas Regional Support Network (CDRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	◉	**Review Tools**	●	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	100.00%	100.00%	Hispanic Origin	98.33%	N/A
First Name	100.00%	100.00%	Preferred Language	99.17%	N/A
Gender	100.00%	100.00%	SSN	99.17%	100.00%
Date of Birth	100.00%	100.00%	Sexual Orientation	97.50%	N/A
Ethnicity	97.50%	100.00%			
Encounter Data					
Procedure Code	58.88%	95.11%	Provider Agency	97.31%	97.67%
Date of Service	97.31%	97.73%	Provider Type	93.39%	96.42%
Service Location	97.31%	95.28%	Clinical Note Matches Procedure Note	59.09%	97.73%
Service Duration	83.68%	97.38%			

Strengths	Recommendations
• CDRSN's demographics match rate is high. • There was little variance between the results of the RSN review and Qualis Health review.	• CDRSN needs to ensure that all encounters contain sufficient documentation of a service that can be encountered and follow SERI and WAC requirements. • CDRSN needs to ensure that all required elements within the EDV deliverable to DBHR are included and adequately documented.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights	1	1
Grievance Systems	2	2
Implementation of the Washington State Children's Mental Health System Principles	2	2
ISCA	12	11

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Grays Harbor Regional Support Network (GHRSN)

GHRSN is a program of Grays Harbor County Public Health and Social Services. The RSN employs a small administrative staff and does not provide any direct client services, however it provides funding and oversight for direct client services and other assistance within available resources and three contracted provider agencies. GHRSN has approximately 23,400 Medicaid beneficiaries enrolled in its service area.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	●	Subcontractual Relationships	⦿
Coordination and Continuity of Care	⦿	Practice Guidelines	○
Coverage/Authorization of Services	⦿	Quality Assessment	⦿
Provider Selection	⦿	Health Information Systems	⦿

Strengths	Recommendations
• GHRSN provides training to the provider agencies on assessment, treatment planning and documentation (the Golden Thread) and on reforming the treatment plans to include statements that the enrollee either agrees with the treatment plan or does not agree. • The RSN monitors the use of services among high utilizers, specifically enrollees who are frequent users of the ED and crisis services. GHRSN states that the emergency room is over-utilized in Grays Harbor, and in 2014 the RSN was having monthly meetings with representatives from the ED to develop and implement interventions.	• The RSN and providers need to run monthly SAM and LEIE checks on all staff who work within the RSN network to ensure that no one is on the excluded provider list. • The RSN needs to adopt performance and quality benchmarks and use valid objective measures to assess their performance against those benchmarks. The RSN needs to evaluate its quality program and submit their annual quality improvement plan to DBHR.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Collaboration and Coordination of Care with Physical Health and Behavioral Health Services Providers and Monitoring of the Medication Side Effects for Persons Who Have Developmental Disabilities/Intellectual Developmental Disorders	○	• GHRSN's chosen study population will have a diagnosis of mental illness, which fits the criteria as a special needs population.	• GHRSN should clarify the study topic, study question, study population and study indicators. The RSN needs to update its PIP to meet the Protocol and criteria.

Non-Clinical PIP	Score	Strengths	Recommendations
Coordination of Physical and Behavioral Healthcare As a Measure of Quality Mental Health Service	○	• GHRSN's study population for its non-clinical PIP will include children and youth in foster care requesting outpatient mental health services, this is a high risk/high need demographic and is an appropriate choice on which to focus.	• GHRSN did not articulate that the study topic was chosen through a comprehensive assessment of enrollee needs care and services. GHRSN needs to clarify the data collection and analysis that was used.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	• GHRSN needs to work with its provider agencies to establish encryption practices in accordance with the DBHR contract requirements. • GHRSN needs to ensure that all RSN disaster recovery policy and procedures are current.
Hardware Systems	●	
Information Security	⦿	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Grays Harbor Regional Support Network (GHRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	◉	**Review Tools**	●	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	98.67%	N/A	Hispanic Origin	92.00%	N/A
First Name	100.00%	N/A	Preferred Language	89.33%	N/A
Gender	97.33%	N/A	SSN	76.00%	N/A
Date of Birth	97.33%	N/A	Sexual Orientation	90.67%	N/A
Ethnicity	90.67%	N/A			
Encounter Data					
Procedure Code	67.83%	94.42%	Provider Agency	85.66%	98.02%
Date of Service	85.27%	97.77%	Provider Type	84.50%	93.93%
Service Location	85.27%	94.18%	Clinical Note Matches Procedure Note	77.52%	87.11%
Service Duration	78.68%	97.03%			

Strengths	Recommendations
	• GHRSN needs to ensure that any crosswalks being utilized are accurate. • GHRSN needs to ensure that required elements, in the EDV deliverable to DBHR, are addressed and adequately documented.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights	9	5
Grievance Systems	3	1
Implementation of the Washington State Children's Mental Health System Principles	2	0
ISCA	3	0

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Greater Columbia Behavioral Health (GCBH)

Greater Columbia Behavioral Health RSN (GCBH) administers public mental health funds for Medicaid participants enrolled in managed care plans in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima counties. The RSN does not provide any direct client services; however, it provides financial and administrative oversight for the direct client services that are provided to enrollees through contracts with provider agencies in the ten-county area.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	Subcontractual Relationships	●
Coordination and Continuity of Care	●	Practice Guidelines	⦿
Coverage/Authorization of Services	●	Quality Assessment	●
Provider Selection	⦿	Health Information Systems	⦿

Strengths	Recommendations
• To meet State standards for timely access to care and services, several provider agencies in population-dense counties offer walk-in services and, in rural counties, in-home services. • The RSN has mechanisms in place to ensure compliance with authorization timeframes and indicated it will be implementing an internal improvement process that will include notifying clinical directors of challenges with meeting timeframes.	• GCBH needs to include in its policies and process, monitoring of the members of its Board of Directors. • GCBH needs to develop a process to hold its provider network accountable for maintaining and following a QM process that includes monitoring and tracking the quality and appropriateness of care furnished to its enrollees.

Performance Improvement Projects

Non-Clinical/Children's PIP	Score	Strengths	Recommendations
Lowered Inpatient Readmission Rates in a High-Risk Population Through the Development of Enhanced Communication with Inpatient Providers	●	• GCBH chose this PIP as a means to facilitate a process that goes beyond presenting problems and determining medical necessity for care. The intervention includes the identification of psychosocial, cultural and environmental factors.	• GCBH should consider ending this PIP or modifying the study topic and study question to address an issue that is in need of true improvement. GCBH should aggregate and analyze the data it has collected from its current intervention and use the information to inform the selection of its new PIP.

Non-Clinical PIP	Score	Strengths	Recommendations
Increasing Inclusion of Healthcare Information and PCP Involvement Into Outpatient Mental Health Treatment Through Provider Training and Shared PRISM Health Information	●	• GCBH has chosen a PIP that is quite fitting, the integration of mental health and physical healthcare needs is a high priority at national, state and local levels.	• If GCBH chooses to continue this PIP to should consider altering the study questions and indicators so that they are less closely ties to current Washington Administrative Code (WAC) and contract requirements.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	●	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Greater Columbia Behavioral Health (GCBH)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	●	**Review Tools**	●	**Methodology and Analytic Procedures**	◉
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	100.00%	N/A	Hispanic Origin	89.21%	N/A
First Name	97.84%	N/A	Preferred Language	0.72%	N/A
Gender	97.84%	N/A	SSN	76.98%	N/A
Date of Birth	100.00%	N/A	Sexual Orientation	82.73%	N/A
Ethnicity	91.37%	N/A			
Encounter Data					
Procedure Code	40.87%	84.00%	Provider Agency	94.29%	84.00%
Date of Service	94.52%	85.00%	Provider Type	84.02%	84.00%
Service Location	89.73%	80.00%	Clinical Note Matches Procedure Note	28.54%	N/A
Service Duration	83.11%	83.00%			

Strengths	Recommendations
	• GCBH needs to ensure that encounters are meeting SERI and WAC requirements and have documented sufficient documented information supporting a clinical service. • GCBH needs to ensure that locations are appropriately crosswalked prior to submitting to ProviderOne. • GCBH needs to ensure that all required elements in the EDV deliverable to DBHR are addressed.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Grievance Systems	1	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

King County Regional Support Network (KCRSN)

King County RSN (KCRSN) administers public mental health funds for Medicaid participants enrolled in managed care plans in King County. KCRSN is managed by the county's Mental Health, Chemical Abuse and Dependency Services division of the Department of Community and Human Services and serves enrollees through contracts with 16 licensed community mental health centers.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	Subcontractual Relationships	●
Coordination and Continuity of Care	●	Practice Guidelines	⦿
Coverage/Authorization of Services	●	Quality Assessment	●
Provider Selection	⦿	Health Information Systems	⦿

Strengths	Recommendations
• KCRSN requires all out-of-network providers to complete and sign a single case service agreement, which requires the provider to submit license(s)/credentials and attest to a background check, and assures the provider is not on the excluded provider list. • KCRSN reviews inpatient reports for inappropriate stays, analyzes encounter and claims data for frequency of services, audits clinical records for appropriateness of care, and tracks and analyzes enrollee complaints and grievances as mechanisms for monitoring for over- and underutilization.	• KCRSN needs to implement a process for monitoring requests for second opinions. • KCRSN needs to develop and implement policies and procedures that address the adoption of practice guidelines, the dissemination of the practice guidelines and how utilization management, enrollee education, coverage of services and other areas are based on and are consistent with the guidelines.

Performance Improvement Projects

Non-Clinical/Children's PIP	Score	Strengths	Recommendations
Effectiveness of the Transitional Support Program	○	• Creating a PIP to decrease re-hospitalization rates amongst involuntarily detained adults is relevant and appropriate.	• KCRSN set up a monitoring system of its TSP program, data collected is considered program evaluation, not performance improvement. KCRSN needs to implement a specific intervention to be monitored, beyond the current practices of the TSP program if it is to be used for a PIP.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Improved Care Coordination with Managed Care Organizations (MCOs) for Children and Youth	⦿	• KCRSN has the foundation for a PIP that meets all the Medicaid required elements. The goal of reducing psychiatrically related ED usage among youth continuously enrolled in both RSN outpatient behavioral services and Molina Healthcare is clear and appropriate.	• This PIP, in its current design, is not fully formulated. All aspects of the PIP protocol must be addressed if KCRSN continues with this topic.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	●	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

King County Regional Support Network (KCRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	●	**Review Tools**	◉	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	100.00%	N/A	Hispanic Origin	89.21%	N/A
First Name	97.84%	N/A	Preferred Language	0.72%	N/A
Gender	97.84%	N/A	SSN	76.98%	N/A
Date of Birth	100.00%	N/A	Sexual Orientation	82.73%	N/A
Ethnicity	91.37%	N/A			
Encounter Data					
Procedure Code	40.87%	84.00%	Provider Agency	94.29%	84.00%
Date of Service	94.52%	85.00%	Provider Type	84.02%	84.00%
Service Location	89.73%	80.00%	Clinical Note Matches Procedure Note	28.54%	N/A
Service Duration	83.11%	83.00%			

Strengths	Recommendations
	• KCRSN needs to ensure that all encounters contain sufficient documentation of a service that can be encountered and follow SERI and WAC requirements.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Grievance Systems	1	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

North Sound Mental Health Administration (NSMHA)

North Sound Mental Health Administration RSN (NSMHA) administers services for public mental health enrollees in Island, San Juan, Skagit, Snohomish and Whatcom counties. The RSN does not provide any direct client services; however, it provides funding and oversight for direct client services and other assistance through contracts with provider agencies. NSMHA has approximately 250,000 Medicaid-eligible beneficiaries within its service area.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	Subcontractual Relationships	●
Coordination and Continuity of Care	⦿	Practice Guidelines	●
Coverage/Authorization of Services	⦿	Quality Assessment	⦿
Provider Selection	⦿	Health Information Systems	●

Strengths	Recommendations
• As part of the annual strategic planning process, provider profiles are completed and reviewed as part of the geographic service area needs assessment. Aggregate utilization data and provider staffing models and ratios are analyzed, and input from enrollees, clinical provider network staff and other stakeholders is solicited. • In response to increases in enrollment due to the Affordable Care Act, NSMHA has been working with provider agencies to attract new clinicians to the area by advertising broadly to graduate programs in other states, offering tuition reimbursements and increasing pay rates. The RSN has also been discussing streamlining the fast-track process for CD certification with the community colleges.	• NSMHA needs to implement a documented process to develop training for authorization staff to ensure that authorizations are done in a consistent and appropriate manner. • NSMHA needs to create a policy and procedure regarding the underutilization and overutilization of individual services and programs. The policy and procedure must address processes for consistent criteria to identify and monitor underutilization and overutilization. NSMHA needs to also have a process for taking corrective action to address underutilization and overutilization.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
WRAP + MAP: Integrating Care Coordination and Clinical Practice Models for Medicaid Children and Youth Enrolled in WISe – Year 2 (2015)	○	N/A	• Solely submitting a document written by an external party does not satisfy the requirements of an acceptable PIP. • When selecting future PIPs, NSMHA should ensure that PIPs are realistic and all aspects can be carried out to their full extent.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Improving the Quality of Care Coordination for High-Risk Transition-Age Youth	⦿	• NSMHA's process for determining this PIP study topic was quite thorough and included multiple steps. Real and sustained improvement was achieved.	• While noting barriers is important, appropriate improvement strategies need to be addressed in future PIPs.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	⦿	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

North Sound Mental Health Administration (NSMHA)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	●	**Review Tools**	●	**Methodology and Analytic Procedures**	○
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	96.43%	100.00%	Hispanic Origin	69.29%	N/A
First Name	99.29%	100.00%	Preferred Language	50.71%	N/A
Gender	97.14%	N/A	SSN	60.00%	N/A
Date of Birth	99.29%	100.00%	Sexual Orientation	64.29%	N/A
Ethnicity	82.86%	98.50%			
Encounter Data					
Procedure Code	64.61%	99.80%	Provider Agency	94.91%	N/A
Date of Service	94.91%	99.70%	Provider Type	94.50%	100.00%
Service Location	94.09%	98.80%	Clinical Note Matches Procedure Note	58.86%	N/A
Service Duration	86.76%	99.00%			

Strengths	Recommendations
• For the three of the elements reviewed by both Qualis Health and the RSN, the discrepancy was small.	• NSMHA needs to ensure that all encounters contain sufficient documentation of a service that can be encountered and follow SERI and WAC requirements • NSMHA needs to ensure that all required elements within the EDV deliverable to DBHR are included and adequately documented.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights	2	1
Information Security	5	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Optum Pierce Regional Support Network (OPRSN)

Optum Pierce RSN (OPRSN) coordinates mental health services for Medicaid participants enrolled in managed care plans in Pierce County. OPRSN does not provide any direct client services; however, it provides financial and administrative oversight for the direct client services that are provided to enrollees through a network of treatment providers in Pierce County. The RSN is operated by OptumHealth, a privately held subsidiary of UnitedHealth Group.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	Subcontractual Relationships	●
Coordination and Continuity of Care	●	Practice Guidelines	●
Coverage/Authorization of Services	●	Quality Assessment	⦿
Provider Selection	●	Health Information Systems	⦿

Strengths	Recommendations
• OPRSN engages in a wide variety of community education and anti-stigma efforts to promote understanding of mental health issues and reduce the stigma associated with seeking mental health services. • To help ensure proper utilization of services, OPRSN monitors utilization reports and performs an annual review of community mental health agencies to determine whether services are provided in a clinically appropriate manner and at the intensity appropriate to each consumer's needs. If services are consistently provided at too high or too low intensity for consumers, it may result in an investigation. Results are reviewed by the Utilization Committee with recommendations going to the Quality Committee.	• OPRSN needs to have a process in place to ensure that if services are provided by an out-of- network provider, the provider meets the same credentialing requirements as in-network providers. • OPRSN needs to expand its year-end program evaluation to include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances, service verification and recommendations for the coming year.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Effects of the WISe Model on Caregiver Strain	○	• OPRSN has chosen a well-researched study population of caregivers who have children and youth enrolled in the WISe program.	• Setting up a monitoring system of an outcome of an already existing program or service is program evaluation. In order to make this a PIP OPRSN needs to create a series of actions to identify, analyze and improve the process, as well as a means to measure the improvement.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Reduction of RTF Average Length of Stay	N/A	• OPRSN has done a significant amount of work and made a considerable amount of progress in the past few years to reduce the average length of stay in its residential treatment facilities (RTF).	• Due to its prior success related to the PIP topic, the small scope of the current PIP and the nature of the elements of the study question, OPRSN needs to consider whether this PIP is worthy of continuation.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	⦿	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Optum Pierce Regional Support Network (OPRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	◉	**Review Tools**	○	**Methodology and Analytic Procedures**	○
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	97.84%	100.00%	Hispanic Origin	82.73%	98.80%
First Name	100.00%	100.00%	Preferred Language	99.28%	99.70%
Gender	98.56%	99.70%	SSN	94.96%	98.80%
Date of Birth	99.28%	99.90%	Sexual Orientation	80.58%	98.60%
Ethnicity	83.45%	98.50%			
Encounter Data					
Procedure Code	64.61%	100.00%%	Provider Agency	79.91%	100.00%
Date of Service	79.91%	100.00%%	Provider Type	67.58%	98.96%
Service Location	73.97%	100.00%%	Clinical Note Matches Procedure Note	57.08%	100.00%
Service Duration	74.20%	100.00%%			

Strengths	Recommendations
• For six elements reviewed by both Qualis Health and the RSN, there was little variance.	• OPRSN needs to ensure that all encounters contain sufficient documentation of a service that can be encountered and follow SERI and WAC requirements. • OPRSN needs to ensure that all required elements within the EDV deliverable to DBHR are included and adequately documented.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Grievance Systems	1	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Peninsula Regional Support Network (PRSN)

Peninsula RSN administers public mental health funds for Medicaid participants enrolled in managed care plans in Clallam, Jefferson and Kitsap counties. The RSN does not provide any direct client services; however, it provides planning, contracting and administration for direct client services that are provided to enrollees through contracts with community health providers, consumer/family advocate groups, and tribal groups in the three-county area. The executive board, composed of nine county commissioners, sets policy and has oversight responsibilities. Currently 76,000 residents are eligible to receive services from the PRSN.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	Subcontractual Relationships	●
Coordination and Continuity of Care	●	Practice Guidelines	⦿
Coverage/Authorization of Services	⦿	Quality Assessment	●
Provider Selection	●	Health Information Systems	●

Strengths	Recommendations
•PRSN generates a monthly Provider Performance Summary Report to describe numbers of services and hours for each state plan modality, utilization rates for inpatient services and crisis services, penetration rates and other performance statistics. •PRSN has several committees responsible for reviewing, analyzing and making recommendations for improvement for both internal processes as well as for contracted agencies. PRSN follows up on all corrective action plans to ensure providers are complying.	• PRSN needs to have a process in place that ensures that out-of-network providers meet the requirements in PRSN's credentialing policies, including ensuring the providers are licensed as appropriate and are not on the excluded provider list. • PRSN needs to implement a policy and procedure to ensure its contracted ASO, CommCare, is consistently applying review criteria for the authorizations of services.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Tobacco Use Cessation: Ask and Record	●	• PRSN has chosen a PIP that was carefully vetted by the quality improvement committee using a system that rated several areas of interest to improve the care and services of enrollees. Interventions chosen were based on research and root cause analysis.	• PRSN should continue this PIP; not enough time has elapsed to assess meaningful change.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Improving Identification of Intensive-Needs Children and Youth	●	• PRSN expanded its indicator in its second re-measurement period with the intention of yielding a larger number of high-risk, -cost and -needs children and youth for whom to provide intensive services and has shown statistically significant improvement.	• PRSN should continue its process of monitoring outcomes and refine aspects of the PIP as needed.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	⦿	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Peninsula Regional Support Network (PRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	●	**Review Tools**	●	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	99.15%	N/A	Hispanic Origin	99.15%	N/A
First Name	98.31%	N/A	Preferred Language	99.15%	N/A
Gender	99.15%	N/A	SSN	99.15%	N/A
Date of Birth	99.15%	N/A	Sexual Orientation	99.15%	N/A
Ethnicity	99.15%	N/A			
Encounter Data					
Procedure Code	59.09%	100.00%	Provider Agency	99.13%	100.00%
Date of Service	99.13%	100.00%	Provider Type	97.84%	97.20%
Service Location	99.13%	99.80%	Clinical Note Matches Procedure Note	57.36%	98.80%
Service Duration	96.75%	100.00%			

Strengths	Recommendations
	• PRSN needs to ensure that its contracted providers are trained on SERI and WAC encounter requirements. • PRSN needs to ensure that all encounters contain sufficient documentation of a service that can be encountered and match the code submitted.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Grievance Systems	1	1
Clinical PIP Evaluation	1	1
Non-clinical PIP Evaluation	1	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Southwest Behavioral Health (SWBH)

Southwest Washington Behavioral Health (SWBH) administers and coordinates public mental services in Clark and Skamania counties. Formed October 1, 2012, SWBH operates through an inter-local agreement between the two counties. The RSN does not provide any direct client services; however, it provides funding and oversight for direct client services and other assistance within available resources and three contracted provider agencies.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	●	Subcontractual Relationships	●
Coordination and Continuity of Care	◉	Practice Guidelines	●
Coverage/Authorization of Services	◉	Quality Assessment	◉
Provider Selection	●	Health Information Systems	●

Strengths	Recommendations
• SWBH utilizes TeleMed services to help meet the needs of the enrollee and to ensure there is adequate access to care. • SWBH has a robust process for monitoring the quality and appropriateness of care furnished to enrollees through quarterly and annual administrative and clinical audits, reviewing grievances and appeals and reviewing enrollee survey results.	• SWBH's monitoring of care coordination revealed challenges with follow-through with treatment plan goals as well as care coordination impacting continuity of care for enrollees. • SWBH needs to continue to provide training to the provider agencies, monitor for compliance and provide corrective actions if the lack of care coordination continues.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Improving Outcomes for Youth with Intensive Mental Health Needs	●	• The study topic was chosen due to the recognition of the of the intensive service needs of at risk children and youth and through the prioritization at the local and statewide level on improving outcomes for youth with acute behavioral needs who are at risk of or have experienced out of home placements.	• SWBH should consider changing the study question and intervention to include other means by which the RSN can measure the outcome of mental healthcare needs of its enrollees as the current means of collecting data is unavailable.

Non-Clinical PIP	Score	Strengths	Recommendations
Reduction of Psychiatric Readmissions for Adult Medicaid Beneficiaries	●	• This PIP, in its first year, focuses on evaluating the effectiveness of an intervention to reduce the percentage of adults readmitted to an impatient psychiatric facility within 30 days of their discharge. SWBH has fully met the first four standards of the PIP protocol.	• SWBH should continue this PIP to allow enough time to elapse to assess meaningful change.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	●	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Southwest Behavioral Health (SWBH)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	●	**Review Tools**	●	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	98.55%	N/A	Hispanic Origin	86.96%	N/A
First Name	98.55%	N/A	Preferred Language	97.10%	N/A
Gender	97.83%	N/A	SSN	97.83%	N/A
Date of Birth	98.55%	N/A	Sexual Orientation	87.61%	N/A
Ethnicity	90.58%	N/A			
Encounter Data					
Procedure Code	88.38%	87.88%	Provider Agency	90.21%	99.49%
Date of Service	90.89%	99.60%	Provider Type	89.29%	99.29%
Service Location	87.70%	98.23%	Clinical Note Matches Procedure Note	85.65%	80.27%
Service Duration	85.65%	98.23%			

Strengths	Recommendations
	• SWBH needs to ensure that its contracted providers are trained on SERI and WAC encounter requirements. • SWBH needs to ensure that all encounters contain sufficient documentation of a service that can be encountered and match the code submitted.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
SWBH had no previous-year corrective action plans.		

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Spokane County Regional Support Network (SCRSN)

SCRSN is a program of Spokane County Public Health and Social Services and administers public mental health funds for Spokane County and seven other counties in North Central Washington. SCRSN provides funding and oversight for direct client services and other assistance within available resources through 22 contracts with provider agencies. SCRSN has approximately 225,000 Medicaid beneficiaries enrolled in its service area.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	●	Subcontractual Relationships	●
Coordination and Continuity of Care	●	Practice Guidelines	⦿
Coverage/Authorization of Services	⦿	Quality Assessment	⦿
Provider Selection	●	Health Information Systems	●

Strengths	Recommendations
• SCRSN maintains an expansive program of compliance and quality monitoring based on data and sophisticated analytical and reporting methods and uses that capability to inform network development and quality initiatives, as well as to drive administrative decision making. • SCRSN has adopted person-centered care as a model of service delivery. The regional support network requires treatment plans are jointly developed with the enrollee and the provider. The treatment plan must incorporate cultural considerations and enrollee strengths. SCRSN actively monitors contractors for evidence of person-centered care planning.	• SCRSN does not have clear, consistent definitions for over-or-under-utilization nor does it have mechanisms in place to detect these phenomena. • SCRSN's current level of care system does not support an expected level of service intensity within each level of care. However, SCRSN is in the process of developing a new level of care system that will allow for the detection of under-utilization and over-utilization based on an expected range of service intensity within each level of care.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Evaluate the Outcome of Implementing Enhanced Care Management to Promote Stabilization and Recovery for Individuals Discharging from the Eastern State Hospital	●	•SCRSN has met all standards for this PIP. The PIP has shown statistical significance in its efforts to decrease in readmissions to Eastern State Hospital from baseline to the second re-measurement period.	• SCRSN should continue to pursue this PIP with the updated intervention.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Evaluate the Outcome of School-Based Mental Health Services As an Intervention to Optimize Access to Care for Mentally Ill Children and Adolescents in Targeted Rural Communities	●	• A task group was formed and a root cause analysis was conducted to select the intervention for this PIP. Key stakeholders, including providers and school administrators, endorsed the intervention chosen for the pilot program.	• An analysis regarding why such a large portion of youth did not return to services should be conducted.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	●	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Spokane County Regional Support Network (SCRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	◉	**Review Tools**	●	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	◉		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	100.00%	N/A	Hispanic Origin	51.33%	N/A
First Name	100.00%	N/A	Preferred Language	67.26%	N/A
Gender	96.46%	N/A	SSN	76.11%	N/A
Date of Birth	98.23%	N/A	Sexual Orientation	30.09%	N/A
Ethnicity	52.21%	N/A			
Encounter Data					
Procedure Code	85.68%	99.78%	Provider Agency	6.71%	99.94%
Date of Service	89.49%	100.00%	Provider Type	83.89%	99.45%
Service Location	84.79%	99.84%	Clinical Note Matches Procedure Note	83.45%	99.92%
Service Duration	79.87%	99.96%			

Strengths	Recommendations
	• SCRSN should utilize encounter data processed by the State rather than data maintained by the RSN when conducting EDV. • SCRSN needs to ensure that all required elements within the EDV deliverable to DBHR are included and adequately documented.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
SCRSN had no previous-year corrective action plans.		

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Thurston-Mason Regional Support Network (TMRSN)

Thurston-Mason Regional Support Network administers public mental health funds for Medicaid participants enrolled in managed care plans. The RSN does not provide any direct client services; however, it provides funding and oversight for direct client services and assistance within available resources, and contracts with provider agencies. In the Thurston-Mason counties region, there were 67,018 Medicaid beneficiaries in the 2014 fiscal year, and of those 6,901 were enrolled with the RSN.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	⦿	Subcontractual Relationships	⦿
Coordination and Continuity of Care	⦿	Practice Guidelines	⦿
Coverage/Authorization of Services	⦿	Quality Assessment	⦿
Provider Selection	●	Health Information Systems	⦿

Strengths	Recommendations
• TMRSN realized there was a significant issue with the level of care assignment for enrollees and determined they may not be receiving the correct level of services. The RSN began a formal performance improvement project and is now using the LOCUS and CALOCUS to help improve level of care assignments. • Out-of-network providers are held to the same credentialing standard as in-network providers, and TMRSN frequently uses providers from another RSN to avoid the use of single case agreements.	•TMRSN needs to consider implementing other options in order to acquire data more accurately and in a timelier manner from its provider agencies, including imposing monetary sanctions when the agencies do not respond appropriately to CAPs. • TMRSN needs to finalize and implement its new process for adopting diagnostic guidelines and base the guidelines on valid and reliable clinical evidence or on the consensus of its healthcare professionals, as well as on the needs of its enrollees.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Implementation of High-Fidelity Wraparound To Achieve Better Outcomes for Children and Youth	●	• TMRSN selected the SDQ Total Difficulties Scale as the indicator for this PIP because it is a valid and reliable metric for measuring emotional and behavioral function of the target population.	• TMRSN should continue this PIP with the incorporation of Child and Adolescent Needs and Strengths (CANS) data and enhance the study question, add new indicators and explain how the comparison of the CANS and SDQ data is appropriate.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Improving TMRSN Utilization Management of Core Outpatient Services	●	• This PIP is consistent with enrollee demographics. Nearly twice as many Medicaid enrolled adults as children received services in 2012. The largest provider of services in the RSN, the provider participating in the PIP, provides 95 percent of outpatient services for TMRSN's adults.	• TMRSN should work to improve the data transfer from the participating provider agency to ensure all data is captured.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	• TMRSN needs to work with its provider agencies to establish encryption practices in accordance with the DBHR contract requirements. • TMRSN needs to continue to actively monitor and intervene regarding its provider agencies' encounter data validation results.
Hardware Systems	●	
Information Security	⦿	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Thurston-Mason Regional Support Network (TMRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	●	**Review Tools**	●	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	98.56%	N/A	Hispanic Origin	92.09%	N/A
First Name	99.28%	N/A	Preferred Language	98.56%	N/A
Gender	99.28%	N/A	SSN	83.45%	N/A
Date of Birth	100.00%	N/A	Sexual Orientation	62.59%	N/A
Ethnicity	96.40%	N/A			
Encounter Data					
Procedure Code	47.69%	91.39%	Provider Agency	93.49%	96.69%
Date of Service	93.28%	96.25%	Provider Type	92.65%	94.92%
Service Location	92.23%	91.83%	Clinical Note Matches Procedure Note	46.85%	90.51%
Service Duration	91.39%	94.48%			

Strengths	Recommendations
	• TMRSN needs to ensure that its contracted providers are trained on SERI and WAC encounter requirements. • TMRSN needs to ensure that clinicians are documenting sufficient information to support a service that can be encountered and that the encounter matches the code submitted.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights	3	2
Grievance Systems	1	1

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Timberlands (TRSN)

Timberlands RSN administers public mental health funds for Medicaid participants enrolled in managed care plans in Lewis, Pacific and Wahkiakum counties. TRSN does not provide any direct client services; it provides financial and administrative oversight for the direct client services that are provided to enrollees through contracts with three community health agencies in the three-county area. TRSN's governing board sets policy and has oversight responsibilities.

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Availability of Services	●	Subcontractual Relationships	⦿
Coordination and Continuity of Care	⦿	Practice Guidelines	⦿
Coverage/Authorization of Services	⦿	Quality Assessment	⦿
Provider Selection	●	Health Information Systems	⦿

Strengths	Recommendations
• TRSN hosts, facilitates and participates in multiple monthly meetings that include a variety of ancillary service agencies, network provider agencies and special service agencies to provide discussion around care coordination and quality of care. • TRSN encourages allied system communication through request for information forms, exchange of records and shared treatment goals. Communication is documented during clinical record and service reviews.	• TRSN needs to continue its efforts to ensure services are provided to help the client attain the goals on their service plan and to ensure the link between the service/intervention provided and the goal/objective is clear. • TRSN needs to continue to work with its provider agencies to ensure the scoring on CA/LOCUS assessments are accurate and also to ensure there is sufficient documentation of the clinical reasoning in the clinical record for changing the level of care.

Performance Improvement Projects

Clinical PIP	Score	Strengths	Recommendations
Improving Identification and Clinical Outcomes for Children in Need of Intensive Home- and Community-Based Mental Health Services	●	• TRSN was able to identify barriers within the PIP. TRSN addressed these barriers and incorporated them into a monitoring and tracking plan.	• TRSN should continue with the second phase of the study.
Non-Clinical PIP	**Score**	**Strengths**	**Recommendations**
Improving Coordination of Care Outcomes for Individuals with Major or Severe Physical Health Co-Occurring Disorder	●	• TRSN has initiated a new PIP that specifically focuses on coordination of care for the subpopulation of enrollees who have comorbid major or severe physical health issues and mental health issues. This is a high-risk/high needs study population that fully fits the criteria for a PIP.	• TRSN should conduct a root cause analysis in order to better understand why the COC protocol is not being used as intended and what further interventions can be implemented to assist in improving.

Information Systems Capabilities Assessment (ISCA)

ISCA Section	Score	Recommendations
Information Systems	●	N/A
Hardware Systems	●	
Information Security	●	
Medical Devices Data	●	
Enrollment Data	●	
Practitioner Data	●	
Vendor Data	●	
Meaningful Use of EHR	N/A	

Timberlands Regional Support Network (TRSN)

Encounter Data Validation (EDV)					
EDV Standard	**Score**	**EDV Standard**	**Score**	**EDV Standard**	**Score**
Sampling Procedure	◉	**Review Tools**	●	**Methodology and Analytic Procedures**	●
Electronic Data Checks	●	**Onsite Clinical Record Review**	○		

Comparison of Qualis Health and RSN EDV Results					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	98.31%	N/A	Hispanic Origin	97.46%	N/A
First Name	98.31%	N/A	Preferred Language	98.31%	N/A
Gender	98.31%	N/A	SSN	95.76%	N/A
Date of Birth	98.31%	N/A	Sexual Orientation	92.37%	N/A
Ethnicity	97.46%	N/A			
Encounter Data					
Procedure Code	52.26%	99.03%	Provider Agency	88.02%	99.51%
Date of Service	88.02%	99.03%	Provider Type	88.02%	99.51%
Service Location	88.02%	95.15%	Clinical Note Matches Procedure Note	57.52%	81.07%
Service Duration	83.22%	98.50%			

Strengths	Recommendations
	• TRSN needs to ensure that its contracted providers are trained on SERI and WAC encounter requirements. • TRSN needs to ensure that clinicians are documenting sufficient information to support a service that can be encountered and that the encounter matches the code submitted.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights	1	1
Grievance Systems	1	1
Children's PIP Validation	2	2
Non-clinical PIP Validation	3	

Scoring Key: Fully Met ● Partially Met ◉ Not Met ○

Appendix C: Regulatory and Contractual Standards

The following is a list of the access, quality and timeliness elements cited in the Code of Federal Regulations (CFR) that MCOs and RSNs are required to meet. These standards, along with state contractual requirements specific to physical or mental healthcare, serve as the basis for the MCO and RSN compliance reviews. The numbers that follow each description denote the corresponding Apple Health Managed Care contract requirement.

438.206 Availability of Services

438.206(b)(1)(i-v) Delivery network, 6.1 and 6.3
438.207(b)(1)(2) Assurances of adequate capacity and services, 6.1 and 6.3
438.206(b)(2) Direct access to a women's health specialist, 10.8 and 12.4.12
438.206(b)(3) Provides for a second opinion, 15.1
438.206(b)(4) Services out of network, 6.1.2
438.206(b)(5) Out of network payment, 5.24.5.3

438.206(c) Furnishing of Services

438.206(c)(1)(i) through (vi) Timely access, 6.3 and 6.7
438.206(c)(2) Cultural considerations, 6.2

438.608 Program Integrity Requirements (Fraud and Abuse)

438.608(a)(b) Program integrity requirements, 12.4
455.104 Disclosure of ownership and control, 12.3
455.23 Provider Payment Suspension, 12.5

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- Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b) Excluded Individuals and Entities, 12.6
- Reporting, 12.7

447.46 Timely Claims Payment by MCOs

447.46 Timely claims payment, 9.11

Apple Health Contract
Coordination of benefits, 5.13.1

438.208 Primary Care and Coordination

438.208(b) Primary care and coordination of healthcare services

438.208(c) Additional Services for Enrollees with Special Healthcare Needs

438.208(c)(1) Identification, 13.2
438.208(c)(2) Assessment, 14.3
438.208(c)(3) Treatment plans, 14.3
438.208(c)(4) Direct access to specialists, 14.12

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- Continuity of Care, 14.1
- Transitional Care, 14.5
- Coordination between the contractor and external entities, 14.4
- Skilled nursing facility coordination, 14.6

- Coordination of care for children in foster care and the fostering well-being program, 14.7
- Care coordination with Regional Support Networks (RSNs), 14.8
- Health Home for individuals with special health care needs, 14.9
- Screening tools, 14.11

438.210 Coverage and Authorization of Services

438.210(b)(1)(2)(3) Authorization of services, 11.1 and 11.3
438.210(c) Notice of adverse action, 11.3.4.2.
438.210(d) Timeframe for decisions (1) (2), 11.3.5
438.210(e) Compensation for utilization management decisions, 11.1.9

438.114 Emergency and Post-stabilization Services

438.114 Emergency and post-stabilization services, (a)(b)(c)(d) and (e), 16.5.5 and 16.5.6

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- Outpatient mental health, 16.5.13
- Second opinion for children prescribed mental health medications, 16.5.14

438.226 Enrollment and Disenrollment

438.226 and 438.56(b)(1)-(3) Disenrollment requested by the MCO, PIHP, 4.11.6
438.56(d) Procedures for disenrollment, 4.6

438.100 Enrollee Rights

438.100(a) General rule, 10.1.1
438.10(b) Basic rule, 3.4.2
438.10(c)(3) Language-non-English, 3.4.2
438.10(c)(4) and (5) Language-oral interpretation, 3.4.1
438.10(d)(1)(i) Format, easily understood, 3.4.2
438.10(d)(1)(ii) and (2) Format, alternative formats, 3.4.1 and 3.4.2
438.10(f) (2-6) General information, 3.2 and 6.15.2
438.10(g) Specific information, 3.2.6.18
438.10(h) Basic rule
438.100(b)(2)(iii) Specific rights, 10.1.2
438.100(b)(2)(iv) and (v) Specific rights, 10.1.2
438.100(b)(3) Specific rights
438.100(d) Compliance with other federal and state laws, 2.5
438.106 Liability for payment, 2.13 and 10.5

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- Customer Service, Subsection 6.6

438.228 Grievance Systems

438.228 Grievance systems, 3.2.5.18.2, and 13.1.1
438.402(a) The grievance system, 1.2, 1.11, 1.12, 1.44, 1.45, 1.46 and 13.10.2
438.402(b)(1) Filing requirements – Authority to file, 13.3.1
438.402(b)(2) Filing requirements – Timing, 13.3.3
438.402(b)(3) Filing requirements – Procedures, 13.2.1 and 13.3.5
438.404(a) Notice of action – Language and format, 11.3.4.2.1
438.404(b) Notice of action – Content of notice, 11.3.4.2
438.404(c) Notice of action – Timing of notice, 11.3.5 and 13.3.9
438.406(a) Handling of grievances and appeals – General requirements, 13.1.2 and 13.1.5
438.406(b) Handling of grievances and appeals – Special requirements for appeals, 13.1.3 and 13.3.7

438.408(a) Resolution and notification: Grievances and appeals – Basic rule, 11.3 and 11.4.1
438.408(b) and (c) Resolution and notification: Grievances and appeals – specific timeframes and extension of timeframes, 13.2.7 and 13.3.9
438.408(d) and (e) Resolution and notification: Grievances and appeals – Format of notice and content of notice of appeal resolution, 13.2.9 and 13.3.10
438.410 Expedited resolution of appeals, 13.4.3
438.414 Information about the grievance system to providers and subcontractors, 9.4.12
438.416 Recordkeeping and reporting requirements, 13.10
438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending, 9.4.12.3, 13.5.2.2 and 13.8
438.424 Effectuation of reversed appeal resolutions, 13.9

438.240 Performance Improvement Projects (PIP)

438.240(b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs, and 438.240(d) Performance improvement projects., 7.2
438.240(e)(1)(ii) MCO conducted and documented results for each required PIP, 7.2 – 7.2.4

438.236 Practice Guidelines

438.236(a)(b) Adoption of practice guidelines, 7.8.1
438.236(c) Dissemination of practice guidelines, 7.8.1.5 and 7.8.1.7
438.236(d) Application of practice guidelines, 7.8.1.6

438.214 Provider Selection (Credentialing)

438.214(a) General Rules and 438.214(b) Credentialing and re-credentialing requirements, 9.13
438.214(c) Nondiscrimination & provider discrimination prohibited, 9.3
438.214(d) Excluded providers, 9.13.2
438.214(e) Provider selection-State requirements, 9.13.2.5, 9.13.13, and 9.13.17

438.240 Quality Assessment and Performance Improvement Program

438.240(a)(1) Quality assessment and performance improvement program – General rules, 7.1.1.2.1
438.240(b)(2) and (c), and 438.204(c) Performance measurement, 7.3.4
438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and underutilization of services, 7.1.1.2.4.3
438.240(b)(4) Basic elements of MCO and PIHP quality assessment and performance improvement – assess care furnished to enrollees with special health care needs, 14.10.1
438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement – evaluating the program, 7.1.1.2.4 and 7.3.9

438.230 Sub-contractual Relationships and Delegation

438.230(a) General rule (b) Specific conditions (1) evaluation of subcontractor prior to delegation, 9.1, 9.5, and 8.6
438.230 (b)(2) Written agreement with subcontractors, 9.5 and 9.6
438.230 (b)(3) Monitoring of performance of subcontractors, 8.6.1.3
438.230 (b)(4) Corrective action of subcontractors, 8.6.1.3 and 8.6.1.4

Apple Health Contract – Health Homes

- Provide Information, Exhibit C
- Health Home Services, Exhibit C 1.28
- Health Action Plan, Exhibit C, 3
- Monthly Reports, Exhibit C, 3.14.1

Appendix D: PIP Review Procedures

Qualis Health PIP Review Procedure

Qualis Health evaluates the RSNs' PIPs to determine whether they are designed, conducted and reported in a methodologically sound manner. The PIPs must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The review process by which Qualis Health evaluates the RSNs' PIPs, based on the current EQR CMS protocol, as well as the scoring method, are outlined below.

Part A: Evaluating the Study Methodology

Step 1: Review the Selected Study Topic(s)

1.1) Was the topic selected through data collection and analysis of comprehensive aspects of specific RSN enrollee needs, care and services?
1.2) Is the PIP consistent with the demographics and epidemiology of the enrollees?
1.3) Did the PIP consider input from enrollees with special health needs?
1.4) Does the PIP address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?

Step 2: Review the Study Question(s)

2.1) Is/Are the study question(s) measurable and stated clearly in writing?

Step 3: Review the Identified Study Populations

3.1) Were the enrollees to whom the study question and indicators are relevant clearly defined?
3.2) If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?

Step 4: Review Selected Study Indicator(s)

4.1) Does the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?
4.2) Did the indicators track performance over a specified period of time?
4.3) Is the number of indicators adequate to answer the study question, appropriate for the level of complexity of applicable medical practice guidelines, and appropriate to the availability of and resources to collect necessary data?

Step 5: Review Sampling Methods

5.1) Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
5.2) Were valid sampling techniques employed that protected against bias?
5.3) Did the sample contain a sufficient number of enrollees?

Step 6: Review Data Collection Procedures

6.1) Did the study design clearly specify the data to be collected?
6.2) Did the study design clearly specify the sources of data?
6.3) Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?

6.4) Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?
6.5) Did the study design prospectively specify a data analysis plan?
6.6) Were qualified staff and personnel used to collect the data?

Step 7: Review Data Analysis and Interpretation of Study Results
7.1) Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes?
7.2) Are the interventions sufficient to be expected to improve processes or outcomes?
7.3) Are the interventions culturally and linguistically appropriate?

Step 8: Assess Improvement Strategies
8.1) Was an analysis of the findings performed according to the data analysis plan?
8.2) Were numerical PIP results and findings accurately and clearly presented?
8.3) Did the analysis identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?
8.4) Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?

Step 9: Assess Whether Improvement is "Real" Improvement
9.1) Was the same methodology as the baseline measurement used when measurement was repeated?
9.2) Was there any documented, quantitative improvement in processes or outcomes of care?
9.3) Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?
9.4) Is there any statistical evidence that any observed performance improvement is true improvement?

Step 10: Assess Sustained Improvement
10.1) Was sustained improvement demonstrated through repeated measurements over comparable time periods?

Part B: Evaluate Overall Validity and Reliability of Study Results

Indicate one of the following regarding the results of the RSN's PIP:

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

PIP Scoring

Qualis Health assigns a score of Met or Not Met to each element that is applicable to the PIP being evaluated. Elements may be Not Applicable if the PIP is at an early stage of design or implementation. If a PIP has advanced only to the first measurement of the study indicator (baseline), elements 1–6 are reviewed. If a PIP has advanced to the first re-measurement, elements 1–9 are reviewed. Elements 1–10 are reviewed for PIPs that have advanced to repeated re-measurement.

If all reviewed elements are assigned a score of Met, the overall score is Met. If any reviewed element is assigned a score of Not Met the overall score is Not Met.

Appendix E: Acronyms

AHAC	Apple Health Adult Coverage
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian/Alaska Native
ALOS	Average Length of Stay
AMG	Amerigroup Washington, Inc.
BBA	Balanced Budget Act of 1997
BC/DR	Business Continuity and Disaster Recovery
BHO	Behavioral Health Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CALOCUS	Child and Adolescent Level of Care Utilization System
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
CCC	Coordinated Care Corporation
CDRSN	Chelan-Douglas Regional Support Network
CHIP	Children's Health Insurance Program
CHP	Community Health Plan of Washington
CFR	Code of Federal Regulations
CFT	Child and Family Team
CIS	Consumer Information System
CMHA	Community Mental Health Agency
CMS	Centers for Medicare & Medicaid Services
COC	Coordination of Care
CPT	Current Procedural Terminology
DBHR	Division of Behavioral Health and Recovery
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment
ED	Emergency Department
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
GHRSN	Grays Harbor Regional Support Network
GCBH	Greater Columbia Behavioral Health
HCA	Health Care Authority
HCPCS	Healthcare Common Procedural Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act
HO	Healthy Options
HOBD	Healthy Options Blind and Disabled
HOFC	Healthy Options Foster Care
IHI	Institute for Healthcare Improvement
ISCA	Information System Capability Assessment
KCRSN	King County Regional Support Network
LEIE	List of Excluded Individuals and Entities
LOC	Level of Care

LOCUS	Level of Care Utilization System
MCO	Managed Care Organization
MHSIP	Mental Health Statistics Improvement Program
MHW	Molina Healthcare of Washington
MMIS	Medicaid Management Information System
MOSES	Monitoring of Side Effects Scale
MSO	Management Services Organization
MY	Measurement Year
NSMHA	North Sound Mental Health Administration
NCQA	National Committee for Quality Assurance
OPRSN	Optum Pierce Regional Support Network
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider
PDSA	Plan, Do, Study, Act
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PRISM	Predictive Risk Intelligence System
PRSN	Peninsula Regional Support Network
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QM	Quality Management
QUIC	Quality Improvement Committee
RY	Reporting Year
RSN	Regional Support Network
SAM	System for Award Management
SCRSN	Spokane County Regional Support Network
SDQ	Strengths and Total Difficulties Questionnaire
SERI	Service Encounter Reporting Instructions
SSA	Social Security Act
SWBH	Southwest Behavioral Health
TEP	Technical Expert Panel
TMRSN	Thurston-Mason Regional Support Network
TRSN	Timberlands Regional Support Network
TSP	Transitional Support Program
UHC	United Healthcare Community Plan
UM	Utilization Management
WAC	Washington Administrative Code
WISe	Wraparound with Intensive Services
WMIP	Washington Medicaid Integration Partnership