2012 External Quality Review Annual Report

Washington State Healthy Options

Children's Health Insurance Program

Division of Behavioral Health and Recovery

Washington Medicaid Integration Partnership

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Acronyms Used in This Report

ADSA	Aging and Disability Services Administration
ALOS	average length of stay
AMM	antidepressant medication management
BBA	Balanced Budget Act of 1997
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DBHR	Division of Behavioral Health and Recovery
DOH	Department of Health
DRP	disaster recovery plan
DSHS	Department of Social & Health Services
E&T	evaluation and treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	emergency room
FFS	fee for service
HCA	Health Care Authority
HEDIS®	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act of 1996
ISCA	Information Systems Capabilities Assessment
MCO	managed care organization
MHSIP	Mental Health Statistical Improvement Project
NCQA	National Committee for Quality Assurance
PACT	Program of Assertive Community Treatment
PCP	primary care provider
PIP	performance improvement project
QA/PI	quality assurance and performance improvement
QI	quality improvement
QM	quality management
QRT	Quality Review Team
RSN	regional support network
SHCN	special healthcare needs
UM	utilization management
WCC	well-child care
WMIP	Washington Medicaid Integration Partnership

Acronyms for individual RSNs and MCOs are listed on pages 18 and 70, respectively.

EXECUTIVE SUMMARY

Federal law requires each state to implement a strategy for assessing and improving the quality of health care delivered to Medicaid enrollees through managed care. The state must provide for an annual, independent external quality review (EQR) of enrollees' access to services and of the quality and timeliness of those services. Acumentra Health produced this annual report on behalf of the Washington Department of Social & Health Services (DSHS) and the Health Care Authority (HCA).

This report builds on the findings of previous annual reports since 2005. Reports from 2005 to 2007 focused on physical health services delivered through the Healthy Options managed care organizations (MCOs). Reports since 2008 have incorporated a review of mental health services provided through the state's regional support networks (RSNs).

Currently, HCA oversees the MCO contracts and monitoring functions, and the Division of Behavioral Health and Recovery (DBHR), within the Aging and Disability Services Administration (ADSA), oversees the RSNs.

Note: This report presents performance results for the 7 MCOs and 13 RSNs that were contracted to provide services during 2011. As of July 1, 2012, HCA began contracting with five MCOs (two previous contractors and three new contractors) to serve Healthy Options, Basic Health, and many blind and disabled enrollees. Future annual reports will present results for the new roster of MCOs. As of October 1, the number of RSNs fell from 13 to 11, following consolidations requested by the participating counties.

This report also presents quality measurements for the Washington Medicaid Integration Partnership (WMIP), a pilot program overseen by HCA for enrollees in Snohomish County who are eligible for both Medicaid and Medicare.

To evaluate the services delivered to Medicaid enrollees, Acumentra Health analyzed data related to a variety of performance indicators and compliance criteria. This analysis reflects MCO and RSN performance in contract year 2011.

State-level strengths

- The average rate of emergency room (ER) visits by Washington MCO enrollees fell significantly for the second straight year. ER utilization remains significantly below the U.S. Medicaid average.
- On average, the MCOs reported that their enrollees with diabetes had significantly better control of their blood pressure than did Medicaid enrollees nationally. The MCOs also significantly improved the rate of delivering well-child care (WCC) visits for infants and adolescents.
- TEAMonitor's 2012 review of the 2011 contract found that the MCOs, as a group, improved their compliance with regulatory and contractual standards related to the quality, accessibility, and timeliness of care.
- In recent years, the WMIP program has demonstrated steady improvement in measures of outpatient follow-up care after hospitalization for mental illness, antidepressant medication management, and management of high-risk medications for elderly enrollees.
- DBHR has made significant progress in improving compliance with federal Medicaid regulations. In response to previous EQR recommendations, DBHR has modified the RSN contract, offered training for the RSNs in areas identified as needing improvement, and clarified or expanded information in the Medicaid benefits booklet and the state website.
- Acumentra Health's 2012 compliance review found that the RSNs, as a group, met or substantially met all regulatory and contractual standards.

- The RSNs continue to work closely with their provider agencies to improve mental health care for enrollees. The RSNs showed marked improvement in this year's review of compliance with quality assurance/performance improvement (QA/PI) standards.
- To improve access and availability, several RSNs' provider agencies made significant changes, such as requiring same-day access, open access, double booking, and expanded hours to include Saturdays and evening hours.
- All RSNs recognize the need to meet the needs of diverse enrollees. Several RSNs have put into place cultural competency committees to address issues related to diversity, staff training, and language barriers.
- The RSNs assess the quality and appropriateness of care for enrollees by performing monthly and yearly chart audits, analyzing data from multiple sources, and reviewing enrollee input from forums, surveys, grievances, and appeals.
- Seven RSNs started new performance improvement projects (PIPs), and most presented strong reports on project plans.

Recommendations

The following recommendations are intended to help HCA, DBHR, and the health plans continue to strengthen the foundation for excellence in Medicaid managed care, comply with federal standards, improve the quality of care, and use resources as efficiently as possible.

Mental health care delivered by RSNs

Program evaluation. Annual internal evaluation of the RSN's QA/PI program can help identify needed improvements as well as achievements in care delivery. Although the RSNs collect and analyze data on many quality indicators, the majority of RSNs do not conduct formal year-end evaluations of their QA/PI programs. Such evaluations can provide a valuable resource by synthesizing the information the RSN collects during its contractually required review of network providers, including results of agency audits and subcontract monitoring, consumer grievances, and service verification. Evaluations should also summarize QI activities, metrics describing how the RSN reached its performance goals, barriers and achievements, and ongoing improvement needs.

- ***DBHR needs to ensure that all RSNs complete end-of-year evaluations that synthesize the results of QA/PI activities defined in the RSN contract.***

Policy review. Although a few RSNs review and update their policies and procedures as often as yearly, many RSNs have not conducted such review in years. To ensure that their policies and procedures reflect current practices and regulatory and contractual requirements, the RSNs should establish schedules for frequent review and updating of policies and procedures.

- ***DBHR needs to work with the RSNs to ensure that all policies and procedures are reviewed and updated regularly.***

Program integrity. All RSNs have procedures in place to ensure that they do not to hire or contract with individuals and organizations that are excluded from participating in federal healthcare programs. However, many RSNs do not require that all RSN staff, board members, committee members, and volunteers be screened for federal exclusion. Also, many RSNs perform screening for exclusion only yearly.

- ***DBHR should ensure that the RSNs screen for federal exclusion all staff, board members, committee members, and volunteers, and that the RSNs screen more often than yearly.***

RSNs need to ensure that all program integrity issues are tracked, reviewed, investigated, and resolved timely and with as little bias as possible. Many RSNs do not have separate compliance

committees but assign program integrity issues to the QA/PI committee. Many of the committees meet only on an ad-hoc basis when an issue of fraud, waste, or abuse is under investigation, usually in connection with encounter data.

- ***DBHR needs to ensure that each RSN has an independent compliance committee that meets regularly. The committee's overview should include fraud, waste, and abuse not only associated with encounter data but also related to internal financial practices, HIPAA, and other areas of risk that might have a negative impact on the RSN, providers, and enrollees. All issues need to be tracked, reviewed, investigated and resolved in a timely manner.***

Many compliance officers at the RSNs and provider offices lack formal or adequate training on compliance and program integrity.

- ***DBHR needs to confirm that the RSNs' and contracted providers' compliance officers have the necessary training to effectively maintain program integrity.***

PIP topics. Documentation for PIPs that were in their fourth or fifth year did not thoroughly demonstrate the reasons why the RSNs changed their interventions, and did not present clear measurements or interpretations of results. None demonstrated improvement in the measure being studied. CMS recommends that PIPs address a broad selection of topics over time.

- ***DBHR needs to establish a recommended period during which a PIP should be completed.***

Validating encounter data. The 2012 encounter data validation (EDV) activity revealed that many RSNs used manual processes to collect, analyze, and record EDV data. Such processes introduce the potential for error in calculating EDV results. An electronic database system could support automatic calculation of EDV results and could improve the efficiency and reliability of data collection and management.

- ***DBHR should work with the RSNs to standardize data collection and analytical procedures for encounter data validation to improve the reliability of encounter data submitted to the state.***

Physical health care delivered by MCOs

Some recommendations presented in previous annual reports continue to apply. The following recommendations apply to the newly contracted MCOs as well as to the ongoing MCOs under contract before mid-2012.

Care coordination. MCOs have strengthened their compliance with care coordination standards over time. However, improving care coordination and continuity across medical and mental health programs will require coordinated efforts between HCA and DBHR—especially since in July 2012, Medicaid recipients with complex medical and behavior needs were moved into managed care.

- ***HCA and DBHR should explore strategies to ensure that all eligible providers and managed care partners have access to the Predictive Risk Intelligence System (PRISM), which provides current Medicaid utilization data to help facilitate appropriate levels of treatment and coordination.***

PIP interventions. TEAMonitor's PIP reviews found that MCOs often failed to provide analysis of the effect of their interventions on subsequent performance. The reviews also cited concerns about passive interventions and the need for new or "refreshed" interventions.

- ***HCA should examine the MCOs' levels of expertise and performance gaps to help determine the level of technical assistance needed to facilitate a successful PIP.***

Data completeness. In 2012, the MCOs as a group reported race and ethnicity as "unknown" for nearly half of all enrollees. A primary reason for gaps in reporting these data is underreporting

at the state level, as these self-reported data are optional when new clients enroll in Medicaid.

- ***HCA should continue to work with state policy analysts to determine the best approach to collect reliable race and ethnicity data for Medicaid enrollees.***
- ***MCOs should continue to explore new data sources to augment the state-supplied race/ethnicity data.***

Performance measure feedback to clinics. Clinical performance reports for providers can identify Medicaid enrollees who do not have claims in the system but who need services—i.e., those without access to care.

- ***To help facilitate targeted interventions, HCA should require the MCOs to provide performance measure feedback to clinics and providers regularly and often.***

Quality-of-care studies. Acumentra Health's special study of asthma care revealed high rates of hospital and emergency room utilization by managed care enrollees with persistent asthma.

- ***Contracted MCOs should implement asthma health management strategies for their enrollees. Successful strategies might involve identifying members with asthma, targeting interventions based on severity of illness, and promoting effective communication and care coordination among providers.***

Acumentra Health's study of antidepressant medication management (AMM) revealed that Washington Medicaid enrollees who were newly diagnosed with major depression completed effective treatment at rates somewhat below the national average rates.

- ***HCA should study the reasons for disparate rates of treatment completion among enrollees in different demographic groups. HCA could then work with MCOs to design interventions aimed at improving AMM rates, possibly including provider incentives for outcomes related to medication management.***

Washington Medicaid Integration Partnership

Washington has established the goal of integrating primary care, mental health, chemical dependency, and long-term care services. As a fully integrated program, the WMIP can provide valuable lessons in integration to accelerate the state's progress toward that goal.

TEAMonitor's review of WMIP has identified deficiencies surrounding timely and complete initial intake screenings and in comprehensive assessment of high-risk enrollees. The following recommendation still applies.

- ***Molina Healthcare of Washington, the WMIP program contractor, should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.***

In addition, Acumentra Health recommends that the WMIP program

- ***ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and up-to-date to meet standards for continuity and coordination of care***
- ***explore ways to increase enrollees' ongoing engagement in alcohol and drug dependence treatment, since a high percentage of WMIP enrollees receive those services***

INTRODUCTION

Washington's Medicaid program provides medical benefits for more than 1.2 million low-income residents, about 700,000 of whom are enrolled in managed care. More than 1.2 million Washingtonians are enrolled in managed mental health services, and about 4,800 beneficiaries are enrolled in the WMIP.

State agencies administer services for these enrollees through contracts with medical MCOs and mental health RSNs. The MCOs and RSNs, in turn, contract with healthcare practitioners to deliver clinical services. HCA oversees the MCO contracts and monitoring functions, and DBHR oversees RSN contracts and monitoring.

In the face of severe budget pressures, the state remains committed to integrating primary care and mental health/substance abuse services by incorporating primary care capacity into behavioral health specialty settings and behavioral health into primary care settings.

EQR requirements

The federal Balanced Budget Act (BBA) of 1997 requires that every state Medicaid agency that contracts with managed care plans must evaluate and report on specific EQR activities. Acumentra Health, as the external quality review organization (EQRO) for HCA and DBHR, presents this report to fulfill the federal EQR requirements. The report evaluates access to care for Medicaid enrollees, the timeliness and quality of care delivered by health plans and their providers, and the extent to which each health plan addressed the previous year's EQR recommendations.

This report contains information collected from MCOs and RSNs through mandatory activities based on protocols of the Centers for Medicare & Medicaid Services (CMS):

- **compliance monitoring**—site reviews of the health plans to determine whether they meet regulatory and contractual standards governing managed care
- **validation of performance improvement projects (PIPs)** to determine whether the health plans meet standards for conducting these required studies
- **validation of performance measures** reported by health plans or calculated by the state, including:
  - Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures of clinical services provided by MCOs
  - statewide performance measures used to monitor the delivery of mental health services by RSNs, including an Information Systems Capabilities Assessment (ISCA) for each RSN

For the MCOs, HCA monitors compliance and validates PIPs through TEAMonitor, a state interagency team responsible for reviewing managed physical health care. For the RSNs, Acumentra Health monitors compliance, validates PIPs and statewide performance measures, and conducts the ISCA.

Acumentra Health gathered and synthesized results from these activities to develop an overall picture of the quality of care received by Washington Medicaid enrollees. Where possible, results at the state level and for each health plan are compared with national data. The analysis assesses each health plan's strengths and opportunities for improvement and suggests ways that the state can help the plans improve the quality of their services.

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

Washington's Medicaid managed care programs

Medicaid eligibility is based on federal poverty guidelines issued annually by the U.S. Department of Health and Human Services. Historically, Washington has chosen to fund its Medicaid program above the federal minimum standard to cover additional low-income residents. Washington Medicaid (Title XIX) coverage for children extends to 200% of the Federal Poverty Level (FPL), or $46,100 annually for a family of four. Washington CHIP (Title XXI) coverage extends to 300% of the FPL, or $69,150 annually for a family of four. Under CHIP, families must pay a small premium for coverage.

The state's Healthy Options program provides comprehensive medical benefits for low-income families, children younger than 19, and pregnant women who meet income requirements. Managed care programs also include Basic Health Plus, providing reduced-cost coverage to qualified residents, and CHIP, covering families who earn too much money to qualify for Medicaid, yet cannot afford private insurance.

Currently, Washington provides medical care for about 700,000 Medicaid enrollees in managed care. More than 80% of Healthy Options enrollees are younger than 19 years old. The state also pays for physical health services for more than 500,000 Medicaid fee-for-service (FFS) recipients—primarily aged, blind, disabled, and children in foster care. More than 1.2 million Washingtonians are enrolled in managed mental health care, delivered through the RSNs.

Washington Medicaid Integration Partnership (WMIP)

This Medicaid project, aimed at improving care for adult residents of Snohomish County who have complex health care needs, began in January 2005. WMIP seeks to coordinate Medicaid-funded medical, mental health, substance abuse, and long-term care within a patient-centered framework. Molina Healthcare of Washington (MHW) coordinates services for WMIP enrollees. As of December 2011, about 4,800 beneficiaries were enrolled in WMIP.

State quality improvement activities

HCA and DBHR conduct and oversee a suite of mandatory and optional QI activities related to Medicaid managed care, as described below.

Managed Care Quality Strategy

HCA's Managed Care Quality Strategy incorporates elements of the managed care contract, state and federal regulations, and CMS protocols related to assessing and improving the quality of services for Medicaid enrollees. Acumentra Health evaluated the quality strategy in August 2005 and found that it complied with the majority of BBA standards regarding managed care. DBHR's Quality Strategy, last updated in April 2007, incorporates QA/PI activities and expectations for the RSNs.

HCA and DBHR are jointly drafting a discussion document to guide the integration of managed physical and behavioral health care.

Performance improvement projects

Under federal regulations, a managed care entity that serves Medicaid enrollees must have an ongoing program of PIPs that focus on improving clinical care and nonclinical aspects of service delivery. The PIPs enable the organization to assess and improve the processes and outcomes of care. PIPs are validated each year as part of the EQR to ensure that the projects are designed, conducted, and reported according to accepted methods, to establish confidence in the reported improvements. The PIPs must include:

- measurement of performance using objective quality indicators
- implementation of system interventions to improve quality
- evaluation of the interventions
- planning and initiation of activities to increase or sustain improvement

The current MCO contract requires each MCO to conduct at least one clinical and one nonclinical PIP. An MCO must conduct a PIP to improve immunization and/or WCC rates if the MCO's rates fall below established benchmarks. The TEAMonitor reviews validate the PIPs' compliance with CMS standards.

For the WMIP program, MHW reported three new PIPs in 2012, targeting reductions in hospital readmissions and emergency room visits, and improvements in screening of new high-risk WMIP enrollees.

Each RSN must conduct one clinical and one nonclinical PIP annually. Acumentra Health validates the PIPs using a review protocol adapted from the CMS protocol.

Performance measurement

Each managed care plan that serves Medicaid enrollees must submit performance measurement data to the state annually. The health plan may measure and report its own performance using standard measures specified by the state, or may submit data that enable the state to measure the plan's performance. The EQRO validates the measures annually through methods specified by CMS or the National Committee for Quality Assurance (NCQA).

Physical health performance measures

The MCO contract incorporates the NCQA accreditation standards related to quality management and improvement, utilization management, and enrollee rights/responsibilities. Specific contract provisions apply to the performance measures described below.

HEDIS®: Since 1998, HCA has required the MCOs to report their performance on HEDIS measures of clinical quality. Valid and reliable, the HEDIS measures allow comparison of the Washington MCOs' performance with national averages for the Medicaid population.

For reporting year 2012, HCA required each MCO to report HEDIS measures of:

- childhood immunization status
- comprehensive diabetes care
- postpartum care
- WCC visits for infants, children, and adolescents
- utilization of inpatient and ambulatory care
- frequency of selected procedures (myringotomy/adenoidectomy, hysterectomy, mastectomy, lumpectomy)
- race/ethnicity diversity of MCO membership

MHW reported 10 HEDIS measures for the WMIP population:

- comprehensive diabetes care
- inpatient care utilization—general hospital/acute care
- ambulatory care utilization
- anti-depression medication management
- follow-up after hospitalization for mental illness
- use of high-risk medications for the elderly
- race and ethnicity of WMIP enrollees
- mental health utilization (new)
- identification of alcohol and other drug services (new)
- initiation and engagement of alcohol and other drug dependence treatment (new)

To ensure data integrity, NCQA requires certification of each health plan's data collection process by a certified HEDIS auditor. HCA funded the 2012 HEDIS audit for the MCOs to fulfill the federal requirement for validation of performance measures. For the WMIP program, MHW underwent a certified HEDIS audit that incorporated the CMS ISCA tool.

CAHPS®: Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, developed by the Agency for Healthcare Research and Quality, are designed to measure patients' experiences with the health care system.

In 2012, the CAHPS survey collected responses from a statewide sample of CHIP enrollees, rather than from a sample of each MCO's enrollees. Results of the 2012 survey were compared with 2010 results and provided to HCA.

Mental health performance measures

Each RSN is required by contract to demonstrate improvement on a set of performance measures calculated and reviewed by the state. If the RSN does not meet defined improvement targets on any measure, the RSN must submit a performance improvement plan. For 2011–2013, two core performance measures are in effect: (1) ensuring that consumers receive routine outpatient service within seven days of discharge from an inpatient setting, and (2) ensuring the accuracy of encounter data submitted to DBHR.

In 2012, Acumentra Health reviewed each RSN's response to findings and recommendations of the full ISCA performed in 2011. The goal was to determine the extent to which the RSN's information technology systems supported the production of valid and reliable state performance measures and the capacity to manage the health care of RSN enrollees.

Compliance monitoring

HCA participates in TEAMonitor with ADSA and the Department of Health (DOH) in overseeing the MCO contracts. TEAMonitor conducts an annual onsite review of each MCO's compliance with federal and state regulations and contract provisions. An MCO that does not meet standards must submit a corrective action plan. TEAMonitor evaluates the MCOs' compliance with about 80 required elements of access, timeliness, and quality of care.

Acumentra Health monitors the RSNs' compliance with regulations and contract provisions during annual site visits, using review methods adapted from the CMS protocol. In 2012, Acumentra Health reviewed each RSN's compliance with managed care standards in eight categories, and reviewed the RSNs' response to the specific 2011 EQR findings for which DBHR required the RSN to perform corrective action.

Value-based purchasing

Washington was among the first states to incorporate value-based purchasing into its managed care contract. Beginning in 2005, HCA provided incentive payments for improvement in WCC and childhood immunization rates, setting aside $1 million per year for each measure. The incentive system rewarded MCOs on the basis of their performance on HEDIS measures. However, because of budget constraints, the state legislature defunded the incentive program. HCA added a quality adjustor in the MCO contract effective July 1, 2012.

Quality oversight

DBHR's External Quality Review Oversight Committee (representing DBHR and Information Systems) reviews the EQR results for RSNs, recommends actions, and follows up on mental health program issues. Since 2008, MCOs and RSNs from across the state have convened regularly to share and discuss EQR results related to quality management.

EQR activities

Table 1 summarizes the mandatory and optional EQR activities and shows which tasks addressed those activities.

Table 1. Required and optional Medicaid managed care EQR activities.		
Activity	**How addressed for MCOs**	**How addressed for RSNs**
Required		
Validation of PIPs	TEAMonitor audits	EQRO onsite reviews
Validation of performance measures	HEDIS audit	Performance measure validation and ISCA by EQRO
Health plan compliance with regulatory and contractual standards	TEAMonitor audits	EQRO onsite reviews
Optional		
Administration or validation of consumer or provider surveys of quality of care	CAHPS survey by EQRO	MHSIP survey

METHODS

In aggregating and analyzing the data for this report, Acumentra Health drew on elements from the following reports based on specific EQR activities:

- 2012 HEDIS report of MCO performance in key clinical areas[1]
- 2012 TEAMonitor reports on MCOs' compliance with BBA regulations and state contractual requirements
- Acumentra Health reports on individual RSNs' regulatory and contractual compliance, PIP validation, and ISCA follow-up, submitted throughout 2011

Each source report presents details on the methodology used to generate data for the report.

BBA regulations require the EQRO to describe how conclusions were drawn about access to care and about the timeliness and quality of care furnished by managed care plans. However, no standard definitions or measurement methods exist for these concepts. Acumentra Health used contract language, definitions of reliable and valid quality measures, and research literature to guide the analytical approach.

The following definitions are derived from established theory and from previous research.

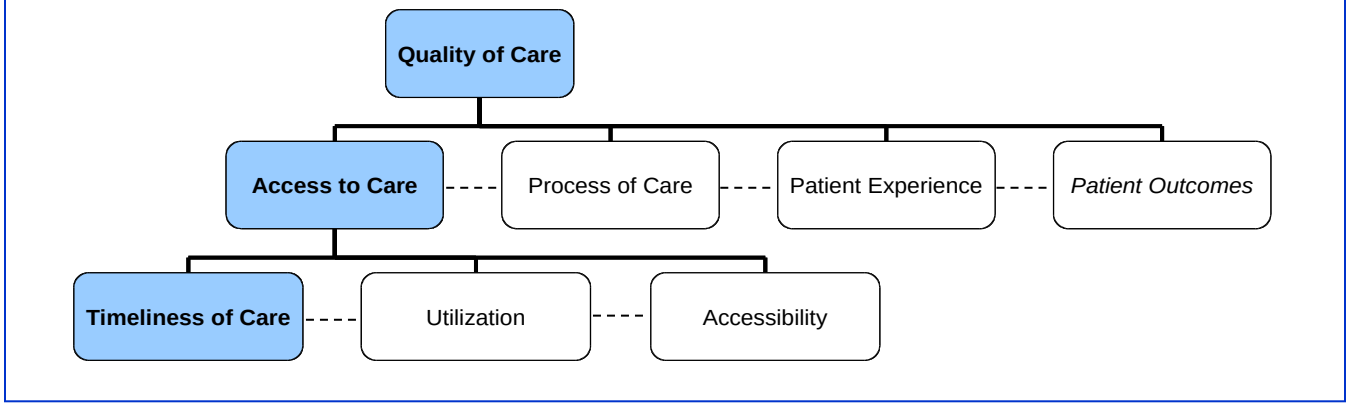
Quality of care encompasses access and timeliness as well as the *process* of care delivery (e.g., using evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as patients' adherence to treatment. Therefore, this assessment excludes measures of patient outcomes.

Access to care is the process of obtaining needed health care; thus, measures of access address the patient's experience *before* care is delivered. 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.[2,3,4] Access to care affects a patient's experience as well as outcomes.

Timeliness, a subset of access, refers to the time frame in which a person obtains needed care. Timeliness of care can affect utilization, including both appropriate care and over- or underutilization of services. The cost of care is lower for enrollees and health plans when diseases are prevented or identified early. The earlier an enrollee sees a medical professional, the sooner he or she can receive necessary health care services. Postponing needed care may result in increased hospitalization and emergency room utilization.[5]

Figure 1 illustrates the relationship of these components for quality assessment purposes.

Figure 1. Components in measuring the quality of heath care.



Certain performance measures lend themselves directly to the analysis of quality, access, and timeliness. For example, in analyzing physical health care, Acumentra Health used NCQA reporting measures and categories (HEDIS data) to define each component of care. In addition, the degree of a health plan's compliance with certain regulatory and contractual standards can indicate how well the plan has met its obligations with regard to those care components.

The following review sections for mental health and physical health discuss the separate data elements analyzed to draw overall conclusions about quality, access, and timeliness.

Mental Health Care Delivered by RSNs

During 2012, DBHR contracted with 13 RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs, in turn, contracted with provider groups, including community mental health agencies and private nonprofit agencies and hospitals, to deliver treatment services. RSNs are responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory standards for effective care.

Each RSN is required to contract with an independent Ombuds service to advocate for enrollees by informing them about their rights and helping them resolve complaints and grievances. A Quality Review Team (QRT) for each RSN represents mental health consumers and their family members. The QRT may monitor enrollee satisfaction with services and may work with enrollees, service providers, the RSN, and DBHR to improve services and resolve problems. Many RSNs also contract with third-party administrators for utilization management services, including initial service authorization.

Table 2 shows the approximate number of enrollees assigned to each RSN and the RSN's percentage of statewide enrollment during calendar year 2011.

NOTE: On October 1, 2012, the number of RSNs fell from 13 to 11, following consolidations requested by the participating counties.

- NCWRSN consolidated with SCRSN to form a multi-county RSN, designated as SCRSN.
- CCRSN, SWRSN, and Skamania County (formerly part of GCBH) consolidated into a new RSN called Southwest Washington Behavioral Health.

This annual report covers the 2011 activities of the 13 RSNs listed below.

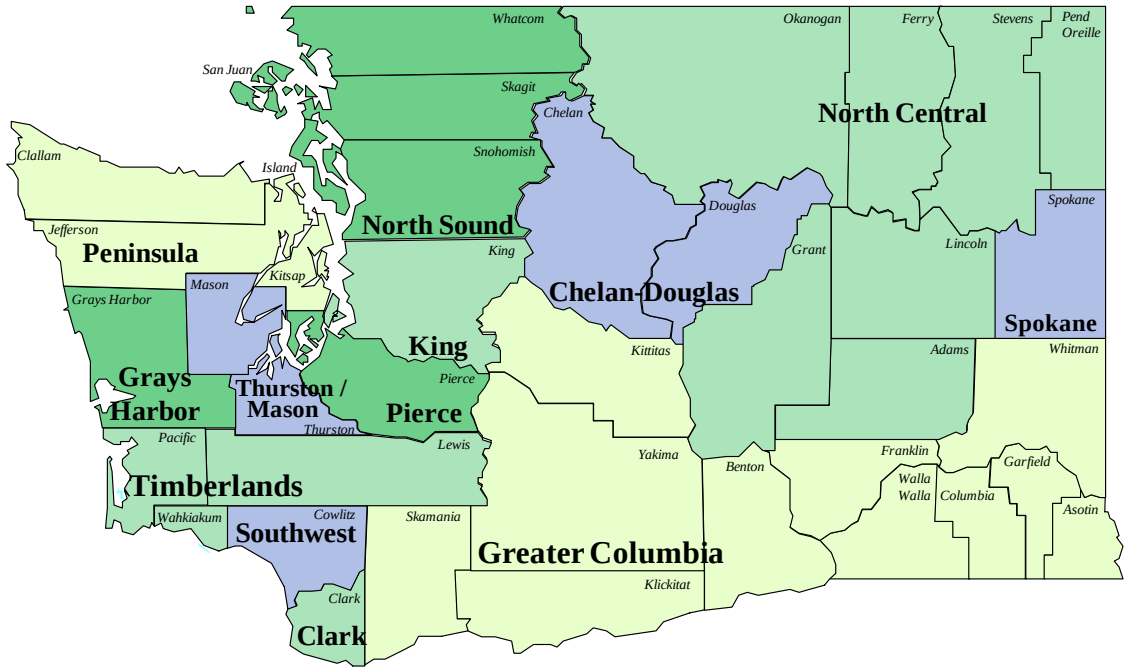
Table 2. Mental health regional support networks and enrollees, 2011.[a]

Health plan	Acronym	Number of enrollees	% of all enrollees
Chelan-Douglas RSN	CDRSN	27,141	2.2
Clark County RSN	CCRSN	85,767	6.8
Grays Harbor RSN	GHRSN	18,874	1.5
Greater Columbia Behavioral Health	GCBH	185,218	14.7
King County RSN	KCRSN	270,032	21.5
North Central Washington RSN	NCWRSN	66,360	5.3
North Sound Mental Health Administration	NSMHA	183,195	14.6
Peninsula RSN	PRSN	54,438	4.3
OptumHealth Pierce RSN	OPRSN	156,055	12.4
Southwest RSN	SWRSN	26,724	2.1
Spokane County RSN	SCRSN	104,779	8.3
Thurston-Mason RSN	TMRSN	54,513	4.3
Timberlands RSN	TRSN	25,066	2.0
Total		**1,258,162**	**100.0**

[a] Source: Washington Mental Health Performance Indicator System.

Figure 2 shows the counties served by each RSN in 2011.

Figure 2. RSN service areas, 2011.



Acumentra Health conducted the compliance review, PIP validation, and ISCA follow-up review for each RSN during 2012. Together, these activities addressed the following questions:

1. Does the RSN meet CMS regulatory requirements?
2. Does the RSN meet the requirements of its contract with DBHR?
3. Does the RSN monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?
4. Does the RSN conduct the two required PIPs, and are they valid?
5. Does the RSN's information technology infrastructure support the production and reporting of valid and reliable performance measures?

Review procedures for the individual activities were adapted from the following CMS protocols and approved by DBHR:

- *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR parts 400, 430, et al.*, Final Protocol, Version 1.0, February 11, 2003
- *Validating Performance Improvement Projects*, Final Protocol, Version 1.0, May 1, 2002
- *Appendix Z: Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans*, Final Protocol, Version 1.0, May 1, 2002

General procedures consisted of the following steps:

1. The RSN received a written copy of all interview questions and documentation requirements prior to onsite interviews.
2. The RSN submitted the requested documentation to Acumentra Health for review.
3. Acumentra Health staff visited the RSN to conduct onsite interviews and provided each RSN with an exit interview summarizing the results of the review.
4. Acumentra Health staff conducted interviews and reviewed documentation of up to four provider agencies and other contracted vendors for each RSN.
5. Acumentra Health scored the oral and written responses to each question and compiled results.

The scoring system for each activity was adapted from CMS guidelines. Oral and written answers to the interview questions were scored by the degree to which they met regulatory- and contract-based criteria, and then weighted according to a system developed by Acumentra Health and approved by DBHR.

The following sections summarize the results of individual EQR reports for 13 RSNs completed during 2012. These results represent established measurements against which DBHR will compare the results of future reviews to assess the RSNs' improvement. Individual RSN reports delivered to DBHR during the year present the specific review results in greater detail.

Access to mental health care

These observations and recommendations arose from the RSN site reviews during 2012.

Strengths

- Most RSNs employ strategies to monitor enrollees' access to care. For example:
  - OPRSN's geo-mapping process identified the need to increase the number of providers in the Gig Harbor service area.
  - Several RSNs (NSMHA, TMRSN, NCWRSN, SWRSN) monitor access by analyzing grievances and utilization rates by age, ethnicity, and gender.
  - NSMHA maintains a key indicator dashboard that includes average daily census, denials, average calls, percentage meeting dispatch time of less than two hours, stabilization bed percentage, law enforcement drop-offs, and other indicators.
- CCRSN implemented an Outreach and Engagement Project to increase service penetration rates for underserved populations.
- SCRSN assisted in establishing a second evaluation and treatment (E&T) facility in its service area to to improve access to inpatient psychiatric care and reduce the practice of boarding people at hospital emergency rooms.
- TMRSN monitors enrollee access to second opinions by reviewing provider logs and treatment documentation, second opinion requests, enrollee complaints and grievances, provider processes, and encounter data.
- Several RSNs (GCBH, NSMHA, TMRSN, OPRSN) have implemented same-day access to intakes to address issues related to routine access.
- Two PIPs related to access to outpatient or inpatient care earned Fully Met ratings:
  - CDRSN's nonclinical PIP involved a gatekeeper program for older adults.
  - SCRSN's nonclinical PIP recorded a reduction in boarding days in hospital emergency rooms after the creation of a new E&T facility improved access to inpatient care.

Opportunities for improvement

- The RSNs need to monitor geographic accessibility to ensure that enrollees have access to services near their homes.
- Several RSNs need to implement mechanisms to monitor enrollees' access to second opinions.
- A few RSNs have difficulty ensuring timely access to services, even after requiring providers to develop plans to address access.
  - ***DBHR needs to continue to work with the RSNs to identify solutions to issues with routine access.***
- A few PIPs related to access did not demonstrate a need or evidence to justify the selection of a particular intervention to improve the chosen measure. For example, two interventions involved a single telephone call, and other PIPs relied on projects initiated by providers.
  - ***DBHR should encourage RSNs to invest adequate resources in PIPs. RSNs should design network-wide interventions that are likely to work and can sustain improvement.***

Timeliness of mental health care

These observations and recommendations arose from the RSN site reviews during 2012.

Strengths

- OPRSN exceeded the state's performance measure for providing an intake within 14 calendar days of the request for services. OPRSN met the goal about 97% of the time from July 2011 through June 2012.
- CCRSN's provider network has made significant changes to meet access and availability timelines. Changes include open access, double booking, and expanded hours to include Saturday and evening hours.
- CCRSN and NCWRSN perform "secret shopping" calls to monitor timeliness of access.
- NCWRSN's and SCRSN's clinical record audits include reviewing the timeliness of intakes, treatment plan development, and follow-up services.
- Several PIPs related to timeliness of care earned Fully Met ratings:
    - KCRSN and NSMHA continued their nonclinical PIPs aiming to improve the percentage of enrollees receiving non-crisis outpatient service within seven days after discharge from an inpatient psychiatric facility. Both PIPs focused on discharge management.
    - NSMHA's clinical PIP focused on timely access to medication evaluations through "planful discharge" in outpatient services.
    - TMRSN's nonclinical PIP studied the impact of a walk-in intake center on timely access to intakes.

Opportunities for improvement

Acumentra Health identified no system-wide compliance issues affecting more than one RSN.

- Many of the PIPs related to timeliness of care, including most of those rated Fully Met, were subject to data limitations that reduced confidence in the results.
    - ***DBHR needs to ensure that the RSNs understand the elements of a sound study design and common challenges to validity of study results.***
- None of the PIPs related to timeliness of care demonstrated improvement in the measure being studied.
    - ***DBHR should encourage more analysis in PIP planning. RSNs should examine the target population proposed for a PIP—including individuals, providers, and other relevant stakeholders, systems, and resources—to identify specific risk factors and barriers to improvement, and use that information to evaluate the possibilities for improvement.***

Quality of mental health care

These observations and recommendations arose from the RSN site reviews in 2012.

Strengths

- RSNs use diverse methods to monitor the quality and appropriateness of care delivered by provider agencies. The primary method is clinical record review. Other methods include performing annual administrative audits; meeting monthly with providers to review reports; conducting enrollee forums and surveys; and analyzing grievance reports.
- All RSNs review clinical records for enrollee or guardian participation in treatment planning. Some RSNs review for consistency between the assessment, diagnosis, treatment plan, and progress notes. Several RSNs look for strength-based, recovery-oriented treatment.
- CDRSN monitors the quality and appropriateness of care for enrollees with specialized needs by reviewing service authorization requests and service utilization, meeting monthly with agency clinical directors, and conducting enrollee satisfaction surveys.
- Most RSNs' quality management (QM) committees include providers, consumers and advocates, and other stakeholders. Several RSNs analyze trends in grievances and appeals and forward this information to their internal quality committees for use in evaluating system improvements.
- PRSN's comprehensive QM program includes both QI and utilization management (UM) activities. Extensive policies and procedures describe day-to-day program functions. The QM plan outlines the flow of communications, responsibility and authority within PRSN and its governing board.
- SWRSN's QA/PI work plan includes developing a strategic plan for the RSN; exploring and creating community-based residential services for adults and elderly consumers; implementing Dialectic Behavioral Therapy at each contracted provider; and exploring alternatives for outpatient service.
- TMRSN's annual quality program evaluation presents an overview of the RSN and information about grievances, access, population served, outpatient and inpatient service utilization, and crisis and stabilization services.
- Most RSNs employ UM strategies, such as monitoring inpatient and outpatient services; matching authorization requests with service utilization by level of care; reviewing the clinical records of high utilizing enrollees; and identifying open authorizations with no services in extended periods. Notable activities include:
    - monthly meetings with providers to discuss authorization data for anomalies, share best practices, and inform providers of upcoming practice changes (PRSN, CCRSN)
    - clinical staff discussion of outpatient and inpatient cases to ensure consistent agreement on service authorization decisions (OPRSN, KCRSN, GCBH)
    - including the RSN medical director in UM team meetings (SWRSN, KCRSN)
- KCRSN's UM function involves a team of professionals who coordinate treatment plans for enrollees with special needs and facilitate out-of-network services.
- CCRSN monitors inappropriate utilization of crisis services by routinely reviewing inpatient admissions, enrollees with four or more episodes of care, types of service hours, and appropriateness of outpatient services. Monthly meetings with providers

include discussion of over- and underutilization.

- Several RSNs have implemented strategies to monitor use of crisis services due to ineffective outpatient services.
- RSNs use a variety of strategies to reduce the need for crisis and inpatient services, such as:
  - mobile outreach services
  - integrating peers and "parent partners" into crisis response teams
  - using the crisis center for stabilization services or as a step-down from more restrictive settings
- RSNs have significantly increased their use of peer support in service delivery, including crisis services. OPRSN developed a "peer bridger" program aimed at increasing recovery and stabilization for enrollees discharged from hospitals.
- Most RSNs have established mechanisms to encourage and monitor coordination of care with primary care providers (PCPs). OPRSN partnered with MultiCare to develop the Mobile Integrated Health Care team, which delivers physical health services to mental health enrollees.
- Several RSNs have implemented programs to improve cultural competency.
  - CCRSN's cultural committee reviews and recommends standards of practice and outcomes related to cultural competency.
  - GCBH's committee on multicultural competency meets quarterly to address issues related to diversity, staff training, and language barriers.
  - GHRSN hosted a Recovery Conference featuring guest speakers who provide behavioral health services to Native American consumers.
- Since identifying a trend in grievances related to dignity and respect, NSMHA has begun participating in the University of Pittsburgh's three-year Dignity and Respect Campaign, which includes Train the Trainer methodology.
- Several PIPs related to quality of care earned Fully Met ratings:
  - KCRSN's clinical PIP focused on screening for metabolic syndrome.
  - OPRSN's clinical PIP focused on consumer participation in treatment planning.
  - PRSN's nonclinical PIP focused on weight monitoring.
  - SCRSN's clinical PIP focused on discharge management, aiming to demonstrate a reduction in inpatient length of stay.
  - TRSN's nonclinical PIP focused on improving care coordination through collaborative contact with medical providers.

Opportunities for improvement

- Several RSNs (CCRSN, NCWRSN, TMRSN) need to establish mechanisms to ensure consistent application of review criteria for service authorization and UM decision making.
  - ***DBHR needs to continue to work with the RSNs to ensure consistency of review criteria for quality and appropriateness of care.***
- Many RSNs, although they review monitoring results, service utilization, and grievances annually, do not summarize the results in a formal QM evaluation. The RSNs could use such annual evaluations to identify QI needs and strengths, and to develop new PIP topics.

  - ***DBHR needs to ensure that all RSNs complete end-of-year evaluations that synthesize EQR findings, agency audit results, subcontract monitoring activities, consumer grievances, and service verification. The evaluations also should include performance improvement activities, metrics, how the RSN reached its performance goals, barriers and accomplishments, and improvement needs for the following year.***

- Many RSNs do not routinely review and update their practice guidelines to ensure that they still apply to enrollees' needs and include current clinical recommendations.
  - ***DBHR needs to ensure that all RSNs routinely review and update practice guidelines to ensure that they still apply to enrollees' needs and include current clinical recommendations.***

- Several RSNs have given their providers flexibility in designing PIP interventions. An example reviewed this year showed that the providers had difficulties designing projects with an adequate study design, and intervention. RSNs have had these same difficulties.
  - ***DBHR needs to work with the RSNs to select PIPs with a higher likelihood of improving enrollee satisfaction, processes, or outcomes of care.***

Mental health regulatory and contractual standards

Acumentra Health's 2012 compliance review addressed federal and state standards related to eight major areas of managed care operations:

1. Delivery Network
2. Coordination and Continuity of Care
3. Authorization of Services
4. Provider Selection
5. Subcontractual Relationships and Delegation
6. Practice Guidelines
7. Quality Assurance and Performance Improvement (QA/PI) Program
8. Certification and Program Integrity

In 2011, the compliance review had addressed standards in two additional areas, Enrollee Rights and Grievance Systems.

The compliance review followed a protocol adapted from the CMS protocol for this activity and modified with DBHR's approval. Each review section contains elements corresponding to related sections of 42 CFR §438, DBHR's contract with the RSNs, the Washington Administrative Code, and other state regulations where applicable.

DBHR's Medicaid waiver exempts RSNs from having to comply with certain federal regulations. For example, because all people in Washington with mental illness are defined as having "special healthcare needs," the criteria for identifying and assessing these enrollees, developing treatment plans, and ensuring direct access to specialists differ from the criteria for serving special-needs populations as defined by federal rules.

For a more detailed description of these standards, including a list of relevant contract provisions and a list of elements within each BBA regulation, see Appendix C.

Within each review section, Acumentra Health used the written documentation provided by the RSN and the answers to interview questions to score the RSN's performance on each review element on a range from 1 to 5.

Acumentra Health combined the scores for the individual elements and used a predetermined weighting system to calculate a weighted average score for each review section. Section scores were rated according to the following scale:

4.5 to 5.0 = Fully met
3.5 to 4.4 = Substantially met
2.5 to 3.4 = Partially met
1.5 to 2.4 = Minimally met
<1.5 = Not met

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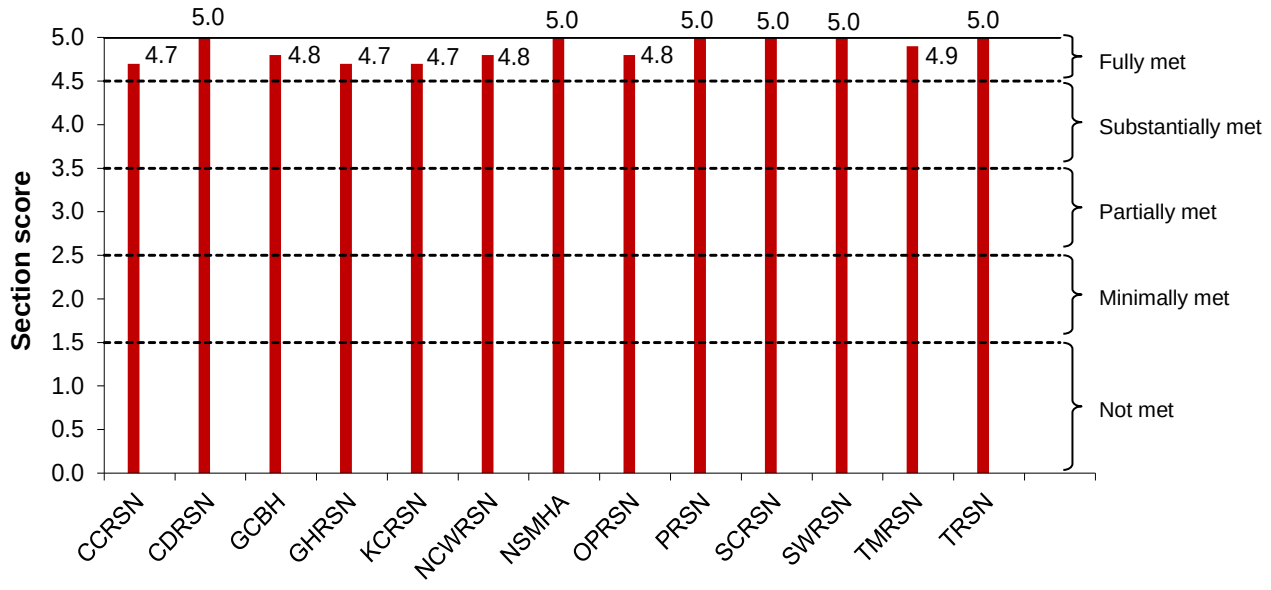
Delivery Network

As shown in Figure 3, all 13 RSNs fully met this standard.

Figure 3. RSN compliance scores: Delivery Network.



Strengths

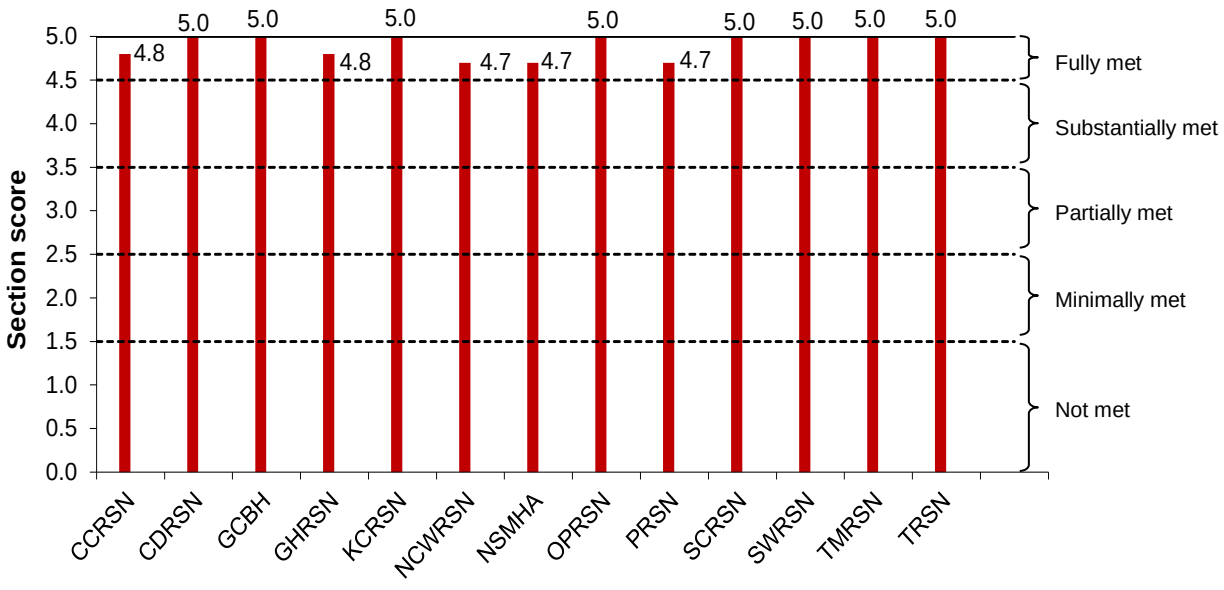
- Most RSNs evaluate access to services by reviewing grievances; conducting surveys of enrollee satisfaction; analyzing service penetration rates for enrollees by age, ethnicity, and gender; and reviewing service utilization.
- Many RSNs have increased the number of provider agencies in their service areas based on geo-mapping analysis.
- Many RSNs have implemented outreach and engagement projects to provide more services for underserved populations.
- KCRSN's UM function involves a team of professionals to coordinate treatment plans for enrollees with special needs and to facilitate out-of-network services.
- TRSN monitors specialist consultations during clinical record review. The intake assessment format includes a section describing the enrollee's culture and relevant issues of concern. This information is incorporated into treatment planning as appropriate for the enrollee. Clinical service reviews of each provider monitor how treatment has addressed cultural issues and needs, and whether specialists' recommendations are followed in the course of treatment.
- OPRSN's excellent geo-mapping process captures enrollees' addresses, Zip codes, age, gender, ethnicity, and service penetration rates.
- As part of annual administrative review, TRSN interviews agency staff on policies and procedures, including their knowledge of enrollees' right to a second opinion.

- TMRSN monitors enrollee access to second opinions by reviewing provider logs and treatment documentation, second opinion requests, enrollee complaints and grievances, provider processes, and encounter data.
- NSMHA maintains a key indicator dashboard that includes average daily census, denials, average calls, percentage meeting dispatch time of less than two hours, stabilization bed percentage, law enforcement drop-offs, and other indicators.

Coordination and Continuity of Care

As shown in Figure 4, all 13 RSNs fully met this standard.

Figure 4. RSN compliance scores: Coordination and Continuity of Care.



Strengths

- Most RSNs' clinical record monitoring tools include assessing coordination of services with other healthcare providers. If the reviewers document a need for coordination, they look for evidence of coordination in the enrollee's treatment plan, information releases, provider correspondence, and whether the progress notes document efforts to coordinate care.
- To identify issues related to timely access to care, most RSNs perform onsite office visits, conduct annual administrative reviews, perform chart reviews, review enrollees' grievances and appeals, and perform "secret shopper" calls.
- Several RSNs have cultural competency committees that address issues related to diversity, staff training, and language barriers.
- OPRSN's cultural committee invites consumers and consumer groups to attend meetings. The committee has provided day-long trainings for agencies and RSN staff, and hosted brown-bag lunches in 2011 on serving the Latino and lesbian/gay/bisexual/transgender populations.
- GHRSN hosted a Recovery Conference in September 2011, featuring guest speakers who provide behavioral health services to Native American consumers.
- NSMHA is participating in the University of Pittsburgh's three-year Dignity and Respect Campaign, which includes Train the Trainer methodology.

- One of TMRSN's QI initiatives in 2011 focused on developing meaningful treatment plans, with special attention to enrollee participation and strength-based discharge planning. The RSN developed several performance improvement plans with providers to improve delivery of recovery-based services.

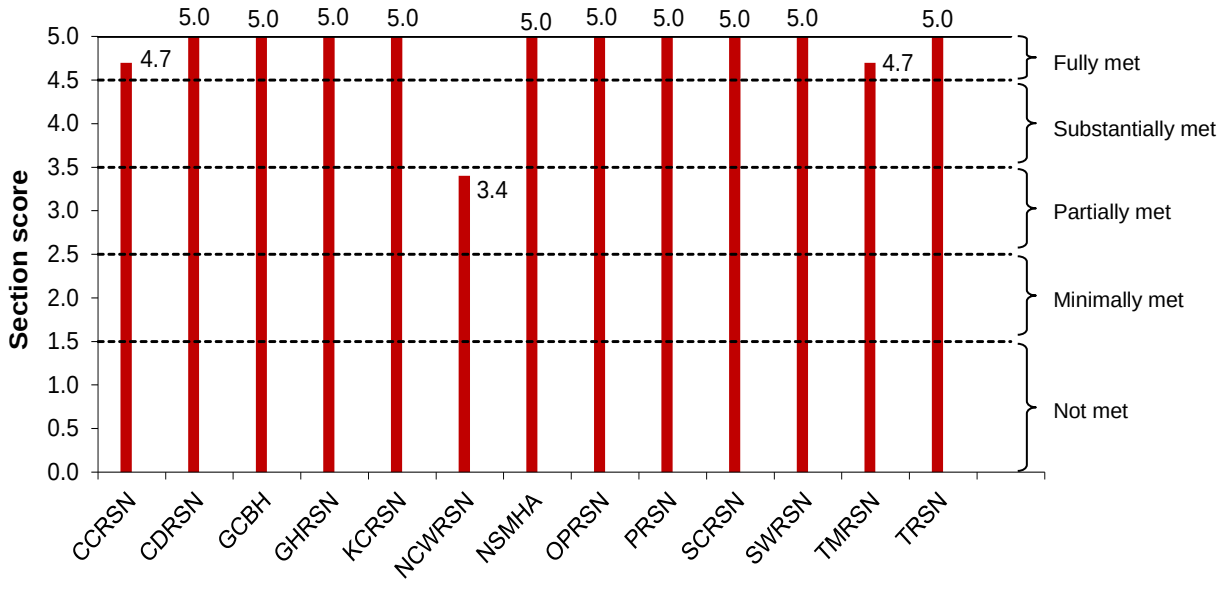
Opportunities for improvement

- Several RSNs lacked formal policies and procedures on providing direct access to specialists.
  - ***DBHR needs to ensure that all RSNs have developed and implemented policies and procedures on providing direct access to specialists.***

Authorization of Services

As shown in Figure 5, 12 RSNs fully met this standard, while NCWRSN partially met the standard.

Figure 5. RSN compliance scores: Authorization of Services.



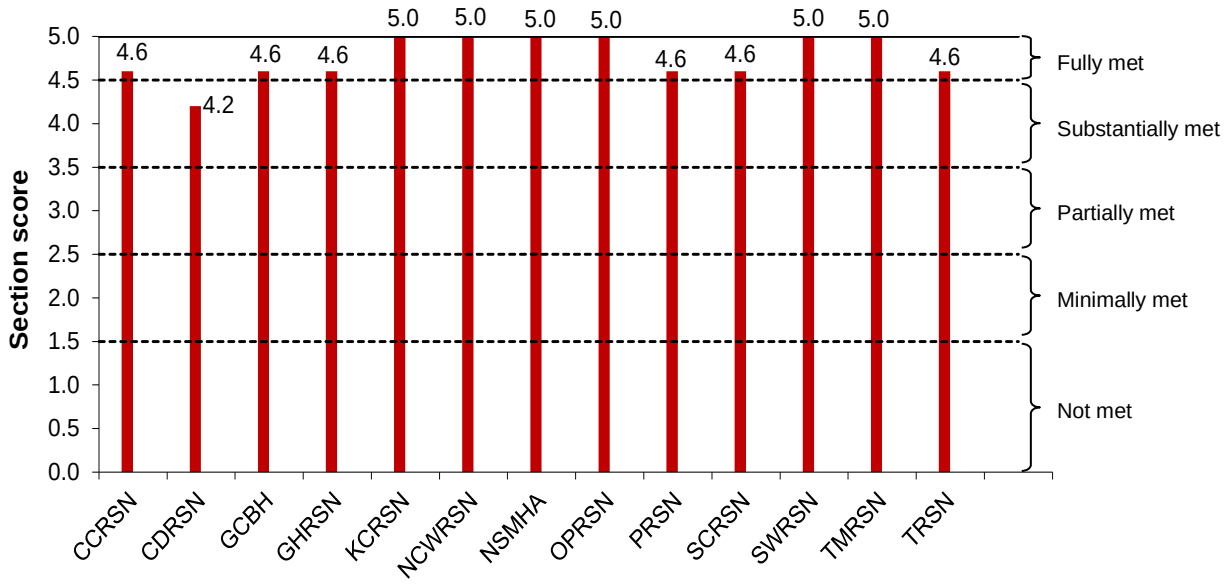
Strengths

- Most RSNs have policies and procedures in place to ensure consisitent application of review criteria for authorization decisions.
- To meet access and availability timelines, several RSNs' provider agencies have made significant changes, including requiring same-day access, open access, double booking, and expanded hours to include Saturdays and evening hours.
- All RSNs have policies and procedures pertaining to crisis, stabilization, and post-hospital follow-up services.
- To help enrollees obtain both physical and mental healthcare services, OPRSN partnered with MultiCare to develop the Mobile Integrated Health Care team.
- CCRSN's policy calls for the care manager to make an authorization decision within 24 hours of receiving a request for services. Provider staff confirmed that the RSN is timely in responding to service requests. All requests are monitored and tracked electronically.
- CDRSN's website informs enrollees about how to obtain crisis services, the role of community crisis response services, and how crisis respite serves people during mental health emergencies and offers an alternative to hospitalization in an emergency and/or crisis situation.

Provider Selection

As shown in Figure 6, 12 RSNs fully met this standard, while CDRSN substantially met the standard.

Figure 6. RSN compliance scores: Provider Selection.



Strengths

- Most RSNs have policies and procedures in place to ensure nondiscrimination in selecting and compensating providers.
- All RSNs' contracts prohibit providers from hiring, contracting, or consulting with individuals or organizations that have been debarred, suspended, or otherwise excluded from participating in federal healthcare programs.
- GHRSN conducts a comprehensive compliance review of each provider in even-numbered years, and a detailed analysis of performance measures and quality indicators in odd-numbered years.
- SWRSN's provider credentialing process includes administrative and clinical chart reviews and a walkthrough of the agency facility to ensure compliance with policies on confidentiality and seclusion and restraint.
- TRSN requires monthly attestation from each network provider that the provider has reviewed all staff, board members, volunteers/interns, and subcontractors and verified their eligibility to participate in federal healthcare programs.

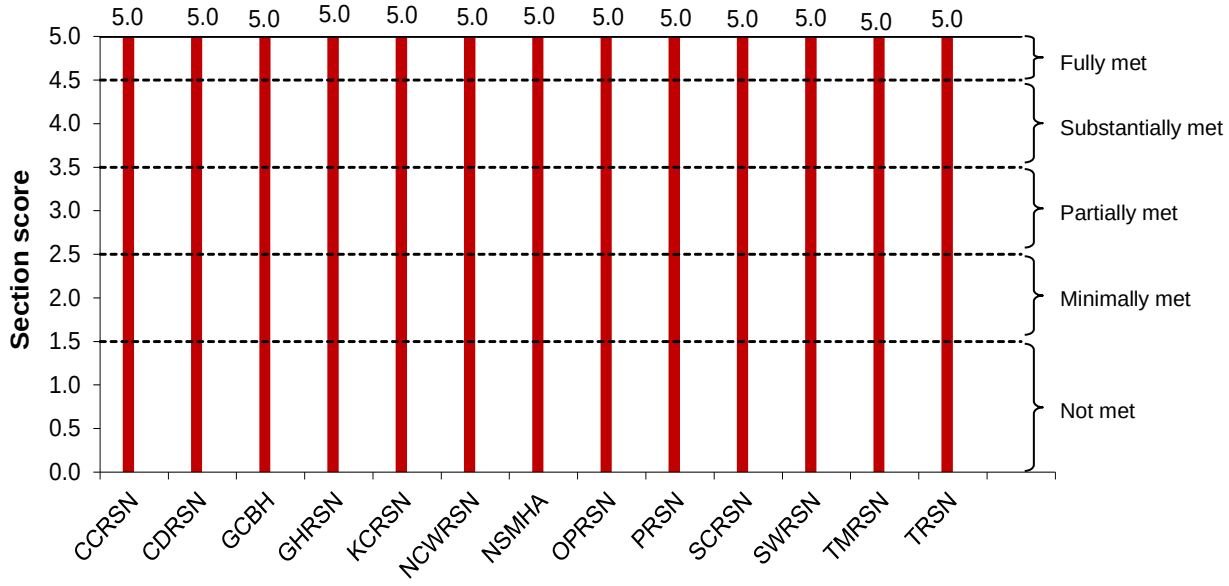
Opportunities for improvement

- Several RSNs lack mechanisms to ensure that the qualifications of the licensed staff of contracted agencies, subcontractors, and the RSN are verified and up to date.
  - ***DBHR needs to ensure that the RSNs' policies and procedures for credentialing and recredentialing include mechanisms to verify the qualifications of all licensed staff of contracted agencies, subcontractors, and the RSN, and to ensure that licenses are up to date.***
- While many RSNs require querying the federal exclusion lists monthly, a few RSNs check the lists yearly.
  - ***DBHR should require the RSNs to screen the federal exclusion lists more often than yearly.***
- Several RSNs do not require that all RSN staff, board members, committee members, and volunteers be screened for federal exclusion.
  - ***DBHR should require the RSNs to screen for federal exclusion all staff, board members, committee members, and volunteers.***

Subcontractual Relationships and Delegation

As shown in Figure 7, all 13 RSNs fully met this standard.

Figure 7. RSN compliance scores: Subcontractual Relationships and Delegation.



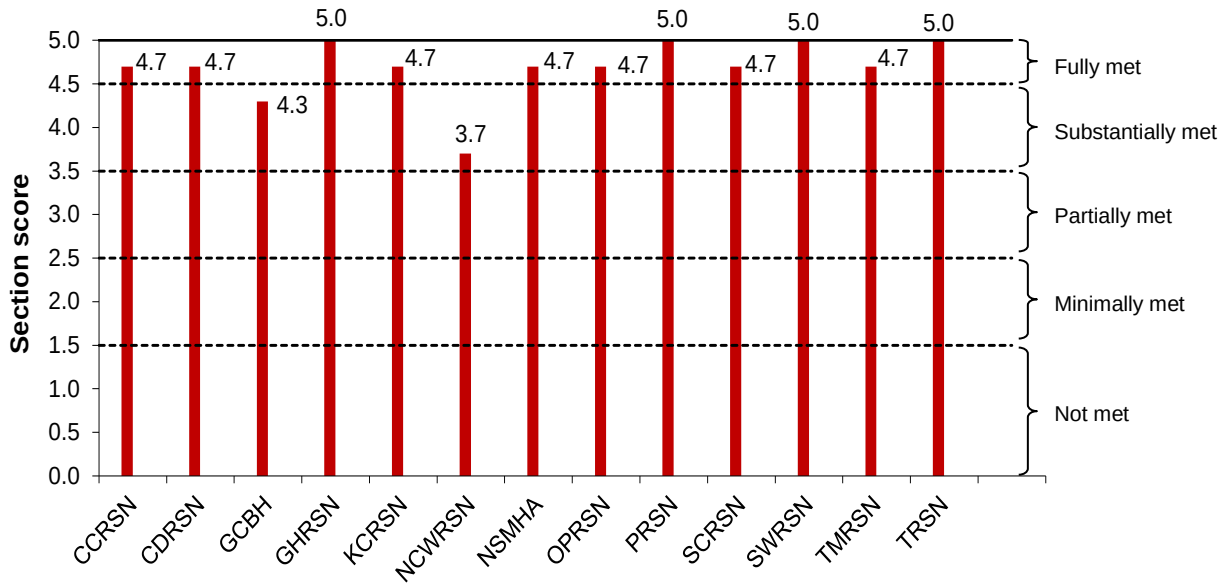
Strengths

- Many RSNs monitor delegated activities monthly and annually by reviewing compliance reports, credentialing, facilities, information systems, and clinical records.
- TMRSN's monitoring program specifies the types of monitoring to be performed, which RSN staff members are responsible for monitoring, which audits are performed by providers, how often monitoring occurs, and the process for initiating corrective action plans if deficiencies are identified.
- NSMHA conducts a comprehensive annual performance evaluation of each contracted provider. Review areas include policies and procedures, credentialing files, financial reports, compliance plan, QI plan and activities, grievance and crisis logs, staff training, and, when applicable, subcontractor agreements and business associate agreements.
- SCRSN monitors delegated activities monthly and yearly through compliance reports from contracted providers and by performing reviews. SCRSN's reviews are well organized and include the results, a detailed narrative, and corrective action plans.

Practice Guidelines

As shown in Figure 8, 11 RSNs fully met this standard, while GCBH and NCWRSN substantially met the standard.

Figure 8. RSN compliance scores: Practice Guidelines.



Strengths

- All RSNs have at least two practice guidelines in place.
- Many RSNs post the practice guidelines on their public websites.
- Many RSNs selected their two practice guidelines on the basis of research on enrollees' needs.

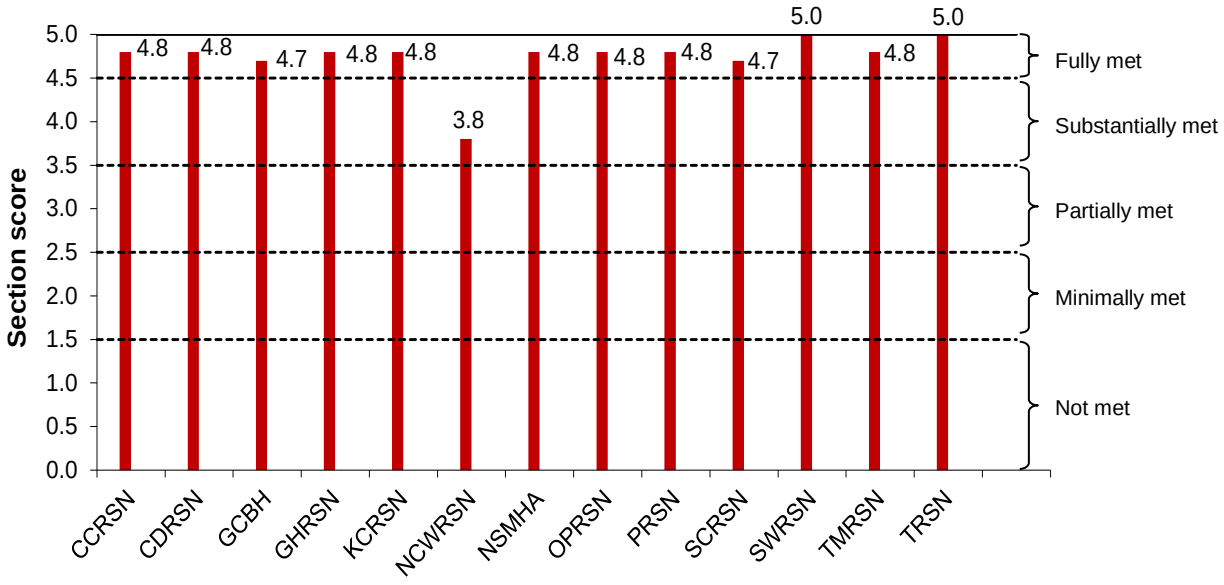
Opportunities for improvement

- Many RSNs do not routinely review and update their practice guidelines to ensure that the guidelines still apply to enrollees' needs and include current clinical recommendations.
  - ***DBHR needs to ensure that all RSNs routinely review and update practice guidelines to ensure they still apply to enrollees' needs and include current clinical recommendations.***
- Some RSNs lacked a policy on the dissemination of practice guidleines.
  - ***DBHR needs to ensure that all RSNs have policies in place on the dissemination of practice guidelines.***

Quality Assurance/Performance Improvement (QA/PI) Program

As shown in Figure 9, 12 RSNs fully met this standard, while NCWRSN substantially met the standard.

Figure 9. RSN compliance scores: QA/PI Program.



Strengths

- The RSNs use diverse methods to assess the quality and appropriateness of care furnished to enrollees. Mechanisms include monthly and yearly chart audits, reviewing reports generated from multiple data sources, conducting enrollee forums, and reviewing enrollee surveys, complaints, and grievances.
- Several RSNs submitted examples of corrective action plans implemented when issues with quality and appropriateness of care were identified through the use of one or more monitoring tools.
- Several RSNs meet monthly with the contracted provider agencies' information services (IS) and data personal to review data validation reports and encounter data to ensure submission of complete, logical, timely, and consistent data.
- Many RSNs have QA/PI work plans that address monitoring tools and activities; analyzing service performance, including utilization trends; monitoring fidelity to practice guidelines; data integrity; delegation; complaints, grievances, and appeals; analyzing quality indicators; and incorporating customer feedback into QI and UM activities.
- PRSN's comprehensive QM plan includes both QI and UM activities. The plan outlines the flow of communication, responsibility, and authority within the RSN and its governing board. PRSN has developed its own quality indicators that measure inpatient service utilization per capita for youth, follow-up services after inpatient services, timely access to services, and inpatient readmission rates.

- CDRSN's policy/procedure on over- and underutilization of services defines the criteria used to identify over- and underutilization, the frequency of review, the reporting committee, and the action taken when issues arise.
- SWRSN requires each provider agency to attend monthly Quality Management Committee meetings, at which RSN policies, procedures, and practice guidelines are reviewed and new guidelines may be discussed and/or adopted and disseminated.
- TMRSN reviews providers' clinical records weekly to assess appropriateness, completeness, adherence to practice guidelines, consumer voice, and recovery-based treatment plans.
- In 2011, SCRSN's IS staff provided trainings for contracted providers on encounter data elements, validation, diagnosis codes, performance measures, treatment goals, and the data dictionary.

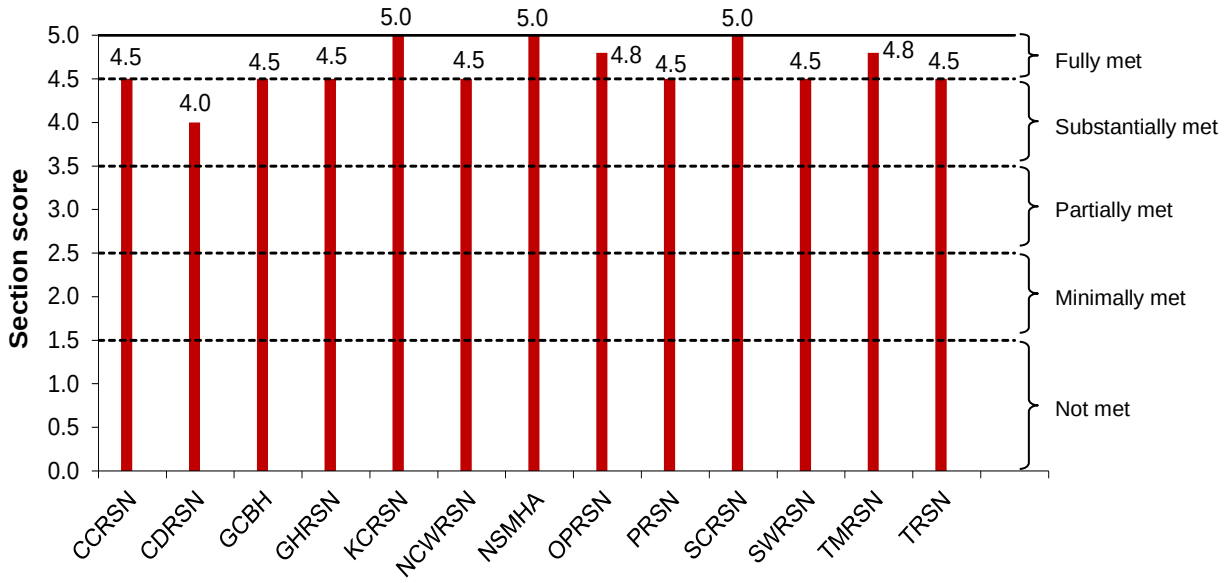
Opportunities for improvement

- Seven RSNs did not conduct a year-end evaluation of the QA/PI program. Such evaluations should synthesize the information collected during the RSN's contractually required review of network providers, including EQR findings, results of agency audits and subcontract monitoring, consumer grievances, and service verification. Evaluations also should summarize performance improvement activities, metrics, how the RSN reached its performance goals, barriers and achievements, and ongoing improvement needs.
    - ***DBHR needs to ensure that all RSNs complete end-of-year evaluations that synthesize the results of QA/PI activities defined in the RSN contract.***

Certification and Program Integrity

As shown in Figure 10, 12 RSNs fully met this standard, while CDRSN substantially met the standard.

Figure 10. RSN compliance scores: Certification and Program Integrity.



Strengths

- Most RSNs have written plans for administrative and management procedures to guard against fraud and abuse.
- GHRSN uses outlier analysis to monitor for fraud and abuse. Every other month, the RSN screens all outpatient service encounters for three types of outliers: single services over three hours in length, enrollees who receive more than eight services in a single month, and those with more than eight hours of total service in a month. GHRSN studies these outliers to determine whether clinical documentation supports the services.
- SCRSN provided evidence of good training on HIPAA and fraud and abuse for RSN staff and contracted providers. Providers use the RSN's template in developing their own compliance programs.
- KCRSN has several mechanisms in place to protect against retaliation for whistleblowing. The RSN's website presents information on how to file a whistleblower complaint, including forms for filing complaints.

Opportunities for improvement

- Many RSNs do not have separate compliance committees but assign compliance issues to the QA/PI committee. Many of the committees meet only on an ad-hoc basis when an issue of fraud, waste, or abuse is under investigation, usually in connection with encounter data.
  - ***DBHR needs to ensure that each RSN has an independent compliance committee that meets regularly. The committee's overview should include fraud, waste, and abuse not only***

associated with encounter data but also related to internal financial practices, HIPAA, and other issues that might have a negative impact on the RSN, providers, and enrollees. All issues need to be tracked, reviewed, investigated and resolved in a timely manner.

- Many compliance officers at the RSNs and provider offices lack formal or adequate training on compliance with program integrity requirements.
  - ***DBHR needs to confirm that the RSNs' and contracted providers' compliance officers have the necessary training to effectively maintain program integrity.***

Issues identified in RSN compliance reviews

Table 3 summarizes the primary issues identified in the 2012 RSN compliance reviews.

Table 3. Issues identified in RSN compliance reviews, 2012.

Compliance area	42 CFR citation (see Appendix C)	Number of RSNs with issues identified
Delivery Network		
General requirements	438.206(b)(1)	0
Second opinions	§438.206(b)(3)	3 (GCBH, NCWRSN, GHRSN)
Out-of-network services	§438.206(b)(4)	1 (GHRSN)
Coordination of out-of-network providers	§438.206(b)(5)	0
Timely access	§438.206(c)(1)	0
Cultural considerations	§438.206(c)(2)	0
Coordination and Continuity of Care		
Primary care and coordination of services	§438.208(b)	0
Identification and assessment of enrollees with special healthcare needs	§438.208(c)(1)–(2)	1 (NCWRSN)
Treatment plans for enrollees with special healthcare needs	§438.208(c)(3)	0
Direct access to specialists for enrollees with special healthcare needs	§438.208(c)(4)	1 (GHRSN)
Authorization of Services		
Authorization of services, notice of adverse action	§438.210(b)–(c)	2 (CCRSN, NCWRSN)
Time frame for decisions	§438.210(d)(1)(2)	1 (NCWRSN)
Compensation for utilization management activities	§438.210(e)	0
Emergency and post-stabilization services	§438.210; §438.114	1 (NCWRSN)
Provider Selection		
General rules and credentialing and recredentialing requirements	§438.214(a)–(b)	2 (TRSN, GCBH)
Nondiscrimination	§438.214(c); §438.12	0
Excluded providers	§438.214(d)	0
Subcontractual Relationships and Delegation		
Subcontractual relationships and delegation—§438.230	§438.230	0
Practice Guidelines		
Basic rule and adoption of guidelines	§438.236(a)–(b)	3 (GCBH, KCRSN, NCWRSN)
Dissemination of guidelines	§438.236(c)	2 (NCWRSN, OPRSN)
Application of guidelines	§438.236(d)	0

Table 3. Issues identified in RSN compliance reviews, 2012 (cont.).		
Compliance area	**42 CFR citation (see Appendix C)**	**Number of RSNs with issues identified**
QA/PI General Rules and Basic Elements		
Performance improvement projects and program review by the state	§438.240(a)–(b)(1); (d)–(e)	3 (KCRSN, NCWRSN, PRSN)
Performance measurement	§438.240(b)(2)–(c); §438.204(c)	0
Mechanisms to detect underutilization and overutilization of services	§438.240(b)(3)	1 (GCBH)
Mechanisms to assess the quality and appropriateness of care	§438.240(b)(4)	0
Health information systems, general rule	§438.242(a)	0
Health information systems, basic elements	§438.242(b)	0
Certification and Program Integrity		
Program integrity: Specific requirements	§438.608(a)	1 (CDRSN)
Program integrity: General requirements	§438.608(b)	0

Table 4 on the following page summarizes the status of findings and recommendations for each RSN arising from the previous year's compliance review (2011), which addressed Enrollee Rights and Grievance Systems.

Table 4. Status of compliance findings and recommendations identified for RSNs in 2011.			
Review section	**RSN**	**Number of findings/ recommendations**	**Status**
Enrollee Rights			
Information requirements: Interpreter services *§438.100(b); §438.10(c)*	GCBH	1	Recommendation addressed
	GHRSN	1	Recommendation addressed
	NCWRSN	1	Not addressed
	NSMHA	1	Recommendation addressed
	OPRSN	1	Recommendation addressed
	SCRSN	1	Recommendation addressed
	TRSN	1	Recommendation addressed
General information for all enrollees: Timing *§438.100(b); §438.10(f)(2–6)*	CCRSN	1	Recommendation addressed
	CDRSN	1	Recommendation addressed
	GHRSN	1	Recommendation addressed
	GCRSN	1	Recommendation addressed
	KCRSN	1	Recommendation addressed
	NCWRSN	1	Recommendation addressed
	OPRSN	1	Recommendation addressed
	SCRSN	1	Recommendation addressed
	SWRSN	1	Recommendation addressed
	TRSN	1	Recommendation addressed
General information for all enrollees: Content *§438.100(b); §438.10(f)(2–6)*	CDRSN	1	Recommendation addressed
	KCRSN	1	Recommendation addressed
	TMRSN	1	Recommendation addressed
Advance directive policies and procedures *§438.100(b)(2)(iv)*	GHRSN	1	Recommendation addressed
	SCRSN	1	Recommendation addressed
	TMRSN	1	Recommendation addressed
Seclusion and restraint *§438.100(b)(2)(v)*	GCRSN	1	Recommendation addressed
	NSMHA	1	Recommendation addressed
	OPRSN	1	Recommendation addressed
Grievance Systems			
General requirements and filing requirements *§438.402(a)–(b)*	SCRSN	1	Recommendation addressed
	GHRSN	1	Recommendation addressed
Record keeping and reporting requirements *§438.416*	NCWRSN	1	Not addressed

Mental health PIP validation

Acumentra Health has evaluated the RSNs' PIPs each year since 2008. Because RSNs begin their PIPs at different times, and because PIPs are typically multi-year projects, these projects may be in different stages at the time of the EQR evaluation.

Per the protocol approved by DBHR, Acumentra Health scores all PIPs according to the same criteria, regardless of the stage of completion. As ongoing QI projects, the PIPs may not meet all standards the first year, but a PIP is expected to achieve better scores as project activities progress, eventually reaching full compliance.

PIP review procedures

Data collection tools and procedures, adapted from CMS protocols, involved document review and onsite interviews. Acumentra Health reviewed PIPs for the following elements:

- a written project plan with a study design, an analysis plan, and a summary of results
- a clear, concise statement of the topic being studied, the specific questions the study is designed to address, and the quantifiable indicators that will answer those questions
- a clear statement of the improvement strategies, their impact on the study question, and how that impact is assessed and measured
- an analysis plan that addresses project objectives, clearly defines the study indicators and population, identifies data sources and collection procedures, and discusses the methods for analyzing the data and performing statistical tests
- if applicable, a sampling methodology that yields a representative sample
- in the case of data collection that involves a clinical record review, procedures for checking inter-rater reliability
- validation of data at the point of data entry for accuracy and completeness
- when claims or encounter data are used for population-based analysis, assessment of data completeness
- a summary of the results of all data collection and analysis, explaining limitations inherent in the data and methodologies and discussing whether the strategies resulted in improvements

PIP scoring

Acumentra Health assigns a score to each standard and to the PIP overall to measure compliance with federal standards. Each standard has a potential score of 100 points. The scores for each standard are weighted and combined to determine an overall score. The maximum overall score is 90 points for Standards 1–8, and 100 points for Standards 1–10. The overall score corresponds to a compliance rating that ranges from Fully Met to Not Met.

Per the protocol approved by DBHR, Acumentra Health scores all PIPs on the first eight standards, regardless of the stage of completion. As ongoing projects, the PIPs are expected to achieve better scores as project activities progress.

The overall scores for PIPs were calculated with a new weighting procedure in 2012. At the direction of DBHR, Acumentra Health modified the standard weights to emphasize the importance of Standard 1, related to developing the study topic. The score for Standard 1 is now weighted double the weight of the other standards in the base set of standards through Standard 8. The weights for Standards 9–10 were reduced. With this change, the scale for Standards 1–8 increased to 90 points, from the previous 80 points.

Overall scores from previous years, wherever they appear in this report, have been recalculated with the new methods to facilitate comparisons.

Table 5 identifies the 10 standards adapted from the CMS protocol for validating PIPs.

Table 5. Standards for RSN PIP validation.	
Demonstrable improvement	
1	Selected study topic is relevant and prioritized
2	Study question is clearly defined
3	Study indicator is objective and measurable
4	Study population is clearly defined and, if a sample is used, appropriate methodology is used
5	Data collection process ensures valid and reliable data
6	Improvement strategy is designed to change performance based on the quality indicator
7	Data are analyzed and results interpreted according to generally accepted methods
8	Reported improvement represents "real" change
Sustained improvement	
9	RSN has documented additional or ongoing interventions or modifications
10	RSN has sustained the documented improvement

Table 6 shows the compliance ratings and associated scoring ranges for PIPs graded on the 90-point and 100-point scales. Appendix D presents a sample scoring worksheet.

Table 6. PIP scoring ranges.			
Compliance rating	**Description**	**100-point scale**	**90-point scale**
Fully met	Meets or exceeds all requirements	80–100	72–90
Substantially met	Meets essential requirements, has minor deficiencies	60–79	54–71
Partially met	Meets essential requirements in most, but not all, areas	40–59	36–53
Minimally met	Marginally meets requirements	20–39	18–35
Not met	Does not meet essential requirements	0–19	0–17

Table 7 shows the topics of the PIPs submitted by each RSN for 2012.

Table 7. PIP topics by RSN, 2012.

RSN	PIP topic
CCRSN	Clinical: Employment Outcomes for Adult Consumers
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
CDRSN	Clinical: Permanent Supported Housing
	Nonclinical: Increased Penetration Rate for Older Adults Enrolled in the Medicaid Program
GCBH	Clinical: Impact of Care Management on Child Readmissions to Inpatient Care
	Nonclinical: Improving Early Engagement In Outpatient Services
GHRSN	Clinical: Reducing Self-Reported Symptoms of Depression Through Participation in Group Psychotherapy
	Nonclinical: Improving Enrollee Engagement
KCRSN	Clinical: Metabolic Syndrome Screening and Intervention
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
NCWRSN	Clinical: Provision of Outpatient Mental Health Services via TeleHealth System
	Nonclinical: Improving the Submission of Correct and Timely Reauthorization Requests
NSMHA	Clinical: Decrease in the Days to Medication Evaluation Appointment After Request for Service
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
OPRSN	Clinical: Consumer Voice in Treatment Planning
	Nonclinical: Consumer Residential Satisfaction
PRSN	Clinical: Healthy Living Program
	Nonclinical: Weight Monitoring
SCRSN	Clinical: Increased Continuity of Care as a Result of Rehabilitation Case Management
	Nonclinical: Improvement in Inpatient Capacity and Placement Using Evaluation and Treatment
SWRSN	Clinical: Treatment Plan Review Following Extraordinary Events
	Nonclinical: Reporting Mental Health Specialist Consultations
TMRSN	Clinical: High-Fidelity Wraparound
	Nonclinical: Improving Percentage of Medicaid Clients Who Receive an Intake Service Within 14 Days of Service Request
TRSN	Clinical: Improving Treatment Outcomes for Adults Diagnosed With a New Episode of Major Depressive Disorder
	Nonclinical: Improving Coordination of Care and Outcomes

Summary of 2012 PIP validation results

Acumentra Health reviewed 26 PIPs in 2012, of which 16 continued from previous years and 10 were new. Overall, 13 PIPs were rated Fully Met, 10 Substantially Met, 1 Partially Met, and 2 Minimally Met. Most of the new PIPs were well developed and achieved a rating of Substantially Met (see Figure 11). All of the continuing PIPs that reported initial study results achieved a rating of Fully Met (see Figure 12). All continuing PIPs showed definite progress in the current year.

PIP topics: The most prominent PIP topic in 2012 related to access to routine outpatient services (6 PIPs). Two of these projects involved a walk-in intake center. Another common theme was continuity of care following discharge from a psychiatric inpatient facility (5 PIPs). Three projects in this area continued to study ways to increase the percentage of enrollees who receive outpatient services within seven days of discharge from a psychiatric inpatient facility (a statewide performance measure). The two other projects measured inpatient length of stay and readmission within 30 days.

Several PIPs focused on treatment plans (4 PIPs). Two of these projects were concerned with documenting consumer participation. Another theme involved community resources (4 PIPs), with projects focusing on supported housing, employment, and wraparound services for at-risk youth. Other projects focused on weight or metabolic syndrome (3 PIPs), depression (2 PIPs), care coordination between mental and physical health providers (1 PIP), and improved access to inpatient facilities (1 PIP).

PIP outcomes: Among the 11 PIPs that presented complete study results, four presented evidence of improvement in the indicator. Among the six PIPs in their fourth and fifth years, none showed improvement on the selected indicator, and had difficulties with changes in the intervention and presenting clear measurements. RSNs at this stage should consider a new topic.

Figure 11 shows overall scores and compliance ratings for PIPs initiated in 2012, all graded on the 90-point scale.

Figure 11. Overall scores for PIPs initiated in 2012.

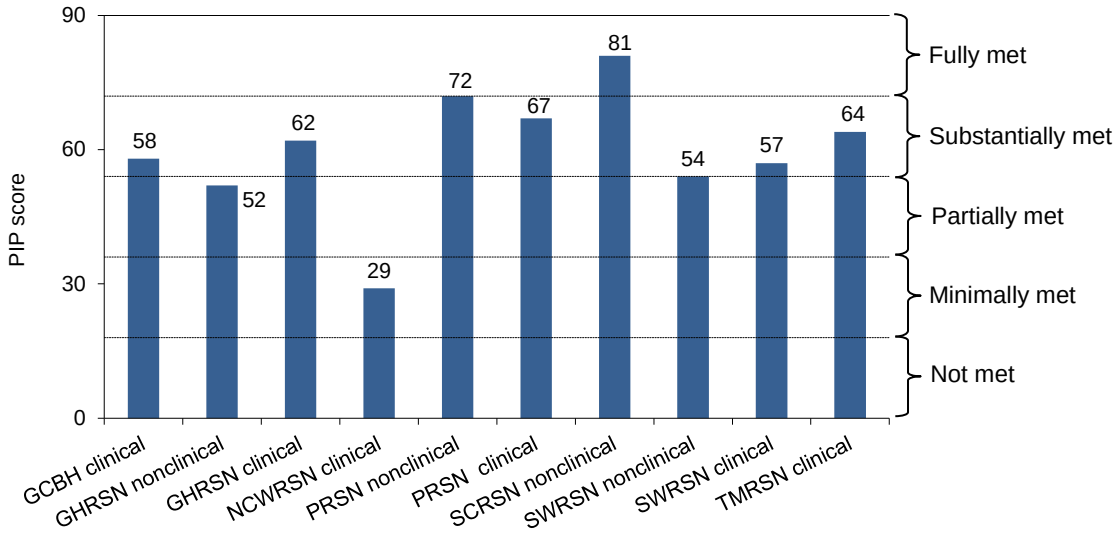


Figure 12 shows overall scores and compliance ratings for continuing PIPs on the 90-point scale.

Figure 12. Overall scores for continuing PIPs, 90-point scale, 2012.

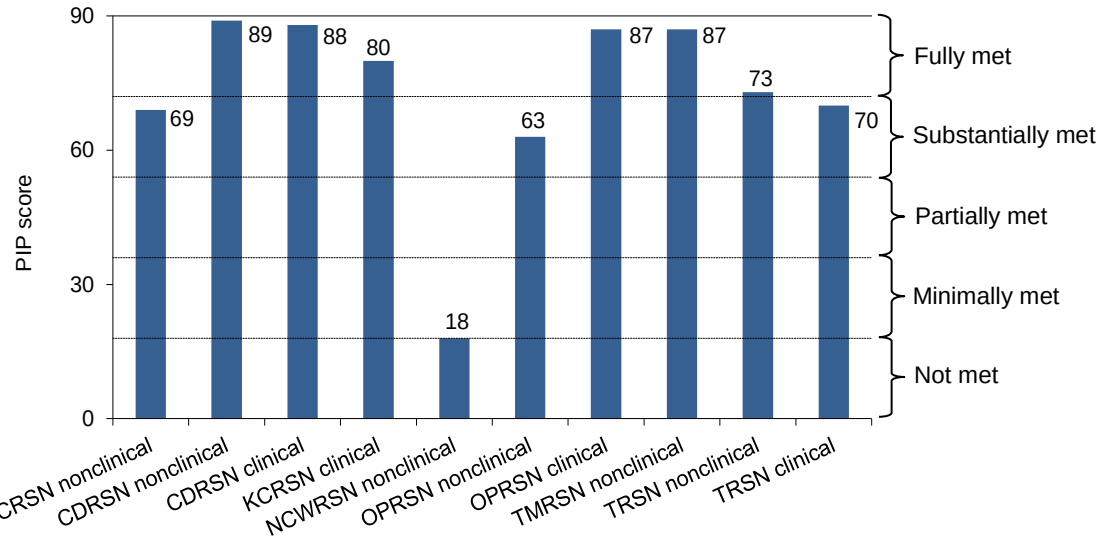


Figure 13 shows overall scores and compliance ratings for continuing PIPs on the 100-point scale. These PIPs completed a second remeasurement and addressed all 10 standards.

Figure 13. Overall scores for continuing PIPs, 100-point scale, 2012.

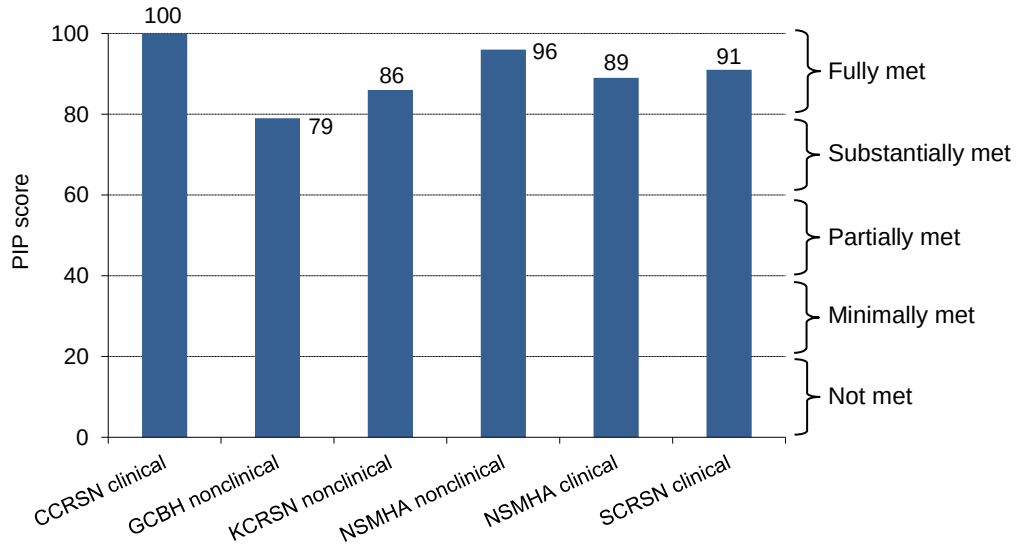
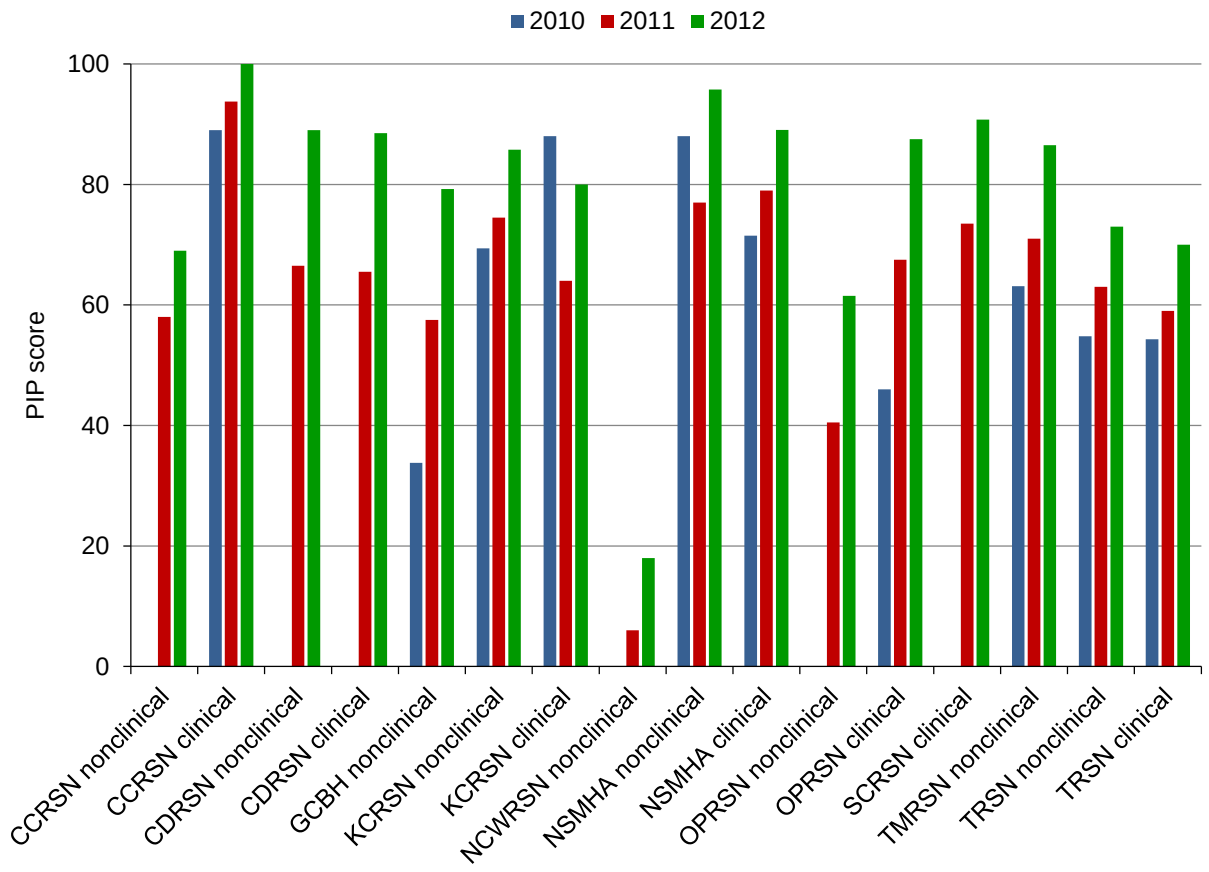


Figure 14 shows progress in the overall scores of the continuing PIPs over the past three years. All but six of the PIPs were initiated in 2010 or 2011 (longer-running PIPs include CCRSN's clinical PIP, TRSN's nonclinical PIP, and both PIPs for KCRSN and NSMHA). Two PIPs in their fifth year (KCRSN clinical and NSMHA nonclinical) showed declining scores in 2011, when the PIP interventions were changed, but both improved to Fully Met in 2012.

Figure 14. Changes in overall scores for continuing PIPs, 2010–2012.



PIP scores by validation standard: Average scores on the individual PIP validation standards illustrate the strong development of the new PIPs through the planning stage, represented by Standards 1–5 (see Figure 15). On average, the continuing PIPs were stronger than the new PIPs in planning, following the first-year review. Among the 10 new PIPs, 5 rated Fully Met and 3 rated Substantially Met on Standard 1, where the topic is identified and prioritized as an area of concern for the local Medicaid population.

The average score for Standard 6, where the intervention is described, was significantly lower for new PIPs relative to continuing PIPs, because many had not yet implemented the intervention. For both new and continuing PIPs, a few RSNs had difficulties explaining why the intervention was expected to affect the chosen indicator.

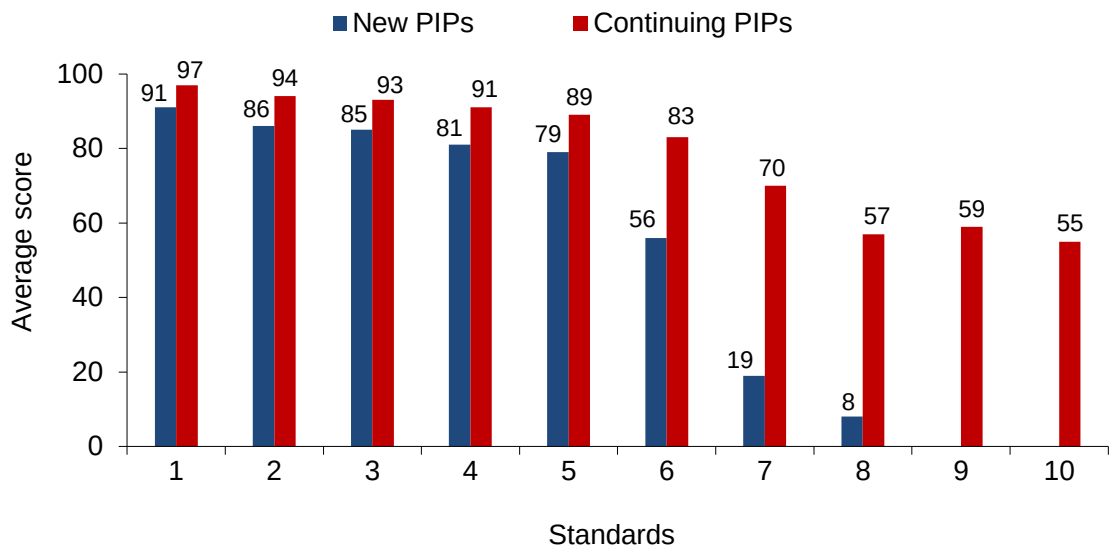
For Standard 7, where study results are reported, 6 of the 10 new PIPs presented baseline data, and one presented remeasurement data and analyzed the complete results. Among the 12 continuing PIPs in their second to fourth years, only half presented initial study results. A few RSNs had difficulties presenting complete, reliable data with clear definitions and measurement periods, which reduced confidence in the results.

Eight of the 13 PIPs that reached the stage of interpreting the study results in Standard 8 rated Fully Met or Substantially Met on the standard. These PIPs also rated high in the presentation of study results. Several PIPs did well in interpreting results though the project demonstrated no improvement, or had serious limitations with methods or confounding factors.

All PIPs are evaluated on the first eight standards. Six PIPs progressed to Standards 9 and 10, where study modifications are discussed and final results are summarized after a second remeasurement. Two PIPs rated Fully Met or Substantially Met on these two final standards. The four lower-scoring PIPs presented incomplete or inconsistent data, and did not analyze the data to summarize the PIP results.

Figure 15 shows the average scores for the 10 new and 16 continuing PIPs on each of the 10 validation standards. The average scores for Standards 9 and 10 include only the six RSNs that completed a second remeasurement.

Figure 15. Average scores by PIP validation standard, 2011–2012.



The following recommendations address issues that appeared in PIPs for more than one RSN.

General recommendations

- PIPs need to address multiple topics of concern over time. Once PIPs reach a second remeasurement, the RSN should select a new topic. The RSN may want to maintain intervention or monitoring activities related to the topic to sustain improvement efforts.
- PIPs should be designed to be completed within no more than three or four years.

Standard 1: Study topic

- Define the problem: When reporting the prevalence of a condition in the local population, provide context as to whether the reported number is high or low and can be expected to improve. (2 RSNs)
- Obtain feedback from providers and other stakeholders to identify areas of concern and barriers to improvement. (2 RSNs)
- Describe how study topic was prioritized among other potential issues. (5 RSNs)

Standard 2: Study question

- Refer to a quantitative metric—usually an average or percentage—to specify how groups will be compared. (4 RSNs)

Standard 3: Study indicator definitions

- Relate the indicator to enrollee outcomes, satisfaction, or quality of care. (3 RSNs)

Standards 4 and 5: Study indicator data collection

- Define study measurement periods precisely. (2 RSNs)
- Standardize the study measurement periods to ensure that the study groups are comparable and that data are defined and measured in the same way. (4 RSNs)
- In the study timeline, report the actual start date of the intervention. Make sure the remeasurement period does not begin before the start of the intervention. (2 RSNs)
- Report how data are validated, or, if data are collected manually, describe procedures to verify accuracy. (5 RSNs)

Standard 6: Study intervention

- Provide evidence to support the selection of the intervention as a way to improve the indicator and address barriers identified in the local system. (3 RSNs)
- Describe details of the intervention, with dates and locations of activities. (5 RSNs)
- Plan and report on tracking measures to evaluate how effectively the intervention was implemented. (7 RSNs)

Standard 7: Study results

- Discuss barriers or lessons learned from the intervention and how these issues affected the study results. (4 RSNs)

Standard 8: Interpretation of study results

- Discuss the impact or lack of impact of the intervention on the study topic. (3 RSNs)
- If appropriate, discuss the clinical significance of the intervention. (2 RSNs)
- Identify limitations and confounding factors in the study methods; discuss how these issues may have affected the study results. (2 RSNs)

Standard 9: Study modifications

- When an indicator is revised, confirm that the new indicator relates to the original study topic and targets an area of concern for the local population. (2 RSNs)

Standard 10: Sustained improvement

- Present complete, consistent data. (2 RSNs)
- Analyze the data and summarize the overall PIP results in relation to the study topic and enrollee outcomes, satisfaction, or quality of care. (4 RSNs)

PIP descriptions and discussion

Clark County RSN

Clinical: Employment Outcomes for Adult Consumers. This PIP, in its fifth and final year, covered three annual remeasurement periods. In 2011, CCRSN continued intervention activities to inform clinicians about employment resources, help job seekers, and improve enrollees' access to employers. Remeasurement results for four quarters in 2011 showed employment rates of between 9.2% and 10.1% for RSN enrollees, similar to the rates observed earlier. Comparison with the 2008 baseline showed no significant differences. CCRSN referred to the "very slow pace of economic recovery" as the principal barrier. Continuing enthusiasm among community partners proved encouraging, and CCRSN expects to continue some aspects of this project.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization. This PIP, in its second year, focused on improving the timeliness of follow-up care for enrollees discharged from two inpatient facilities in Vancouver, totaling about 87% of all discharges in the RSN region in 2010. CCRSN's intervention strategy, developed in collaboration with local providers, involved systematic communication and collaborative discharge planning. In addition, post-discharge support was expected to help enrollees make and keep outpatient service appointments. At the time of the PIP evaluation, CCRSN had not yet implemented the intervention.

Chelan-Douglas RSN

Clinical: Permanent Supported Housing. Homelessness is a critical issue affecting the provision of outpatient mental health services. Local providers identified 109 homeless persons in 2010, 11% of the eligible population receiving noncrisis outpatient services. This grant-funded project seeks to reduce homelessness among Medicaid enrollees through supported housing. The intervention assisted 42 individuals with housing and provided help with life skills, treatment planning, vocational skills, coordination with community services, and other support. Analysis of remeasurement data revealed a statistically significant increase in homelessness, contrary to what was expected. CDRSN intends to redefine the homeless indicator to make it more sensitive to the kinds of changes documented during implementation of the intervention.

Nonclinical: Increased Penetration Rate for Older Adults. This PIP addresses underutilization of mental health services by older adults enrolled in Medicaid. Local data showed a service penetration rate for older adults of 4.5% in 2011, whereas an estimated 20% of adults aged 65 and over may have mental health issues. CDRSN's intervention involved strengthening an existing Gatekeeper Program operated by Aging and Adult Care of Central Washington (AACCW). Elements included gatekeeper recruitment and training, a referral system, and a "community response system" involving mental health providers. A provider agency trained 160 people as gatekeepers, and AACCW processed six known referrals during the remeasurement period. A slight increase in the penetration rate was not statistically significant, and CDRSN attributed the change to factors unrelated to the intervention. The RSN needs to consider revising its remeasurement period so that the time frame does not include a period before the intervention occurred.

Grays Harbor RSN

Clinical: Reducing Self-Reported Symptoms of Depression Through Participation in Group Psychotherapy. This new project builds on GHRSN's previous PIP related to major depression. GHRSN documented major depressive disorder as the "second most commonly diagnosed condition" treated by the RSN. The current version of the PIP involves closer examination of the results of group treatment sessions for enrollees with major depression. GHRSN will measure results by comparing PHQ-9 scores, administered at intake and again following six group sessions within 180 days. As of the PIP review, GHRSN had not yet implemented its intervention.

Nonclinical: Improving Enrollee Engagement. GHRSN found that 30% of enrollees scheduled for a first appointment following intake failed to show up for the appointment. This raised concern about enrollees' mental health outcomes and about providers' diminished productivity. This PIP aims to reduce the percentage of no-shows for first appointments. The RSN's administrative staff will make utilization management phone calls to determine which enrollees are "engaged" and likely to keep an appointment. Those who are assessed to be not engaged will have their files directed to a closing process. Callers will compile information on barriers to engagement to help the RSN frame future interventions. At the time of the PIP evaluation, GHRSN had not yet implemented its intervention.

Greater Columbia Behavioral Health

Clinical: Impact of Care Management on Child Readmissions to Inpatient Care. This PIP is in its first year. In examining local data, GCBH found an average of 42 child admissions to inpatient psychiatric settings each quarter, with an average of 8.5% of those children readmitted within 30 days of discharge. Providers expressed concerns that they did not know when enrollees were admitted to inpatient services and had "no opportunity to impact the decision to admit, nor the opportunity to facilitate smooth return to services upon discharge." In 2011, GCBH instituted its own Authorization Center for inpatient admissions to take over functions previously performed by an independent contractor. GCBH stated that its new supervision of care management would promote continuity planning. The proposed intervention to reduce child readmissions within 30 days involves making suggestions to inpatient providers about "resources that could benefit a child following discharge." GCBH presented no evidence to indicate that inpatient discharge planners needed additional knowledge of resources, and the intervention did not address coordination of care with outpatient providers. As of the PIP review, the study had not advanced to remeasurement.

Nonclinical: Improving Early Engagement in Outpatient Services. In its third year of work on this PIP, GCBH linked the topic of improving engagement in routine outpatient services to an intervention—a walk-in intake model—that was about to be launched at Central Washington Comprehensive Mental Health (CWCMH) in Yakima, the RSN's largest network provider. GCBH revised its indicator to measure one outpatient service within 90 days following intake, but also reported the original indicator of six service events within 90 days of the first service following intake. GCBH reported results for both indicators over two measurement periods, compared with a baseline control group selected to match the pilot intervention groups by gender and ethnicity. Analysis revealed no statistical improvement for either indicator, though CWCMH reported a notable reduction in no-shows for intakes.

King County RSN

Clinical: Metabolic Syndrome Screening and Intervention. This PIP, now in its fifth year, addresses the increased risk of morbidity and mortality among people diagnosed with schizophrenia who take atypical antipsychotic medications, with attendant risk factors known collectively as metabolic syndrome. This is the second year with the current intervention strategy. KCRSN allowed provider agencies to choose between two indicators for the target population: one related to increasing the percentage of enrollees with PCP contact, and the other related to reducing the percentage of enrollees with screening values above a threshold for selected conditions (weight, blood pressure, smoking, glucose level). Each agency developed its own intervention. KCRSN stated that the agencies' data collection plans were often unclear, and that the interventions required RSN assistance to incorporate evidence-based practices. Remeasurement data showed statistically significant improvement for PCP contact, but not for the various wellness interventions. Going forward, KCRSN needs to discuss the results in

the context of a system-wide intervention that seeks to coordinate independent projects aimed at improving different indicators.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization. Also in its fifth year, this PIP is aligned with the statewide effort to improve the timeliness of follow-up care for enrollees discharged from inpatient facilities. KCRSN reported on the indicator, outpatient appointment within seven days of discharge (a statewide performance measure), for the whole RSN and separately for Navos, the provider with the most inpatient admissions. The RSN conducted its intervention, involving discharge planning by a Cross-System Diversion Team, only at Navos hospital and E&T facilities. Data for two remeasurement periods showed no significant improvement in the indicator. Acumentra Health recommends that KCRSN retire this mature PIP and choose a new nonclinical topic for 2013.

North Central Washington RSN

Clinical: Provision of Outpatient Mental Health Services via TeleHealth System. This PIP addresses the problem of Medicaid enrollees' difficulty in obtaining needed services due to travel requirements over long distances. Telehealth services established in Grant County provided an opportunity to expand services to remote areas. NCWRSN proposed a study design to compare the satisfaction of enrollees receiving telehealth services with the satisfaction of those receiving face-to-face services. The study question omits some elements essential for creating an analytical framework, and the PIP documentation lacks specific details needed to define the study indicators and populations.

Nonclinical: Improving the Submission of Correct and Timely Reauthorization Requests. Having identified a pattern of "markedly late or nonexistent" requests for reauthorization of outpatient mental health services, NCWRSN has sought to address this problem through a nonclinical PIP. The 2011 review found that this topic was not appropriate for a PIP. In 2012, NCWRSN essentially submitted the same PIP, with additional arguments to support the topic selection. NCWRSN reframed the issue of reauthorization requests as an opportunity for the consumer to engage in decisions about treatment. Further discussion of the topic, however, reverted to a focus on timely and accurate submission of the reauthorization request. The PIP's deficiencies are similar to those noted for the NCWRSN's clinical PIP, above.

North Sound MHA

Clinical: Decrease in the Days to Medication Evaluation Appointment After Request for Service. This PIP, first reported in 2009, aims to reduce the number of days between an enrollee's request for service and a medication evaluation appointment. For its original intervention, NSMHA developed a decision tree tool for clinicians to use at the first ongoing appointment following intake, to help identify needs and make timely referrals. At the end of the first intervention period, the average interval from service request to medication evaluation showed no change from baseline. NSMHA began a second intervention to address capacity issues. "Planful discharge," initiated in May 2012, seeks to improve "the flow of people through treatment," making RSN resources available on a more timely basis. As of the PIP review, NSMHA had not yet reported full remeasurement data. The RSN identified significant confounding factors that need to be addressed.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. This PIP, initiated in 2008, seeks to increase the percentage of enrollees who receive a non-crisis outpatient service within seven days of being discharged from a community psychiatric unit or evaluation and treatment (E&T) facility. NSMHA has addressed this topic through a series of different interventions. For 2012, NSMHA implemented a fourth intervention, a follow-up case management program funded by a federal grant. Remeasurement data following this

intervention showed a significant decrease in the study indicator since baseline. NSMHA did not feel confident in attributing any changes in the indicator to the series of interventions, as none had been implemented effectively. NSMHA decided to discontinue this study topic, concluding that the biggest barrier to improvement in all interventions had been hospitals' lack of incentive to partner with the RSN.

OptumHealth Pierce RSN

Clinical: Consumer Voice in Treatment Planning. This PIP is in its third year. OPRSN described the importance of consumer involvement in treatment planning, documented by a signature or inclusion of consumer quotations. A review of local mental health agencies indicated a need for improvement to meet a benchmark of 90% compliance. OPRSN conducted a barrier analysis to identify issues in treatment planning, and determined that training could encourage providers to give greater attention to consumer participation. The RSN hired two prominent trainers to conduct group training for all providers, followed by individual consultations at each agency. Fifty staff members from five agencies attended the group training. Data for the baseline and remeasurement periods showed a statistically significant overall improvement, from 81.7% to 89.0% compliance.

Nonclinical: Consumer Residential Satisfaction. This PIP is in its second year. In early 2012, OPRSN contracted with Recovery Innovations to implement a Community Building program, focused on engaging people at residential treatment facilities in community-based housing alternatives. In association with this intervention, OPRSN is monitoring Medicaid enrollees' satisfaction with their new environment. OPRSN adopted a validated survey instrument to measure housing satisfaction, designed specifically for people with psychiatric disabilities, and conducted a first survey prior to the intervention. A second survey is scheduled one year later. Residents were expected to move into new housing between September 2012 and June 2013. In a preparatory phase of the intervention, residents are educated in topics that may help them live independently. At the time of the PIP review, OPRSN had not reported baseline results.

Peninsula RSN

Clinical: Healthy Living Program. The 2010 PIP revealed that 77% of PRSN's adult enrollees for whom body mass index was recorded were overweight or obese. PRSN implemented a four-module Healthy Living Program, focusing on healthy nutrition and physical activity behaviors. During the onsite PIP review, PRSN decided to simplify this project to focus on pre- and post-intervention weight loss. The PIP resubmission presented no baseline or remeasurement data, as the loss of the RSN staff member who had designed the original PIP made it impossible to capture data for many enrollees in the study. PRSN stated that it will probably discontinue this PIP, while continuing to offer the Healthy Living Program to educate consumers about nutrition, activity, and weight loss.

Nonclinical: Weight Monitoring. Local data showed that 76% of PRSN enrollees who were prescribed atypical antipsychotic medications were overweight or obese, putting them at risk of early death from diabetes and cardiovascular conditions. PRSN identified regular weight monitoring as an essential first step in clinical intervention to improve weight outcomes. The new PIP focused on weight monitoring at the provider agency with the lowest level of compliance. PRSN modified its policy to require that all enrollees receiving medical appointments at the agency have their weight assessments documented in the electronic medical record. PRSN provided training for all medical staff at the agency, and supplied agency leadership with quarterly compliance reports. The PIP had not progressed to remeasurement at the time of the onsite evaluation.

Southwest RSN

Clinical: Treatment Plan Review Following Extraordinary Events. SWRSN found that only 45% of enrollees who experienced an extraordinary event (an interpersonal, social, or environmental stressor) had an updated treatment plan that reflected this major life event. The RSN planned to conduct training in early 2012 with provider management and clinical staff to focus on the importance of updating treatment plans after such events. SWRSN provided few details about the intervention, and, at the time of the PIP review, had not conducted a barrier analysis to determine why clinicians were not updating enrollees' treatment plans. More work was necessary before SWRSN could identify an appropriate intervention that would be likely to result in improvement.

Nonclinical: Reporting Mental Health Specialist Consultations. SWRSN identified a problem with inconsistent documentation of required mental health specialist consultations for special populations, including ethnic minorities and enrollees with impairments. This PIP seeks to improve both the completion rate and the reporting of such consultations. However, the RSN did not identify the barriers to completing consultations, identify an intervention strategy aimed at improving the completion rate, or report data on the percentage of consultations that were completed at baseline. SWRSN needs to conduct a barrier analysis to pinpoint the nature of the problem. If the analysis reveals that the problem lies with reporting and coding, this project is not likely to improve the quality of care, outcomes, or enrollee satisfaction.

Spokane County RSN

Clinical: Increased Continuity of Care as a Result of Rehabilitation Case Management. Coordinated discharge planning for children in an inpatient setting may prevent delays in discharge and facilitate ongoing outpatient treatment. In SCRSN's model of rehabilitation case management, a mental healthcare provider takes part in inpatient treatment team meetings, evaluation, discharge planning, personal contact with the child and family, and referrals to community services. For this second-year PIP, SCRSN selected length of stay as a new indicator to evaluate the success of its intervention. The number of patients discharged during the study's nine-month measurement periods was small, and the RSN reported no statistically significant reduction in length of stay. However, favorable feedback from providers and families led SCRSN to conclude that the intervention improved coordination of care.

Nonclinical: Improvement in Inpatient Capacity and Placement Using Evaluation and Treatment. The goal of this new PIP is to reduce the practice of boarding people who require psychiatric inpatient care at hospital emergency rooms when a bed at an appropriate facility is not available. Boarding has become an urgent concern for SCRSN as the number of inpatient beds allocated for the RSN has declined. SCRSN and community partners opened a 16-bed E&T facility in an effort to improve access to inpatient psychiatric care. The number of people boarded per day in the first quarter after this intervention declined, but it was unclear how many people were affected, as the original emergency room data could not distinguish individuals, and each person could stay multiple days. Data quality improved during the study period, making it possible to count individuals and hours boarded.

Thurston-Mason RSN

Clinical: High-Fidelity Wraparound. This PIP was new for 2012. TMRSN noted that the high rate of childhood adverse events in its service area increases the need for mental health care and community services. In response, the RSN has implemented a wraparound model of care for at-risk children and youth. Assisted by the University of Washington Evidence-Based Practice Institute, TMRSN will measure outcomes through scores on the standard Strengths and Difficulties Questionnaire, which measures overall emotional and behavioral functioning.

Workgroups will evaluate enrollee eligibility, coordinate and track operations, and steer the overall project. TMRSN did not describe the intervention, and no data were available.

Nonclinical: Increasing Percentage of Medicaid Clients Who Receive an Intake Service Within 14 Days of Service Request. This PIP is in its third year. Timely intake service is a statewide performance measure on which TMRSN performed below the state benchmark. Consumer complaints and system data indicated a need to improve timeliness of intakes at Behavioral Health Resources (BHR), the RSN's largest provider. BHR established an Access Center to provide walk-in appointments. The center became the primary point of entry for outpatient services, though BHR maintained standard appointment practices at several satellite locations. TMRSN reported remeasurement data showing that the percentage of enrollees receiving an intake within 14 days of a service request rose from 71% in 2009 to 79% in 2011, a statistically significant increase. However, several confounding factors raise doubts about whether these results truly demonstrate a successful intervention.

Timberlands RSN

Clinical: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder. TRSN adopted a practice guideline and is monitoring the clinical outcomes of adult enrollees treated for major depressive disorder. This PIP, initiated in 2010, seeks to determine whether implementing the guideline will reduce clinical symptomatology for enrollees, as indicated by self-reported scores on the PHQ-9 survey. TRSN trained clinical staff at provider agencies on how to use the PHQ-9, and collected baseline data through May 2012. The RSN will conduct its first measurement during September 2012–May 2013.

Nonclinical: Improving Coordination of Care and Outcomes. TRSN identified a need to improve coordination of care between mental health clinicians and PCPs for RSN enrollees. This PIP, in its third year, seeks to determine whether implementing a new standard protocol will increase the percentage of qualified enrollees who receive coordinated care. The protocol outlines a systematic process for determining the level of care coordination with PCPs depending on enrollees' physical health functioning. TRSN implemented the new protocol January 1, 2012, and trained agency clinicians on the use of new service codes. The RSN plans to finish collecting remeasurement data by the end of 2012.

Mental health performance measure validation

By contract, each RSN is required to show improvement on a set of performance measures that the state calculates and reviews. If the RSN does not meet defined improvement targets on any measure, the RSN must submit a performance improvement plan.

Looking Glass Analytics, an Olympia-based consulting firm, contracts with the state to calculate the measures according to state-supplied methodology. Data for the calculations are collected through regular encounter data submissions from the RSNs to DBHR.

For 2012, DBHR calculated three statewide performance measures, and submitted materials for use in validating these measures:

1. Consumers receiving intake services within 14 days of service request
2. Consumers receiving first routine service within 7 days of discharge from a psychiatric inpatient setting
3. Consumers receiving first routine service within 28 days of service request

The current RSN contract, effective October 2011, retires measures 1 and 3 above and adds a new performance measure related to ensuring the accuracy of encounter data submitted to DBHR. The contract specifies that the new measure will be due at the end of each 12-month period, but not when the first 12-month period begins. Acumentra Health is uncertain as to whether the new measure should have been validated in 2012. DBHR submitted no materials related to the new measure for this performance measure review.

Acumentra Health assessed the completeness and accuracy of the three measures DBHR submitted, seeking to answer these questions:

- Are the measures based on complete data?
- How valid are the measures? That is, do they measure what they are intended to measure?
- How reliable are the performance measure data? That is, are the results reproducible?
- Can the state use the measures to monitor the RSNs' performance over time and to compare their performance with health plans in other states?

Review procedures

Following the CMS protocol for this activity, Acumentra Health typically conducts performance measure validation in three phases.

1. Acumentra Health requests relevant documents from the state agency in advance of an onsite interview.
2. Acumentra Health uses the documents to refine the questions to be asked at the onsite interview.
3. Acumentra Health uses oral responses and written materials to assign compliance ratings for each performance measure.

Due to the late submission of the documentation and code used in calculating each performance measure, Acumentra Health was not able to schedule an onsite interview, and so completed only Phase 1 and part of Phase 3 after the submission of the performance measures.

The compliance ratings, also adapted from the CMS protocol, are:

Fully compliant: Measure is complete as reported, accurate, and can be easily interpreted by the casual reader.

Partially compliant: Measure is either complete as reported or accurate, but not both, and has deficiencies that could hamper the reader's ability to understand the reported rates.

Not valid: Measure is either incomplete as reported or inaccurate.

Validation results

In 2011 and 2012, DBHR submitted for review the SAS programs Looking Glass uses to calculate each performance measure, including SAS code that processes and moves the data to the Looking Glass web servers. DBHR also submitted documentation describing the variables and datasets Looking Glass should use in calculating the measures. However, in 2012 as in 2011, the documentation did not explain the data flow from DBHR through the layers of processing Looking Glass performs to make the data ready for the programs that calculate each measure. This makes it difficult to tell what checks occur to ensure that Looking Glass uses accurate and complete data—e.g., whether Looking Glass has checked DBHR's submission for missing and out-of-range data and logic errors, and how Looking Glass ensures the accuracy of its data manipulation. In addition, the SAS programs that calculate each performance measure contain no notes to explain what a particular portion of code does. Acumentra Health verified the lines of calculations that build each of the performance metrics, but could not verify that the calculations are based on complete and reliable data.

Generally, the algorithm the state specified to build each measure would appear to measure what it is intended to measure. The state provided thorough documentation describing which datasets and variables to use, and how to calculate the metrics and apply exclusions. One exclusion could be more clearly defined, as noted below.

The reports Looking Glass produces can be used to compare performance among RSNs and show RSN performance for a particular time period.

Because of the issues with data completeness and reliability, the measures remain only *partially compliant* (see Table 8).

The following discussion summarizes the strengths of the current system of producing performance measures, with recommendations for improving the system.

Table 8. Performance measure validation ratings, 2012.

Performance measure	Status	Rating
Consumers receiving intake services within 14 days of service request	Calculated	Partially compliant
Consumers receiving first routine service within 7 days of discharge from a psychiatric inpatient setting	Calculated	Partially compliant
Consumers receiving first routine service within 28 days of service request	Calculated	Partially compliant

Strengths

- The documentation describing how to construct each performance measure is thorough. For each measure, a separate document describes the dataset, variables, exclusions, and algorithms used to build each component of the measure. Actual SAS code that performs the calculations and exclusions is provided. The layout of the report showing the measure is described, and additional useful variables, like the median and mean, are requested.
- The website displaying each measure is simple to use and provides layers of useful details. RSNs can see their performance in different periods (quarter, calendar year, fiscal year) and in various formats (.pdf, .html, and .rtf). Performance measure rates are easily interpreted from the tables, and details about the overall distribution of the performance measure (median, averages), are displayed.
- Looking Glass code that performs the initial processing of the state data,

automatically unzipping state files and placing them on Looking Glass servers, has built-in quality checks to alert staff if the downloads are unsuccessful.

Opportunities for improvement

The set of performance measures DBHR submitted for review in 2012 differs from the measures set out in the current RSN contract, effective October 2011. Because the contract does not specify when the new measure on validating encounter data should be due, Acumentra Health is uncertain whether the new measure should have been validated in 2012.

- ***DBHR's contract should define clearly the review period for which performance measure results are to be calculated.***

The following recommendations appeared in the 2011 annual report and remain valid.

A key feature of a valid performance measure is that it can be used to monitor the performance over time of health plans providing similar services, both within the state and nationally. The current reporting system lets the user select the period for analysis—quarter, calendar year, or fiscal year—and select statistics on each measure. However, it does not make multiple quarters or years available in a single report.

- ***DBHR should work with Looking Glass to extend the functionality of its performance measure reporting.***
    - Allow users to select a range of years or quarters for a specific RSN.
    - Use statistical tests to identify significant changes in performance measures from one time period to the next—e.g., changes in the percentage of enrollees who have intakes within 14 days of service request. Test trends to detect shifts in rates over more than two time periods.
- ***DBHR should have a system in place to replicate the performance measure analyses performed by Looking Glass. For example, DBHR should develop query language to reproduce the numerator and denominator for the percentage of intakes completed within 14 days of service request by RSN for a select time frame. This would allow DBHR to validate the Looking Glass calculations, creating greater confidence in the reported results.***

An issue of concern is the performance measure relating to routine service after discharge from an inpatient setting. This measure could be affected by how the data are collected. RSNs indicated that the E&T facilities report encounters for those enrolled in the RSN where the E&T is located, regardless of where the enrollee resides. This limits this performance measure to showing only statewide outcomes, and does not allow individual RSNs to understand their contribution to the performance measure.

Extensive documentation of data processing before and during performance measure analyses is essential to help outside reviewers understand the calculation process. It is also invaluable to internal staff when they need to modify the existing data management system.

- ***Looking Glass should develop detailed documentation of the calculation of each performance measure, if it does not exist already. Data flow diagrams should be created for each metric, showing the state data source, which variables are extracted and calculations performed, which new datasets are created and where they are stored, and which program uses those new datasets to calculate the measure. SAS code used to process the data and calculate the measures should include notes explaining what each portion of code does.***

Information Systems Capabilities Assessment follow-up

In association with the performance measure validation, Acumentra Health conducted a full ISCA for DBHR and for all RSNs in 2011. These reviews examined the 2010 status of the state and RSN information systems and data processing and reporting procedures, identifying strengths, challenges, and recommendations.

In 2012, Acumentra Health reviewed the DBHR and RSN responses to the recommendations of the 2011 EQR report. Tables 9 and 10 summarize the results of the follow-up reviews.

Responding to some ISCA recommendations may require a significant planning effort. As a result, organizations may not fully address all recommendations in the follow-up year. In 2012, Acumentra Health found that DBHR and the RSNs were still in the process of addressing most recommendations from the 2011 ISCA. The next round of full ISCA reviews in 2013 will enable Acumentra Health to review the status of these recommendations more thoroughly.

The full ISCA conducted in 2011 revealed the following strengths at the RSN level:

- RSNs' overall performance has improved since 2009, with many more RSNs meeting the requirements of various review sections. All RSNs earned scores in the Fully Met range for Staffing, Administrative Data, Vendor Data Integrity, and Provider Data.
- All RSNs have worked successfully with their providers to eliminate use of paper encounters and claims for all outpatient services. This reduces the probability of error and increases throughput.
- By 2011, most RSNs had enhanced their provider profile directories to enable enrollees to make informed choices among network providers.

The 2012 follow-up review addressed the areas for improvement noted in 2011 and updated the RSNs' progress as noted below:

- A few RSNs have made improvements in IT governance, but most are still working to implement control frameworks, steering committees, and management reports.

  Update: *RSNs are implementing newly adopted internal control structures and are formalizing monitoring activities.*

- RSNs have improved their oversight of support functions outsourced to third-party data administrators, application service providers, and vendors. Two RSNs still have oversight issues to resolve.

  Update: *One RSN has implemented a formal policy on monitoring third-party contracts, and needs to continue to work toward effective oversight and monitoring of contracted activities. The other RSN has terminated its third-party contract, so this recommendation no longer applies.*

- RSNs have made progress in creating disaster recovery plans (DRPs), though many still struggle with keeping the plans current. Six RSNs have not completed initial testing of plans.

  Update: *One RSN has implemented a DRP and has conducted table-top testing of the plan. Two other RSNs planned to conduct table-top testing of their DRPs by the end of 2012.*

- Some RSNs still lack 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.

  Update: *The RSNs continue to develop monitoring policies and reporting procedures and to implement peer review of documentation to improve validity and accuracy.*

- Most RSNs have successfully addressed issues related to encrypting and securely transporting backup data files. However, many provider agencies still are not encrypting offsite backup media. RSNs and provider agencies need to begin addressing encryption of personal hardware, USB drives, and other removable media.

  Update: *Most RSNs have updated their policies and procedures to require that all backups be encrypted. These procedures are being implemented at the provider agencies where needed.*

- RSNs generally need to ensure that they update hardware at regular intervals to avoid disruption of services caused by hardware failures. Three RSNs have specific issues with older hardware that needs to be updated.

  Update: *Two RSNs have completed projects addressing aging hardware by replacing their desktops, servers, and operating systems with updated models. The other RSN has terminated its third-party contract, so this recommendation no longer applies.*

Table 9. Status of ISCA recommendations identified for DBHR in 2011.		
2011 opportunities for improvement	**2011 recommendations**	**RSN response**
Information Systems		
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 purchased a subscription to online training services for each member of the programming staff. Staff will use this resource until budget allows more focused hands-on training to resume. ***Status: Recommendation in progress.***
Staffing		
None		
Hardware Systems		
DBHR has not formally audited CNSI, which operates and maintains the ProviderOne system.	DBHR needs to conduct a formal audit of CNSI to review business needs and technical requirements.	DBHR needs to work with HCA, which oversees CNSI, to create an audit plan and to ensure that CNSI is formally audited. ***Status: Recommendation stands.***
Security		
None		
Administrative Data		
DBHR performs only ad-hoc audits of post-adjudicated encounter data stored in the data warehouse.	DBHR needs to perform routine post-adjudication audits of encounter data based on lessons learned from its ad-hoc audits of adjudicated data.	DBHR is developing a quality management program, and discussions are underway to define processes to be included within the program. Routine post-adjudication audits are part of this planning. ***Status: Recommendation in progress.***

Table 9. Status of ISCA recommendations identified for DBHR in 2011.		
2011 opportunities for improvement	**2011 recommendations**	**RSN response**
DBHR uses a HIPAA-compliant 837 electronic format that accepts more than one diagnosis. 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 develop a method to ensure that the diagnosis being treated at the time of service is reported on the 837.	The Performance Indicator Workgroup (PIWG)/Data Quality 4 Group (DQ4) have discussed this issue, and further review and recommendations will be developed after the first of the year (2013). ***Status: Recommendation in progress.***
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 provide direction for the RSNs about the new process that is available to update eligibility data.	DBHR has sent several notices regarding this process to RSNs over the past year and has discussed the process. ***Status: Recommendation in progress.***
ProviderOne uses an enrollee's ZIP code of residence to assign the RSN. However, several RSNs share ZIP codes. In some cases, an enrollee may receive services from a particular RSN, but the encounter data show that another RSN provided the services.	DBHR needs to work to address enrollment issues for RSNs that share ZIP codes.	This issue will be discussed as part of the 2013 DBHR ISCA to clarify the issue and discuss potential strategies. ***Status: Recommendation in progress.***
RSNs report concern about the quality of 834 enrollment data. This concern arises from multiple issues, including retroactive enrollment changes, changes from one RSN to another, and frequent updates to enrollees' status. Many RSNs report that frequent data changes for an enrollee make it difficult to determine eligibility at any moment with certainty.	DBHR needs to work with RSNs to resolve issues related to the quality of 834 enrollment data.	This issue will be discussed as part of the 2013 DBHR ISCA to clarify the issue and discuss potential strategies. ***Status: Recommendation in progress.***
The majority of RSNs do not verify Medicaid eligibility before submitting encounters to DBHR, making it difficult to determine what services are paid by Medicaid, as opposed to state funds.	DBHR needs to work with RSNs to define expectations for checking enrollee eligibility when submitting encounters.	This issue will be discussed as part of the 2013 DBHR ISCA to clarify the issue and discuss potential strategies. ***Status: Recommendation in progress.***

Table 9. Status of ISCA recommendations identified for DBHR in 2011.		
2011 opportunities for improvement	**2011 recommendations**	**RSN response**
File Consolidation		
As of the ISCA review, the ProviderOne/ CIS file consolidation project was not complete and thus was not included in the review. This project was completed subsequently, but documentation was not available at the time of review.	DBHR needs to fully document the process used to extract source data from CIS, how these data will be aggregated and uploaded to DBHR's SAS server, and how it will be available for Looking Glass to use.	DBHR and Looking Glass are working on determining the best approach to creating additional performance measure documentation. ***Status: Recommendation in progress.***
Performance Measure Repository		
DBHR does not keep a frozen data set for the timeliness performance measures it calculates. ProviderOne data are dynamic, preventing replication of these reports in the event of loss.	In the absence of a frozen data set, DBHR needs to determine procedures to validate the integrity of the data undergoing formatting changes during the move from ProviderOne to Looking Glass.	DBHR is working with Looking Glass to validate and replicate these performance measures. ***Status: Recommendation in progress.***
Report Production		
As of the ISCA review, DBHR relied on one staff person to generate two performance measures. DBHR had not documented the process for producing the two timeliness performance measure reports and the three web-based performance measure reports, produced by Looking Glass.	DBHR needs to train more than one staff programmer how to generate its timeliness performance measures. DBHR needs to fully document each process that produces performance measures.	DBHR now has three staff members with knowledge and permissions to generate timeliness performance measures. ***Status: Recommendation in progress.***

Table 10. Status of ISCA findings and recommendations identified for RSNs in 2011.

Review section	RSN	Number of findings/ recommendations	Status
Information Systems			
Assess the entity's systems development life cycle and supporting environments, including database management systems and/or billing software, programming languages, and programmer training.	GCBH	1	Recommendation in progress
	GHRSN	2	Recommendations in progress
	NCWRSN	6	Recommendations in progress
	NSMHA	3	1 recommendation in progress 2 recommendations addressed
	PRSN	3	Recommendations in progress
	SWRSN	4	3 recommendations in progress 1 recommendation addressed
	TMRSN	1	Recommendation in progress
	TRSN	1	Recommendation in progress
Staffing			
Assess physical access to IT assets, as well as specific training requirements for new and existing staff.	GCBH	2	Recommendations in progress
	GHRSN	1	Recommendation in progress
	OPRSN	1	Recommendation in progress
	SWRSN	2	Recommendations in progress
Hardware Systems			
Assess network infrastructure and hardware systems in terms of infrastructural support and redundancy or duplication of critical components of hardware systems.	CDRSN	1	Recommendation addressed
	GHRSN	2	Recommendations in progress
	KCRSN	2	Recommendations in progress
	NCWRSN	3	Recommendations in progress
	NSMHA	2	1 recommendation stands 1 recommendation not applicable
	OPRSN	2	Recommendations in progress
	PRSN	1	Recommendation in progress
	TMRSN	1	Recommendation in progress
	TRSN	1	Recommendation addressed
Security			
Assess information systems in terms of integrity and the capacity to prevent data loss and corruption.	CCRSN	3	1 finding addressed 2 recommendations addressed
	CDRSN	2	Recommendations in progress
	GCBH	2	Recommendations in progress
	KCRSN	1	Recommendation stands
	NCWRSN	3	Recommendations in progress
	NSMHA	4	2 recommendations stand 2 recommendations in progress
	OPRSN	3	Recommendations in progress
	PRSN	1	Recommendation in progress
	SCRSN	5	1 finding in progress 4 recommendations in progress

Table 10. Status of ISCA findings and recommendations identified for RSNs in 2011.			
Review section	**RSN**	**Number of findings/ recommendations**	**Status**
	SWRSN	2	1 recommendation addressed 1 recommendation in progress
	TMRSN	3	Recommendations in progress
	TRSN	2	1 finding in progress 1 recommendation in progress
Adminstrative Data			
Assess accurate submission of information, process for describing differences when verifying accuracy of submitted claims, and data assessment and retention.	GCBH	1	Recommendation in progress
	KCRSN	1	Recommendation stands
	NCWRSN	4	Recommendations in progress
	NSMHA	2	1 recommendation stands 1 recommendation in progress
	OPRSN	1	Recommendation addressed
	PRSN	1	Recommendation stands
	SWRSN	1	Recommendation addressed
	TMRSN	1	Recommendation in progress
	TRSN	1	Recommendation in progress
Enrollment Systems			
Assess systems pertaining to enrollment and disenrollment processes, tracking of claims and encounter data, Medicaid enrollment data updates, Medicaid enrollment codes, and data verification.	CCRSN	1	Recommendation addressed
	GHRSN	1	Recommendation in progress
	NCWRSN	1	Recommendation in progress
	NSMHA	1	Recommendation in progress
	OPRSN	1	Recommendation addressed
	SWRSN	1	Recommendation in progress
Provider Data			
Assess the provider directory in terms of accessibility of complete and accurate provider profile information.	CDRSN	1	Recommendation in progress
	GHRSN	1	Recommendation in progress
	NSMHA	1	Recommendation in progress
	PRSN	1	Recommendation addressed

Mental health encounter data validation

Medicaid encounter data must be complete and accurate to be useful in calculating statewide performance measures and determining managed care capitation rates. DBHR's contract requires each RSN to conduct an annual encounter data validation (EDV) to determine the accuracy of encounter data submitted by providers.

As an independent check of the RSNs' EDV results, Acumentra Health performed a parallel EDV for each RSN. Beginning in 2012, DBHR will accept the RSNs' self-validation of their encounter data, subject to audit and verification by the EQRO. This change is intended to reduce the burden of provider-level reviews.

In conjunction with each RSN site visit in 2012, Acumentra Health reviewed a sample of the encounter data and clinical records each RSN examined to ensure that the RSN's EDV contained no significant errors. For each RSN, the EQRO team visited one provider agency to review clinical records. Acumentra Health also reviewed the computer code each RSN used to draw its random sample and the analytical code used to create the summary statistics, as well as the data entry system or database the RSN used to conduct its EDV.

Review results

This discussion focuses on the general trends Acumentra Health found in reviewing the RSNs' EDV systems: whether the RSNs used sampling procedures that resulted in pulling a random sample; whether data entry tools appropriately displayed encounter and demographic data; and whether the analytical tools accurately calculated the EDV results. The individual RSN profiles in Appendix A present specific EDV results and recommendations for each RSN.

Basic EDV procedures. All RSNs submitted documentation describing the dates when they performed the EDV and the time period covered by the encounters they reviewed. Each RSN also described its sampling procedure, submitted to Acumentra Health its data entry tool (if the RSN used one), described the analytical methods used to calculate EDV results, and submitted the EDV report deliverable.

Almost all RSNs used their internal data, rather than data downloaded from ProviderOne, to compare with provider agency data, although most RSNs stated that the data had been accepted by ProviderOne. Several RSNs went beyond contract requirements and reviewed a wide range of demographic data, such as living situation and education level, in addition to the required field of ethnicity. The encounter data fields reviewed by almost all RSNs included procedure code, service date, service duration, service location, and provider type.

RSN sampling procedures. Acumentra Health evaluated each RSN's sampling procedure on the basis of two criteria. First, was the sample large enough (at least 411 encounters or 1% of all encounters, whichever was less)? Second, was it a random sample?

All RSNs pulled samples of adequate size. Of the 13 RSNs, 11 used procedures that should have resulted in a random sample. One used a manual sampling process, and another used a web-based approach that could not be validated.

RSN sampling procedures were similar. First, the RSN assigned a randomly generated number to each encounter that occurred in a specific time period, or to each enrollee who had encounters in that period. The list of encounters was sorted by random number in ascending order, and a target number of encounters (at least 411) was selected from the top of the list. The RSNs used a variety of software to generate random numbers, from MS Access and MS Excel to websites that provide lists of randomly generated numbers.

Data entry tools. Only 4 of the 13 RSNs used data entry tools (all MS Access) to capture EDV results. Acumentra Health reviewed these four Access databases and found that three of them worked appropriately.

Other RSNs either manually entered the results of their data checks onto hard-copy forms and then entered the results into Excel to analyze, or they entered data directly into Excel. Acumentra Health recommended that these RSNs develop database systems to reduce the potential for error involved in entering results twice.

Analytical procedures. None of the RSNs had developed code using statistical software such as SAS or SPSS to analyze the EDV results. Almost all used Excel to calculate the summary statistics reported in the EDV deliverable. Most RSNs recorded non-matches between chart and RSN data with a "0" and matches with a "1," then divided the total number of "1" entries by the total possible number of matches for a field. In this approach, Excel formulas would calculate for each field the percentage of encounters that matched between chart and RSN data. Separate Excel spreadsheets were created to analyze the agency-level and RSN-level results. Acumentra Health reviewed the Excel formulas for the RSNs that used this approach and verified that all calculations worked correctly.

For the small number of RSNs that used Access to calculate the EDV results, Acumentra Health reviewed the Access reports and found them working correctly.

Comparison of data matching results. For each RSN, Acumentra Health typically reviewed 82 encounters at one agency. The encounters usually represented services for about 20 enrollees. The demographic data Acumentra Health reviewed most often included name, date of birth, and ethnicity. If the RSN selected more demographic fields to validate, Acumentra Health tried to review those additional fields. The encounter data fields reviewed most often included procedure code, service date, service minutes, service location, and provider type.

For 10 of the 13 RSNs, Acumentra Health found high rates of matching (at least 95%) between the chart and RSN data for most of the demographic and encounter fields. For a few RSNs, Acumentra Health found large percentages of mismatches in the fields for service minutes, service location, and especially for provider type.

- High rates of mismatch in the *provider type* field usually occurred because the chart omitted this information or because Acumentra Health's reviewers found the information illegible.
- Mismatches in *minutes of service* most often occurred when this information was captured in the electronic record but omitted from the chart, or simply differed between the electronic and chart data. Sometimes these mismatches could have been due to a switch from 15-minute units of service to minutes.
- One RSN had an issue with *service location* because the progress note contained no field for service location.

In comparing Acumentra Health's results with the RSN results for the same encounters, the most frequent differences between the two audit teams concerned provider type. These differences often involved illegible or missing data in the chart. In some cases, when the RSN reviewer knew the providers' credentials from having reviewed encounters at the agency before, the reviewer might have recorded a match if the electronic data included the correct credentials, even if the credentials in the chart note were illegible.

Acumentra Health sometimes found *procedure codes* not matching between chart and RSN data, whereas the RSN's audit team reported a match. In some instances, a single service had been unbundled and reported as two or more separate services. For example, some intake encounters were unbundled and each of three distinct intake activities was recorded as a separate encounter; in other cases, all three activities were included in the intake encounter. Occasionally the service represented a simple phone call to schedule a meeting with the enrollee. Acumentra Health recorded such cases as a mismatch between the chart and RSN data.

Discussion and recommendations

Overall, the RSNs have developed systems that appear to work appropriately to validate providers' encounter data. Acumentra Health's review found that the sampling procedure almost always resulted in random samples of more than adequate size. The data entry tools developed by a few RSNs displayed the demographic and encounter data correctly and recorded EDV results appropriately. The Excel tools most RSNs used to calculate the summary results contained formulas that appeared to correctly tabulate the EDV results. For 10 of the 13 RSNs, Acumentra Health's data matching results closely matched what the RSN found for the same encounters.

In reviewing individual RSNs' EDV procedures, Acumentra Health often recommended that the RSN develop a database system to display the demographic and encounter data elements to be checked, and to record the EDV results. Such systems can also support automatic calculation of EDV results at the agency and RSN levels. This would reduce the potential for error in recording results twice, once on paper and again in Excel. It would also cut down on the manual manipulation of Excel tools used to calculate EDV results.

Acumentra Health recommends that DBHR

- ***work with the RSNs to standardize data collection and analytical procedures for encounter data validation to improve the reliability of encounter data submitted to the state***
- ***provide guidance for RSNs as to when services can be bundled under a single service code and when services should be unbundled into separate service codes***

PHYSICAL HEALTH CARE DELIVERED BY MCOS

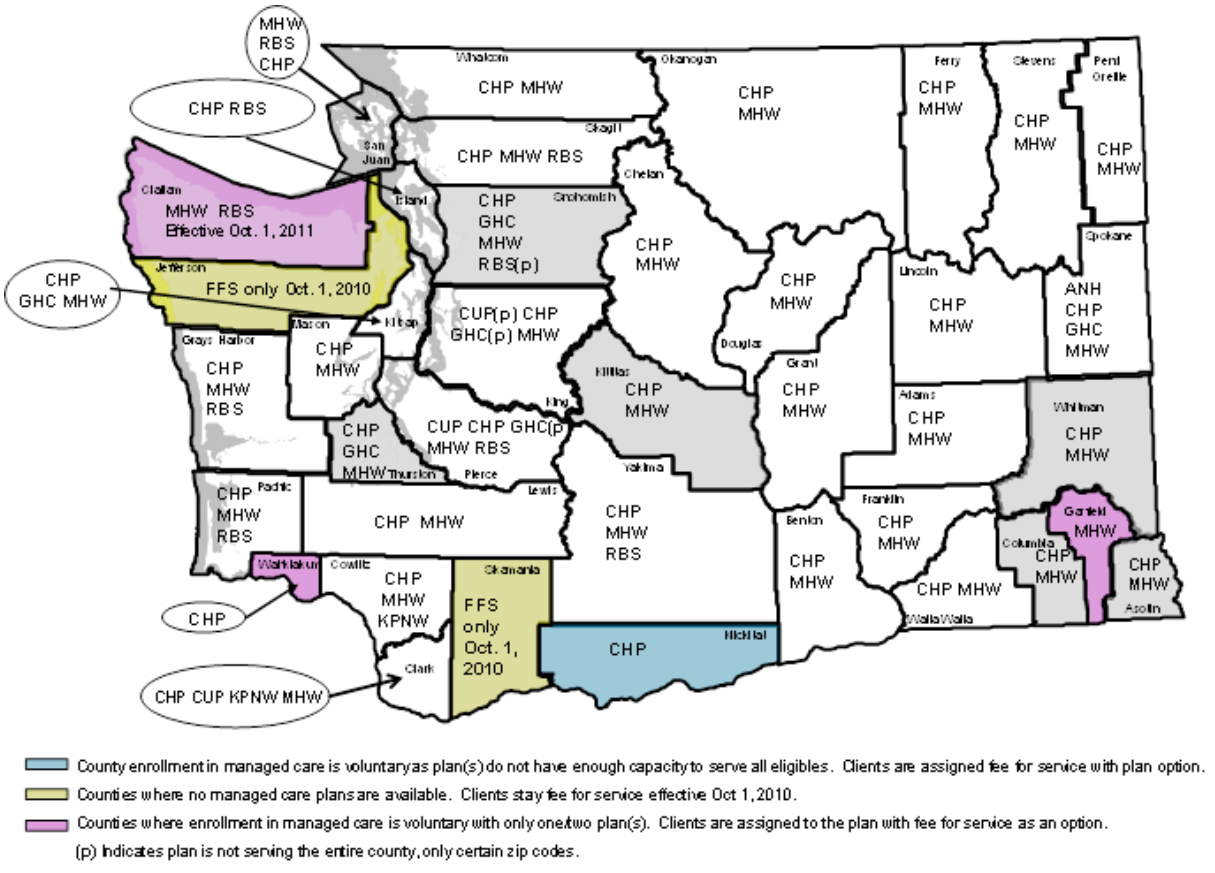
HCA contracts with seven MCOs to deliver physical healthcare services to Medicaid managed care enrollees. Table 11 shows the approximate number and percentage of enrollees assigned to each health plan as of December 2011. Figure 16 shows the counties served by each plan.

Table 11. Managed care organizations and Medicaid enrollees, December 2011.[a]

Health plan	Acronym	Number of enrollees	% of all enrollees
Asuris Northwest Health	ANH	4,499	0.6
Community Health Plan	CHP	231,353	33.3
Columbia United Providers	CUP	58,826	8.5
Group Health Cooperative	GHC	20,775	3.0
Kaiser Permanente Northwest	KPNW	1,101	0.1
Molina Healthcare of Washington	MHW	339,728	48.9
Regence BlueShield	RBS	38,635	5.6
Total		**694,917**	**100.0**

[a] Source: DSHS. Enrollment includes Healthy Options, CHIP, and Basic Health Plus.

Figure 16. Healthy Options/CHIP service areas, December 2011.



NOTE: This report reflects results for the above MCOs based on 2011 measurements. Effective July 1, 2012, HCA began contracting with five MCOs (CHP, MHW, and three new contractors) to provide services for Healthy Options, Basic Health, and some Supplemental Security Income clients through a joint managed care procurement. Therefore, this year's report presents the final comparative data for the seven MCOs listed above. Future reports will present results for the new roster of contracted MCOs.

HCA uses the annual HEDIS measures to gauge the MCOs' clinical performance against national benchmarks. The Healthy Options contract contains specific provisions based on the health plans' HEDIS scores. Acumentra Health's subcontractor, Health Services Advisory Group, audits each MCO's data collection process to ensure data integrity.

TEAMonitor conducts the regulatory/contractual compliance review for all Healthy Options MCOs and validates the health plans' PIPs. Review procedures are based on the CMS protocols for these activities. For the 2011 review, TEAMonitor requested preassessment documentation from each health plan supporting the plans' compliance with specific regulatory and contractual provisions. Following a desk audit of these materials, TEAMonitor performed a one- to two-day site visit for each plan.

In analyzing quality, access, and timeliness measures for physical health care, this report considers performance at both a statewide and health plan level. The sections reporting statewide results present analysis in table format with star ratings. The star ratings show the results of comparing the statewide Healthy Options score with the NCQA Medicaid national average for each element. State average percentages were calculated by adding individual plan numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and multiplying the resulting proportion by 100. For the national comparison, Acumentra Health referred to the 2011 Medicaid averages from the NCQA *Quality Compass*.[6]

In this rating system, one star means that Washington scored within the 10th percentile of national scores; two stars, between the 10th and 25th percentile (below average); three stars, between the 25th and 50th percentile (average); four stars, between the 50th and 75th percentile, and five stars, above the 90th percentile (above average). Figure 17 shows the stars and the percentile ranges.

Figure 17. Percentiles and star ratings used in this report.

Access to physical health care

HCA has several mechanisms in place to monitor MCOs' success in providing access to care for Healthy Options enrollees. Through TEAMonitor, HCA assesses the MCOs' compliance with regulatory and contractual requirements related to access. (See Appendix C.) HCA also monitors MCO performance on the standardized clinical performance measures discussed below.

Compliance with access standards

The Healthy Options contract requires each MCO to demonstrate that its provider network has the capacity to serve all eligible enrollees, in terms of the number and types of providers required, the geographic location of providers and enrollees, and enrollees' cultural, ethnic, and language needs. Each MCO must ensure timely access to services and must monitor network capacity in relation to enrollee utilization patterns. The plans must comply with regulations in 42 CFR §438 pertaining to Availability of Services, Furnishing of Services, Coverage and Authorization of Services, and Additional Services for Enrollees with Special Healthcare Needs (SHCN).

TEAMonitor's 2012 review found that the MCOs, as a group, demonstrated strong compliance with access standards. The MCOs met all elements of Availability of Services and Furnishing of Services, and they met more than 90% of the elements of Additional Services for Enrollees with SHCN, Coverage and Authorization of Services, and Emergency and Post-stabilization Services. Lingering deficiencies mainly involved documentation of MCO policies and procedures. (See page 79.)

Performance on access measures

Three HEDIS measures assess health plans' success in providing access to WCC, expressed as the percentage of enrollees in each age group who received the recommended numbers of visits:

- Infants in the first 15 months of life should receive *six or more* WCC visits.
- Children in the 3rd, 4th, 5th, and 6th years of life should receive *at least one* WCC visit each year.
- Adolescents ages 12–21 should receive *at least one* WCC visit each year.

Statewide results: Table 12 compares access to WCC in Washington with the national Medicaid averages. The Washington MCOs' average rate of delivering WCC visits for infants and for adolescents rose significantly in 2012 (to 58% and 39%, respectively), yet remained significantly below the national average. Average visit rates for children aged 3–6, at 62%, also remained significantly below the U.S. average.

Table 12. Washington scores and national averages for physical health access measures, 2012.

Measure	National average	Washington score	Washington rating
Infant WCC Visits (6 or more)	62%	58%*	☆☆☆
WCC Visit, 3–6 years	72%	62%*	☆☆
Adolescent WCC Visit	50%	39%*	☆☆

Stars represent Washington's performance compared with the 2012 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.
*State average is significantly different from the NCQA average.

MCO results: The percentages of WCC visits for enrollees in all three age groups varied widely by health plan in 2012 (see Table 13). RBS reported the highest visit rate for infants (62%), while KPNW reported the highest rates for children aged 3–6 (83%) and for adolescents (48%).

Infants: No MCOs' rates differed significantly from the state average of 58%, though both CUP and RBS improved their rates significantly from 2011 to 2012.

Ages 3–6: KPNW's visit rate for this age group significantly exceeded the state average, as in 2011. MHW, CHP, and GHC also reported rates above the state average.

Adolescents: MHW and GHC, at 46% and 45%, respectively, significantly exceeded the state average for this age group. Visit rates for ANH and CUP were significantly below average.

Table 13. MCO and state scores for physical health access measures, 2012.

Measure	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
Infant WCC (6+ visits)	—	54%	55%	61%	—	59%	62%	58%
Child WCC, 3 to 6 Years	60%	64%	60%	63%	83% ▲	66%	58%	62%
Adolescent WCC Visit	33% ▼	40%	31% ▼	45% ▲	48%	46% ▲	37%	39%

▲ Health plan percentage is significantly higher than state average ($p<0.05$).
▼ Health plan percentage is significantly lower than state average ($p<0.05$).
— Sample size was less than the minimum required.

Timeliness of physical health care

The Healthy Options contract incorporates federal standards for timely care and makes MCOs responsible for monitoring their networks to ensure that enrollees receive timely care. (See Appendix C.) HCA assesses compliance with these standards through TEAMonitor and also monitors the plans' performance in providing timely postpartum care for female enrollees.

Compliance with timeliness standards

By contract, each MCO must offer designated services 24 hours a day, seven days a week by telephone. For preventive care, office visits must be available from the enrollee's PCP or another provider within certain time frames, depending on the urgency of the enrollee's condition. Federal regulations require each MCO to provide hours of operation for Medicaid enrollees that are no less than the hours for any other patient.

TEAMonitor's 2012 review found that all MCOs demonstrated full compliance with the standards for timely access to services. (See page 79.)

Performance on timeliness measure

The HEDIS measure of postpartum care assesses the timely initiation of postpartum visits for female enrollees who delivered a live birth during the measurement year, expressed as the percentage of such enrollees who had a postpartum visit on or between 21 days and 56 days following delivery.

Statewide results: Table 14 shows that the 2012 Washington average for this measure, 63%, was essentially level with the U.S. average. Statewide performance on this measure has remained static for 10 years, while the national average has improved steadily, from 52% in 2002 to the current 64%.

Table 14. Washington scores and national averages for physical health timeliness measure, 2012.

Measure	National average	Washington score	Washington rating
Postpartum Care	64%	63%	☆☆☆

Stars represent Washington's performance compared with the 2012 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.

MCO results: Table 15 compares the performance of Washington MCOs with the statewide score on the timeliness measure. Rates for timely postpartum care ranged from RBS's 57%, significantly below the state average, to GHC's 69% and MHW's 68%, both significantly above average. RBS reported a significant decline from 2011 to 2012, while CUP reported a significant increase.

Table 15. MCO and state scores for physical health timeliness measure, 2012.

Measure	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
Postpartum Care	62%	60%	60%	69% ▲	—	68% ▲	57% ▼	63%

▲ Health plan percentage is significantly higher than state average ($p<0.05$).
▼ Health plan percentage is significantly lower than state average ($p<0.05$).
— Sample size was less than the minimum required.

Quality of physical health care

Federal EQR regulations (42 CFR §438.320), echoed in the Healthy Options contract, define quality as the degree to which a managed care plan "increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." Appendix C itemizes many quality-related standards covered by TEAMonitor's compliance reviews. HCA also monitors MCO performance on the standardized quality measures discussed below.

Compliance with quality standards

Quality standards are embedded in the portions of the compliance review addressing Primary Care and Coordination, Provider Selection, Practice Guidelines, QA/PI, Enrollee Rights, and Grievance Systems, as well as in contractual requirements to ensure continuity and coordination of care.

TEAMonitor's 2012 review found that the MCOs, as a group, strengthened their compliance with quality-related standards compared with 2011. The MCOs met all elements of Primary Care and Coordination, Practice Guidelines, and Provider Selection, and met more than than 90% of the elements of Enrollee Rights, QA/PI Program, and Grievance Systems. (See page 79.)

Performance on quality measures

Three HEDIS measures are available for analyzing the quality of physical health care: two measures of childhood immunization and a measure of diabetes care, HbA1c testing.

The first immunization measure, Combination #2 (Combo 2), assesses the percentage of enrolled children who turned 2 years old during the measurement year and who received *all* of these immunizations by their second birthday:

- four diphtheria, tetanus, and pertussis (DTaP)
- three polio (IPV)
- one measles, mumps, and rubella (MMR)
- three Haemophilus influenza type b (HiB)
- three hepatitis B (Hep B)
- one varicella-zoster virus (VZV) or chicken pox

The second measure, Combination #3 (Combo 3), assesses the percentage of enrolled children who turned 2 years old during the measurement year and who received *all* of the above immunizations *plus* the pneumococcal conjugate vaccine (PCV) by their second birthday.

The diabetes care measure assesses the percentage of adult enrollees with diabetes (type 1 or type 2) who received an HbA1c test during the measurement year. Because children younger than 18 account for more than 80% of Washington's Medicaid population, health plans with low overall enrollment may have difficulty finding enough adult enrollees eligible for the diabetes measure components.

Statewide results: Table 16 on the following page compares Washington's performance on these quality measures with the nationwide performance.

Washington's Combo 2 immunization rate held steady at 70% in 2012, still significantly below the national Medicaid average of 74%. Average rates for all individual vaccines in Combo 2 remain below 90%. The federal benchmarking report, *Healthy People 2010*, sets 80% as the target for health plans to achieve by 2010 for DTaP, IPV, MMR, HiB, and HepB, and 90% percent as the target for PCV.

The 2012 statewide average for Combo 3 was 67%, also significantly below the U.S. average of 71%. The average PCV vaccination rate remained at 77%, well below the federal benchmark.

The Washington MCO average for the diabetes care indicator in 2012 was about 83%, equivalent to the national Medicaid average.

Table 16. Washington scores and national averages for physical health quality measures, 2012.			
Measure	**National average**	**Washington score**	**Washington rating**
Childhood Immunizations (Combo 2)	74%	70%*	☆☆☆
Childhood Immunizations (Combo 3)	71%	67%*	☆☆☆
Diabetes Care (annual HbA1c test)	83%	83%	☆☆☆☆

Stars represent Washington's performance compared with the 2012 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.
*State average is significantly different from the NCQA average.

MCO results: Table 17 compares individual health plans' performance with the statewide scores on the quality measures.

Combo 2 immunizations: The Washington MCOs reported no significant changes in Combo 2 rates from 2011 to 2012. CHP once again significantly outperformed the statewide average at 77%.

Combo 3 immunizations: As with Combo 2, CHP again significantly outperformed all other MCOs in 2012, at 73%. CUP remained significantly below the state average.

Diabetes care: MCO performance in 2012 varied around the state average of 83%, with no MCO reporting a significant change from 2011.

Table 17. MCO and state scores for physical health quality measures, 2012.							
Measure	**CHP**	**CUP**	**GHC**	**KPNW**	**MHW**	**RBS**	**State**
Childhood Immunizations (Combo 2)	77% ▲	65%	65%	—	72%	69%	70%
Childhood Immunizations (Combo 3)	73% ▲	61% ▼	64%	—	69%	67%	67%
Diabetes Care (annual HbA1c test)	83%	83%	85%	—	83%	78%	83%

▲ Health plan percentage is significantly higher than state average ($p<0.05$).
▼ Health plan percentage is significantly lower than state average ($p<0.05$).
— Sample size was less than the minimum required.

Physical health regulatory and contractual standards

In 2012, TEAMonitor reviewers scored MCOs on their compliance with approximately 80 required elements of BBA regulations and Healthy Options contract provisions. Reviewers rated each MCO as having met, partially met, or not met the requirements for each standard listed below:

- Availability of Services
- Furnishing of Services (Timely Access)
- Program Integrity
- Timely Claims Payment
- Primary Care and Coordination
- Additional Services for Enrollees with Special Healthcare Needs (SHCN)
- Patient Review and Coordination
- Coverage and Authorization of Services
- Emergency and Post-Stabilization Services
- Enrollee Rights
- Enrollment and Disenrollment
- Grievance Systems
- Performance Improvement Projects
- Practice Guidelines
- Provider Selection (Credentialing)
- QA/PI Program
- Subcontractual Relationships and Delegation

For a more detailed description of these standards, including a list of relevant Healthy Options contract provisions and a list of elements within each BBA regulation, see Appendix C.

Separately, HCA and ADSA reviewed the WMIP program contractor's compliance with relevant regulations and contract provisions (see page 94).

Compliance scoring methods

The comprehensive TEAMonitor audits produce a large amount of data. For purposes of analysis, Acumentra Health designed a scoring system that is intended to provide an easily understandable presentation of the data.

TEAMonitor assigned each of the required elements a score of Met, Partially Met, or Not Met, unless the element was not scored. Using scores from the TEAMonitor reports, Acumentra Health calculated compliance scores for each standard, expressed as a percentage of each standard's elements that were Met. These percentage scores appear in Table 18 and in the MCO Profiles in Appendix B. The scores were calculated as follows.

Denominator: the number of scored elements within a particular standard. Elements not scored by TEAMonitor were removed from the denominator.

Numerator: the number of scored elements that received a Met score. Compliance is defined as fully meeting the standard, since the HCA contract requires an MCO to implement a corrective action plan to achieve full compliance with any standard that is below a Met score.

For example, five elements comprise the standard for Availability of Services. If an MCO scored Met on three elements, Partially Met on one element, and Not Met on one element, the MCO's score would be based on a denominator of 5 (total elements scored) and a numerator of 3 (elements Met). The MCO's percentage score on that standard would be 3/5, or 60%. However, if the MCO scored Met on three elements and Partially Met on one element, and TEAMonitor did not score the fifth element, the MCO's score would be based on a denominator of 4 (the element not scored is excluded) and a numerator of 3 (elements Met). The MCO's score on that standard would be 3/4, or 75%.

Summary of compliance review results

Table 18 breaks out the 2012 compliance scores assigned by TEAMonitor for each of 16 standards (excluding PIPs) by health plan. (TEAMonitor combines its review of RBS and ANH, since the two plans share administrative functions and resources.) Figure 18 shows the change in compliance scores on selected standards from 2010 through 2012.

In 2012, HCA conducted condensed reviews and readiness assessments of CHP and MHW, which continued to serve as contracted MCOs after June 30, 2012. HCA conducted closeout reviews of CUP, GHC, KPNW, and RBS/ANH, whose contracts ended on that date. HCA reviewed all MCOs' files to monitor grievances and appeals and coordination-of-care standards. In addition, HCA conducted readiness assessments of the three newly contracted MCOs.

Collectively, the MCOs greatly improved their performance on compliance standards in 2012 by successfully completing corrective actions. As a group, the MCOs met between 90% and 100% of the elements of all standards, except for Patient Review and Coordination.

Almost all standards not fully met were at least partially met. Many of the lingering Partially Met or Not Met scores relate to gaps in the MCOs' documentation to support compliance. This is particularly true for the standard related to the Patient Review and Coordination program, the elements of which include guidelines, enrollee placement, appeals, and notification.

Table 18. MCO compliance scores for physical health regulatory and contractual standards, 2012.

Percentage of elements Met, Partially Met, and Not Met

Standard (# of elements)	CHP			CUP			GHC			KPNW			MHW			RBS/ANH			State average		
	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM
Availability of Services (5)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Furnishing of Services (2)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Program Integrity (2)[a]	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	*	0	0	**100**	0	0	**100**	0	0
Claims Payment (1)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Primary Care and Coordination (1)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Additional Services for Enrollees with SHCN (4)[b]	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**50**	50	0	**100**	0	0	**92**	8	0
Patient Review and Coordination (8)	**88**	12	0	**100**	0	0	**63**	12	25	**100**	0	0	**88**	12	0	**75**	12	12	**85**	8	6
Coverage and Authorization of Services (4)	**100**	0	0	**100**	0	0	**75**	25	0	**100**	0	0	**75**	25	0	**100**	0	0	**92**	8	0
Emergency and Post-stabilization Services (2)	**100**	0	0	**100**	0	0	**50**	50	0	**100**	0	0	**100**	0	0	**100**	0	0	**92**	8	0
Enrollment/Disenrollment (1)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Enrollee Rights (13)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**92**	8	0	**100**	0	0	**99**	1	0
Grievance Systems (19)	**89**	11	0	**100**	0	0	**95**	0	5	**100**	0	0	**89**	0	11	**100**	0	0	**95**	2	3
Practice Guidelines (3)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Provider Selection (3)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
QA/PI Program (5)	**100**	0	0	**100**	0	0	**80**	20	0	**100**	0	0	**80**	20	0	**100**	0	0	**93**	7	0
Subcontractual Relationships and Delegation (4)	**100**	0	0	**100**	0	0	**75**	25	0	**100**	0	0	**100**	0	0	**100**	0	0	**96**	4	0

M=Met; PM=Partially Met; NM=Not Met

NOTE: These standards were scored over the course of 2012. MCOs with a score of "Partially Met" or "Not Met" for any standard may have submitted corrective action plans to address deficiencies following review; therefore, the above scores may not reflect the status of plan performance as of December 2012.

[a] CUP was scored on 1 element; all other MCOs were scored on 2 elements.

[b] CHP was scored on 5 elements; all other MCOs were scored on 4 elements.

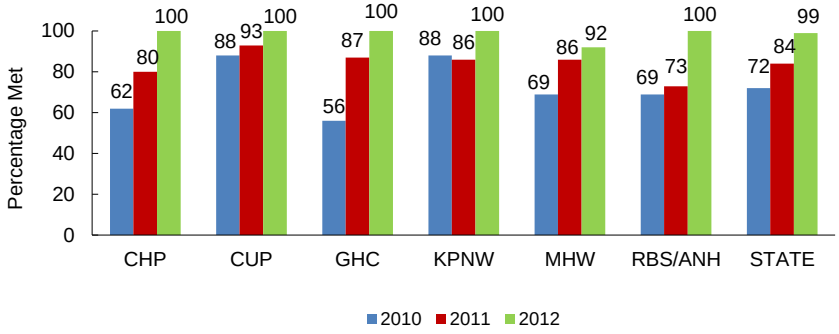
* Reviewed as part of 2012 readiness assessment.

Figure 18. Changes in compliance scores for selected physical health regulatory standards by MCO, 2010–2012.

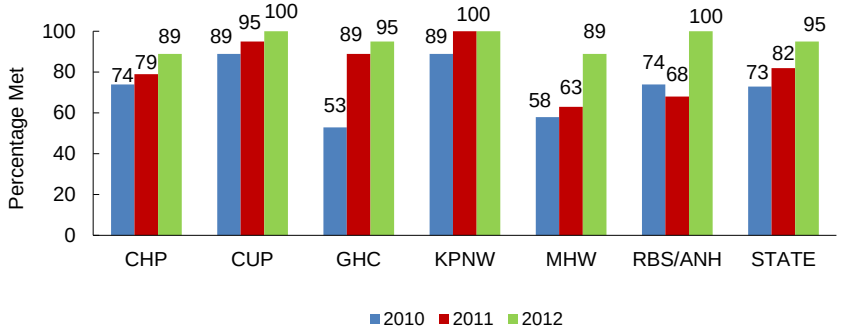
Figure 18. Changes in compliance scores for selected physical health regulatory standards by MCO, 2010–2012 (cont.).

Timeliness and Quality Standards

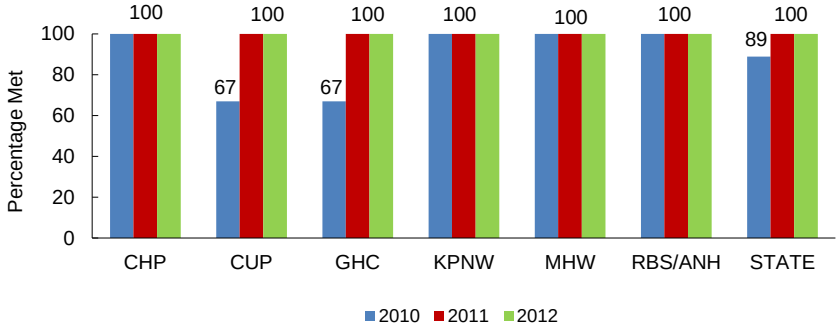
Enrollee Rights



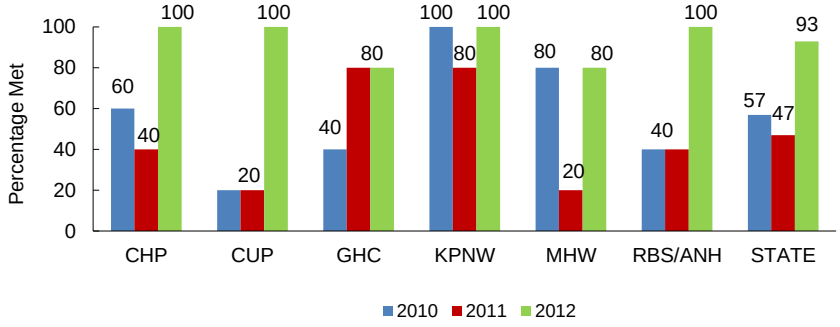
Grievance Systems



Provider Selection



QA/PI Program



Corrective action plans

In 2012, TEAMonitor reviewed the MCOs' 2011 corrective action plans (CAPs) and documented how the MCOs had resolved corrective actions. If this review identified old or new findings, TEAMonitor required the MCO to perform corrective action in 2012.

With the end of the contract between HCA and some MCOs on June 30, 2012, corrective action for those MCOs was determined not to be legally warranted. HCA encouraged those MCOs to consider the results of the TEAMonitor report and make improvements as necessary.

Table 19 shows the disposition of CAPs required in 2012. TEAMonitor assigned a total of 17 CAPs to CHP and MHW, the two continuing MCOs, and accepted 15, or 88%.

Corrective action in response to TEAMonitor findings is an ongoing activity for MCOs. TEAMonitor expects that MCOs will provide updates on the effectiveness of most required actions at the time of the next TEAMonitor review, and that MCOs will continue to address unresolved CAPs.

Table 19. Disposition of MCOs' corrective action plans.

Health plan	2012 CAPs required	2012 CAPs accepted	2012 percentage accepted	2011 CAP status not resolved
CHP	4	4	100%	0
CUP	0	0	—	0
GHC	0	0	—	6
KPNW	0	0	—	0
MHW/WMIP	13	11	85%	9
RBS/ANH	0	0	—	2

Physical health PIP validation

The managed care contract requires each MCO to conduct at least one clinical and one nonclinical PIP. An MCO must conduct a PIP to improve immunization and/or WCC rates if the plan's reported rates fall below established benchmarks. (See Appendix C, page C-4.)

PIP validation by TEAMonitor follows CMS standards. MCOs must conduct their PIPs as formal studies, describing the study question, numerator and denominator, confidence interval, and tests for statistical significance. In addition, all Medicaid enrollees must have access to the interventions described in the PIP.

TEAMonitor's 2012 review evaluated the PIPs each MCO conducted during 2011.

Table 20 shows the topics of each MCO's PIPs and the scores assigned by TEAMonitor. As required by contract, all MCOs addressed WCC visits through their clinical PIPs, and four MCOs conducted immunization PIPs. The nonclinical PIP topics varied as shown. GHC earned a "Met" score for all three PIPs reported, and KPNW met requirements for both of its PIPs. Other MCOs achieved varying degrees of success.

A discussion of each MCO's PIPs follows. The comments regarding strengths, opportunities for improvement, and other aspects of the PIPs are based on the TEAMonitor reports. Appendix D itemizes the steps that TEAMonitor used in assessing the MCOs' PIPs.

Table 20. PIP topics and scores by MCO, 2012.

MCO	PIP topic	Score
CHP	Clinical: Well-Child Exams: Improving HEDIS Rates	Met
	Nonclinical: Improving Customer Service Representative Handling of Benefit Calls	Not Met
CUP	Clinical: Improving Well-Child Visit Rates	Partially Met
	Clinical: Improving Childhood Immunization Rates	Partially Met
	Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Partially Met
GHC	Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Met
	Clinical: Improving Childhood Immunization Rates	Met
	Nonclinical: Increasing Percentage of Members With Race and Ethnicity Data	Met
KPNW	Clinical: Improving Well-Child Visit Rates	Met
	Nonclinical: Regional Appointment Center Call Answer Timeliness	Met
MHW	Clinical: Improving Well-Child Visit Rates	Partially Met
	Clinical: Improving Childhood Immunization Rates	Partially Met
	Nonclinical: Pharmacy Authorization Turnaround Times	Met
RBS/ANH	Clinical: Well-Child Visits With a Disparity Aspect Involving Hispanic Population	Not Met
	Clinical: Improving the Rate of Childhood Immunizations	Partially Met
	Nonclinical: Improving Employees' Understanding of Cultural Competency and Health Disparities	Not Met

Community Health Plan

Table 21 displays the topics and scores of CHP's PIPs in the past three years. CHP carried over its clinical project aimed at improving WCC visit rates, as required by contract. The MCO reported a new nonclinical PIP in 2012, Improving Customer Service Representative Handling of Benefit Calls.

Strengths

- CHP's clinical PIP has shown consistent execution over time. Additional data from the project are incorporated at the MCO and provider levels to improve monitoring of performance.
- The nonclinical PIP sets a worthy goal of improving the accuracy and completeness of responses to benefit inquiries.

Opportunities for improvement

- For the clinical PIP, CHP needs to develop refreshed interventions with an eye toward future improvements. CHP may wish to target interventions to address cultural and linguistic barriers to WCC visits. The MCO needs to expand its barrier analysis to continue improvement efforts.
- According to TEAMonitor, the nonclinical PIP was poorly designed and did not adequately define measurable indicators of improved service. CHP needs to reexamine its sampling methodology; specify a plan for data collection and analysis that ensures valid and reliable data; and improve the analytics (linking findings to interventions), including barrier analysis.

Table 21. Community Health Plan PIP topics and scores, 2010–2012.

Topic	2010	2011	2012
Clinical: Well-Child Exams: Improving HEDIS Rates	Met	Partially Met	Met
Nonclinical: Improving Customer Service Representative Handling of Benefit Calls	Not reported	Not reported	Not Met
Nonclinical: Improving Mental Health Support Services	Not reported	Not Met	Not reported
Nonclinical: Improving Call Resolution Performance	Not Met	Not reported	Not reported

Columbia United Providers

Table 22 displays the topics and scores of CUP's PIPs in the past three years. For 2012, as for 2011, CUP submitted clinical PIPs related to childhood immunizations and WCC visits, as well as a nonclinical PIP on reducing inappropriate ER utilization.

Strengths

- CUP's clinical PIPs exhibited improved documentation, with data presented in clear, easy-to-read tables.
- CUP implemented five interventions for the nonclinical PIP in 2011, which together reduced inappropriate ER usage. The PIP reporting format showed clinic-specific ER usage, with drill-down of information to the clinic level.

Opportunities for improvement

- The clinical PIPs were unsuccessful in improving immunization and WCC visit rates; in fact, these measures declined. The decline for Combo 2 immunizations was statistically significant. The interventions (outreach calls to parents) were not implemented until late 2011 and did not affect the measures. Planned follow-up activities were not robust or aggressive.

Table 22. Columbia United Providers PIP topics and scores, 2010–2012.

Topic	2010	2011	2012
Clinical: Improving Childhood Immunization Rates	Not Met	Partially Met	Partially Met
Clinical: Improving Well-Child Visit Rates	Not Met	Partially Met	Partially Met
Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Not reported	Partially Met	Partially Met
Nonclinical: HEDIS Process Quality Improvement	Not Met	Not reported	Not reported

Group Health Cooperative

Table 23 displays the topics and scores of GHC's PIPs in the past three years. GHC has carried over its clinical PIP on WCC visit rates since 2008, as required by contract. In 2012, the MCO also reported a contractually required PIP aimed at improving childhood immunization rates. The MCO's nonclinical PIP topic of improving race and ethnicity data for Medicaid enrollees was new for 2012.

Strengths

- GHC's clinical PIP on WCC visits has earned a "Met" score in each of the past four years. Project documentation includes an excellent description of barriers and interventions and a graphical display of data over time.
- The immunization PIP uses a best-practice intervention: a social marketing campaign and development of a training toolkit for providers to address parents' hesitancy to have their children vaccinated.
- TEAMonitor commended the nonclinical PIP as a best-practice project, using objective, measurable indicators, sound barrier analysis, and meaningful interventions that were followed by a significant increase in the collection of race and ethnicity data for members.

Opportunities for improvement

- For the PIP on WCC visits, GHC needs to consider refreshed interventions to sustain improvements on these measures.

Table 23. Group Health Cooperative PIP topics and scores, 2010–2012.

Topic	2010	2011	2012
Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Met	Met	Met
Clinical: Improving Childhood Immunization Rates	Not reported	Not reported	Met
Nonclinical: Increasing Percentage of Members With Race and Ethnicity Data	Not reported	Not reported	Met
Nonclinical: Reducing Healthy Options/Basic Health Plus Member Complaints	Not reported	Partially Met	Not reported
Nonclinical: Improving Practitioner Communication with Members	Not Met	Not reported	Not reported

Kaiser Permanente Northwest

Table 24 displays the topics and scores of KPNW's PIPs since 2010. As shown, both PIPs have met HCA requirements in each of the past three years. KPNW has conducted the clinical PIP since 2003 and the nonclinical PIP since 2006.

Strengths

- KPNW's clinical PIP shows consistent execution over time and uses excellent visual displays of data in table and graph form, including trend analysis.
- Over the years, the nonclinical PIP has improved call-response times so much that KPNW made its measure more stringent, reducing the expected response time from 90 to 30 seconds. Interventions have changed over time in response to analysis of the factors driving outcomes.

Opportunities for improvement

- Regarding the clinical PIP, KPNW atributed this year's decline in adolescent WCC visit rates to the late start of the most recent intervention—Interactive Voice Response (IVR) phone calls to enrollees with follow-up letters as needed. KPNW planned activities to augment the IVR calls and refresh interventions.
- The current goal of the nonclinical PIP (80% of calls answered within 30 seconds) has proved unsustainable.

Table 24. Kaiser Permanente Northwest PIP topics and scores, 2010–2012.

Topic	2010	2011	2012
Clinical: Improving Well-Child Visit Rates	Met	Met	Met
Nonclinical: Regional Appointment Center Call Answer Timeliness	Met	Met	Met

Molina Healthcare of Washington

Table 25 displays the topics and scores of MHW's PIPs since 2010. MHW has conducted both its clinical PIP, on WCC visit rates, and its nonclinical PIP, on pharmacy authorization turnaround times, over the past three years. In 2012, the MCO conducted a clinical PIP on improving childhood immunization rates, as required by contract.

Strengths

- MHW's clinical PIPs were generally well documented. TEAMonitor cited the format of MHW's barrier and intervention lists as a particular strength.
- The nonclinical PIP has shown real improvement in reducing the time it takes the MCO to authorize a prescription. Provider and enrollee satisfaction survey results, added to the data collection and analysis plan in 2012, afford an additional measure of success.

Opportunities for improvement

- Ongoing interventions for both of the clinical PIPs are mostly passive, involving reminders sent to providers and members. MHW needs to revisit its interventions and consider using more active strategies to achieve and sustain improvement in WCC and immunization measures.
- For the nonclinical PIP, MHW may wish to consider whether the volume of pharmacy authorization requests correlates to turnaround times, and gear its possible interventions toward periods with peak authorization requests.

Table 25. Molina Healthcare of Washington PIP topics and scores, 2010–2012.

Topic	2010	2011	2012
Clinical: Improving Well-Child Visit Rates	Met	Partially Met	Partially Met
Clinical: Improving Childhood Immunization Rates	Met	Not reported	Partially Met
Nonclinical: Pharmacy Authorization Turnaround Times	Met	Met	Met

Regence BlueShield/ Asuris Northwest Health

Table 26 displays the topics and scores of RBS/ANH's PIPs since 2010. In 2012, RBS/ANH carried over the contractually required clinical and nonclinical PIPs from previous years.

Strengths

- TEAMonitor commended RBS/ANH's efforts to reduce disparity in WCC visit rates between the Hispanic and non-Hispanic populations, though the project's degree of success cannot be gauged from the PIP submission.

Opportunities for improvement

- Both clinical PIPs are hindered by weak, passive interventions, lack of written analysis, and inadequate documentation. The MCO submitted no action plan for refreshing its interventions as required by TeaMonitor.
- In 2012, RBS/ANH submitted the same nonclinical PIP as in 2011, with no update to demonstrate an active project. The PIP did not address specific corrective actions required by TeaMonitor.

Table 26. Regence BlueShield/Asuris Northwest Health PIP topics and scores, 2010–2012.

Topic	2010	2011	2012
Clinical: Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Partially Met	Partially Met	Not Met
Clinical: Improving the Rate of Childhood Immunizations	Partially Met	Partially Met	Partially Met
Nonclinical: Improving Employees' Understanding of Cultural Competency and Health Disparities	Partially Met	Partially Met	Not Met

Washington Medicaid Integration Partnership Evaluation

The Washington Medicaid Integration Partnership (WMIP) seeks to integrate medical, mental health, chemical dependency, and long-term care services for categorically needy aged, blind, and disabled beneficiaries who are eligible for both Medicaid and Medicare. These beneficiaries, who tend to have complex health profiles, are the fastest growing and most expensive segment of DSHS's and HCA's client base. Intermediate goals of the WMIP include improving the use of mental health and substance abuse services, which account for a large portion of total healthcare costs. Longer-term objectives are to improve the beneficiaries' quality of life and independence, reduce ER visits, and reduce overall healthcare costs.

The state contracts with MHW to conduct this pilot project in Snohomish County. MHW is expected to

- provide intensive care coordination to help clients navigate the healthcare system
- involve clients in care planning
- assign each client to a care coordination team and have consulting nurses available on the phone 24 hours per day
- use the Chronic Care Model to link medical, pharmacy, and community services
- use standards for preventive health and evidence-based treatment to guide care plan development and improve health outcomes

The WMIP target population is Medicaid enrollees age 21 or older who are aged, blind, or disabled, including Medicaid-only enrollees and those dually eligible for Medicare and Medicaid. WMIP excludes children under 21, Healthy Options enrollees, and recipients of Temporary Assistance for Needy Families. As of December 2011, WMIP enrollment totaled about 4,800.

Because the WMIP population differs categorically from the traditional Medicaid population, it is not possible to compare the WMIP data meaningfully with the data reported by Healthy Options plans or with national data for health plans serving traditional Medicaid recipients. However, it is possible to evaluate year-to-year changes in the WMIP measures for diabetes care and service utilization.

WMIP performance measures

For 2012, MHW reported 10 HEDIS measures for the WMIP population:

- comprehensive diabetes care
- inpatient care utilization—general hospital/acute care
- ambulatory care utilization
- anti-depression medication management
- follow-up after hospitalization for mental illness
- use of high-risk medications for the elderly
- race and ethnicity of WMIP enrollees
- mental health utilization (new)
- identification of alcohol and other drug services (new)
- initiation and engagement of alcohol and other drug dependence treatment (new)

Data were validated through CMS's ISCA tool and the NCQA HEDIS compliance audit.

Table 27 on the next page presents the WMIP results for comprehensive diabetes care over the past three years. The 2012 results generally reflect less positive trends than in 2011. The percentage of enrollees with good control of their HbA1c levels fell significantly to 50.40%, while the percentage of those with poor control rose significantly to 41.04%. Most other measures came in below the 2011 levels, though not significantly lower.

Table 28 presents WMIP results for inpatient utilization, general hospital/acute care in the past three years. In 2012, discharge rates rose slightly for medical care and fell slightly for total inpatient (acute) care and for surgical care, but the changes were not statistically significant. Total inpatient (acute) and medical days for WMIP enrollees rose significantly in 2012, while surgical days remained level with 2011.

WMIP enrollees' average length of stay (ALOS) for medical care rose significantly in 2012; the apparent increases in the other two categories of care were not statistically significant.

Looking at ambulatory care measures (Table 29), the ER visit rate for WMIP enrollees declined significantly for the second straight year, while the outpatient visit rate registered an insignificant increase from 2011 to 2012.

Table 27. WMIP comprehensive diabetes care measures, 2010–2012.

	2010	2011	2012
HbA1c tests (percentage tested)	86.84	87.95	86.06
Enrollees with poor control of HbA1c levels (percentage >9.0%)	42.40	31.03	41.04 ↑
Enrollees with good control of HbA1c levels (percentage <8.0%)	50.58	60.00	50.40 ↓
Dilated retinal exams (percentage examined)	55.26	59.49	53.98
Lipid profile (LDL-C) performed (percentage profiled)	78.65	76.92	74.50
Lipids controlled (percentage with <100mg/dL)	31.58	39.23	34.46
Nephropathy monitored annually (percentage monitored)	81.58	86.41	83.07
Blood pressure control (percentage with <140/90 mm Hg)	61.11	64.36	60.36

↓↑ Indicates statistically significant difference in percentages from 2011 to 2012 ($p \leq 0.05$).

Table 28. WMIP inpatient utilization, general hospital/acute care measures, 2010–2012.

	Discharges/1000MM[a]			Days/1000MM[a]			ALOS[b]		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Total inpatient	15.14	15.55	15.21	76.73	72.54	78.00 ↑	5.07	4.67	5.13
Medical	8.48	9.33	9.53	32.79	35.31	41.44 ↑	3.86	3.79	4.35
Surgical	5.95	5.55	5.24	42.28	35.15	35.23	7.11	6.33	6.73

[a]1000MM = 1000 member months. [b]ALOS = average length of stay in days.

↓↑ Indicates statistically significant difference in percentages from 2011 to 2012 ($p \leq 0.05$).

Table 29. WMIP ambulatory care measures, 2010–2012.

	Visits/1000MM[a]		
	2010	2011	2012
Outpatient visits	563.98	539.06	546.91
Emergency room visits	119.94	109.83	101.85 ↓

[a]1000MM = 1000 member months.

↓↑ Indicates statistically significant difference in percentages from 2011 to 2012 ($p \leq 0.05$).

Tables 30 and 31 present WMIP results for behavioral health measures. The antidepressant medication management measure (Table 30) examines the percentage of patients beginning antidepressant drug treatment who received an effective acute phase trial of medications (three months) and the percentage who completed six months of continuous treatment for major depression. The percentage of WMIP enrollees receiving effective acute and continuation phase treatment continued to show positive change in 2012, though the increases from 2011 were not statistically significant.

The follow-up measure (Table 31) looks at continuity of care—the percentage of enrollees who were hospitalized for selected mental disorders and were seen by an outpatient mental health provider within 30 days or within 7 days after discharge from the hospital. The percentage of WMIP enrollees receiving follow-up care within 7 days rose to 57.38% in 2012, and the 30-day follow-up rate rose to 70.49%, though neither increase was statistically significant.

Table 32 reports the percentage of enrollees age 65 or older who received at least one prescription for a high-risk medication, or at least two different prescriptions. The percentages for both indicators have declined (i.e., improved) significantly since 2008, pointing to better management of these medications for WMIP enrollees.

Table 30. WMIP antidepressant medication management measures, 2010–2012.

	Effective acute phase treatment			Effective continuation phase treatment		
	2010	2011	2012	2010	2011	2012
Percentage of patients receiving medication management	52.78	56.86	67.50	36.11	47.06	55.00

No statistically significant differences in percentages from 2011 to 2012 ($p \leq 0.05$).

Table 31. WMIP follow-up after hospitalization for mental illness measures, 2010–2012.

	30-day follow-up			7-day follow-up		
	2010	2011	2012	2010	2011	2012
Percentage of patients receiving follow-up	48.84	64.81	70.49	32.56	55.56	57.38

No statistically significant differences in percentages from 2011 to 2012 ($p \leq 0.05$).

Table 32. WMIP use of high-risk medications for the elderly measures, 2010–2012.

	One prescription			At least two prescriptions		
	2010	2011	2012	2010	2011	2012
Percentage of patients receiving medication	12.81	11.94	10.94	2.23	2.11	1.72

No statistically significant differences in percentages from 2011 to 2012 ($p \leq 0.05$).

For the first time in 2012, MHW reported three additional HEDIS measures for WMIP (two utilization measures and an access/availability measure), defined below.

Mental Health Utilization summarizes the number and percentage of enrollees who received mental health services in various settings during the measurement year. "Any service" includes at least one of the following, and some enrollees received services in multiple categories:

- Inpatient
- Intensive outpatient/partial hospitalization
- Outpatient or ER

Identification of Alcohol and Other Drug (AOD) Services summarizes the number and percentage of enrollees with an AOD claim who received chemical dependency services in those same three settings.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measures the percentage of enrollees with a new episode of AOD dependence who

- *initiated AOD treatment* through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis
- *engaged in AOD treatment* by receiving two or more additional services within 30 days of the initiation visit

Tables 33–35 report the results of these first-year measures. The data in Table 35 indicate that the majority of WMIP enrollees who began treatment for AOD dependence did not become engaged in treatment services as defined by the measure. This indicates a need to increase the rate of engagement of enrollees who receive approval for AOD services.

Table 33. WMIP mental health utilization, 2012.

	Number	Percent
Any service[a]	1,875	41.63
Inpatient	71	1.58
Intensive outpatient/partial hospitalization	60	1.33
Outpatient/ER	1,840	40.85

[a] "Any" service is person-based; the other categories are visit-based.

Table 34. WMIP identification of alcohol and other drug services, 2012.

	Number	Percent
Any service[a]	918	20.38
Inpatient	234	75.87
Intensive outpatient/partial hospitalization	0	0.00
Outpatient/ER	819	18.18

[a] "Any" service is person-based; the other categories are visit-based.

Table 35. WMIP initiation and engagement of alcohol and other drug dependence treatment, 2012.

AOD treatment	Percent
Initiation	26.32
Engagement	2.63

WMIP compliance review

HCA and ADSA reviewed MHW's compliance with managed care regulations and contractual provisions. This review addressed many of the same standards addressed by TEAMonitor's MCO compliance reviews, as well as elements related to specific WMIP contract provisions. Table 36 reports the 2012 WMIP compliance scores.

MHW fully met all elements of seven of the 13 standards, and met the majority of elements for four other standards, including 90% of the Enrollee Rights elements and 89% of the Grievance Systems elements.

Overall, MHW demonstrated markedly better performance in 2012 than in 2011, particularly on Coverage and Authorization of Services, QA/PI Program, Practice Guidelines, and Grievance Systems. MHW completed the required corrective actions related to assessment and treatment plans for enrollees with SHCN, and to mental health intake evaluations. At the time of review, MHW had not completed corrective actions related to initial screening of enrollees and long-term care coordination, required under contractual elements of Coordination and Continuity of Care.

Table 36. WMIP compliance scores, 2012.

Standard (# of elements)	Percentage of elements Met (M), Partially Met (PM), Not Met (NM)		
	M	PM	NM
Availability of Services (8)	**100**	0	0
Program Integrity (1)	**100**	0	0
Claims Payment (1)	**100**	0	0
Coordination and Continuity of Care (9)	**44**	44	12
Coverage and Authorization of Services (5)	**80**	20	0
Enrollment and Disenrollment (1)	**100**	0	0
Enrollee Rights (14)	**90**	10	0
Grievance Systems (19)	**89**	0	11
Performance Improvement Projects (2)	**50**	50	0
Practice Guidelines (3)	**100**	0	0
Provider Selection (3)	**100**	0	0
QA/PI Program (5)	**80**	20	0
Subcontractual Relationships and Delegation (4)	**100**	0	0

WMIP PIP validation

For 2012, MHW submitted three new PIPs, targeting reductions in hospital readmissions and emergency room visits, and improvements in screening of new high-risk WMIP enrollees. MHW discontinued five previous PIPs, as listed in Table 37.

Strengths

- **Project 1:** TEAMonitor cited this as a well-designed study of an important topic, with clear, measurable indicators and a robust care management intervention, featuring an RN coach and community health workers.
- **Project 2:** This PIP met all requirements in the first year, showing statistically significant reductions in ER visits by WMIP enrollees in the first three remeasurement periods.
- **Project 3:** MHW provided a barrier table and an intervention table that may help to achieve and track future improvement in the percentage of new high-risk enrollees contacted for screening.

Opportunities for improvement

- **Project 3:** According to TEAMonitor, documentation errors and poor study design rendered this PIP unacceptable. TEAMonitor cited a disconnection between the study indicators, population, time period criteria, and improvement goal, calling MHW's evaluation into question. In particular, MHW did not explain how the indicators, which measure successful contacts for new enrollees, demonstrate a change in health status. MHW plans to continue this PIP.

Table 37. WMIP PIP topics and scores, 2011–2012.

Topic	2011	2012
1. Clinical: Decreasing Inpatient Hospital Readmission Rates	Not reported	Met
2. Clinical: Decreasing Emergency Department Utilization	Not reported	Met
3. Nonclinical: Increasing Percentage of New High-Risk Members Contacted for Screening	Not reported	Not Met
Clinical: Improving Compliance with Chemical Dependency Assessment and Follow-Up Referrals for Chemical Dependency	Not Met	Not reported
Clinical: Increasing Depression Assessments	Partially Met	Not reported
Clinical: Increasing Influenza Vaccine Participation	Partially Met	Not reported
Nonclinical: Improving Identification of Members at High Risk for Chemical Dependency Issues	Partially Met	Not reported
Nonclinical: Increasing Successful Initial Contacts Between WMIP Members and the Care Coordination Team	Partially Met	Not reported

Recommendations for WMIP

The WMIP program serves enrollees with complex healthcare issues, including enrollees who receive mental health and chemical dependency services and who are in long-term care. These enrollees typically have received substantial amounts of inappropriate care in hospitals and ER facilities due to lack of care management by physicians and nursing facilities and because the clients were unaware of how to obtain access to the care available to them.

The 2012 results for the WMIP program were mixed. The diabetes care measures generally reflected less positive trends than in 2011. The percentage of enrollees with good control of their blood-sugar levels fell significantly, while the percentage of those with poor control rose significantly. On a positive note, ER visit rates for WMIP enrollees continued to fall, and the indicators for antidepressant medication management, follow-up after hospitalization for mental illness, and high-risk medications for the elderly also continued to improve.

TEAMonitor's review of WMIP has identified deficiencies surrounding timely and complete initial intake screenings and in comprehensive assessment of high-risk enrollees. The following recommendation still applies.

- ***MHW should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.***

In addition, Acumentra Health recommends that the WMIP program

- ***ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and up-to-date to meet standards for continuity and coordination of care***
- ***explore ways to increase enrollees' engagement in alcohol and drug dependence treatment, since a high percentage of WMIP enrollees receive AOD services***

QUALITY-OF-CARE STUDIES

Acumentra Health conducted two special quality-of-care studies for HCA, focusing on asthma care utilization and antidepressant medication management for Washington Medicaid enrollees. The analysis focused on MCO-level administrative data for Medicaid managed care and FFS enrollees. For both studies, Acumentra Health used the same outpatient and inpatient claims data and demographic, enrollment, and pharmacy data to select enrollees for the study population and to segment the target population by race, gender, age, and location.

Acumentra Health analysts worked to construct the quality study metrics over a period of several years. However, state resources, data quality issues, and a lack of documentation prevented completion of the quality study analyses prior to 2012. For example, analysis by demographic characteristics could not be completed in 2011 because many enrollees identified as having new episodes of major depression did not have records in the demographic data. Data completeness issues were due, in part, to the state's conversion from the previous Medicaid Management Information System to ProviderOne.

Asthma care utilization

Asthma prevalence in Washington is among the highest in the United States. According to the state Department of Health, an estimated 400,000 adults and 120,000 youth in Washington currently have asthma, and 1 in 10 households with children have at least one child with asthma.[7] Each year, more than 5,000 Washingtonians are hospitalized and nearly 100 die as a direct result of asthma. Each year, about 1 in 7 seven adults and 1 in 5 youths make an asthma-related ER visit. In 2010, 57,000 Washington adults with asthma visited the ER at least once, accounting for about 164,000 ER visits. Utilization is driven by a small fraction of asthma patients with very poorly controlled asthma.

This special study considered changes in asthma-related hospitalizations and ER visits for Medicaid enrollees from 2008 through 2010 at the health plan level, and compared utilization rates for the managed care and FFS populations. The eligible population included 17,645 enrollees with persistent asthma who met at least one of the following criteria:

- four asthma medication dispensing events
- four outpatient asthma visits and at least two asthma medication dispensing events
- one asthma-related ER visit
- one asthma-related inpatient admission

Study highlights

- The persistent asthma population for this study was predominantly female (63%), white (70%), and English speaking (89%).
- In both 2009 and 2010, Medicaid managed care enrollees with persistent asthma used hospital and ER services at significantly higher rates compared with FFS enrollees.
- In 2010, 37% of managed care enrollees in the study visited the ER for asthma at least once, compared with 4% of FFS enrollees. However, both hospitalizations and ER visits for managed care enrollees declined significantly from 2009 to 2010. It is conceivable that more recent data on asthma care utilization would show a continuing decline.
- Counties with the highest rates of asthma-related hospitalizations (3 to 4%) in 2010 included Benton, King, Pacific, Pierce, Whatcom, and Yakima counties.
- The highest rate of asthma-related ER visits was reported in Franklin County (20.9%). Rates between 10 to 20% were reported in Benton, Island, King, Kittitas, Skagit, Snohomish, Whatcom, and Yakima counties.

Table 38 shows that 2.6% of the study population members were hospitalized for asthma in 2010, while 9.7% of the population visited the ER for asthma at least once.

Table 38. Asthma-related hospitalizations and emergency room visits for persistent asthma population, 2010 (N=17,645).

	N	%
Number of people hospitalized	457	2.6
Number of people visiting ER	1,709	9.7

As shown in Table 39, significantly higher percentages of managed care enrollees than of FFS enrollees were hospitalized or visited the ER for asthma in 2010. Asthma-related ER visits were reported for 37% of the managed care population.

Table 39. Asthma-related hospitalizations and emergency room visits, managed care vs. FFS, 2010.

		N	%
Number hospitalized	Managed care (N=2,203)	169	7.7*
	FFS (N=14,234)	196	1.4
Number visiting ER	Managed care (N=2,203)	818	37.1*
	FFS (N=14,234)	572	4.0

* Indicates statistically significant difference ($p<0.05$).

Table 40 shows that nearly 12% of the managed care population visited the ER multiple times for asthma (averaging three visits), compared with only 1% of the FFS population.

Table 40. Percentage of enrollees with multiple asthma-related emergency room visits, 2010.

	%	Average number of visits
Total population (N=17,645)	3.0	3
Managed care (N=2,203)	11.7	3
FFS (N=14,234)	1.1	3

Figures 19 and 20 depict changes in asthma-related hospitalizations and ER visits from 2009 to 2010. While much higher percentages of managed care enrollees than of FFS enrollees were hospitalized or visited the ER in both years, the percentages for managed care fell significantly in 2010.

Figure 19. Asthma-related hospitalizations by population, 2009 vs. 2010.

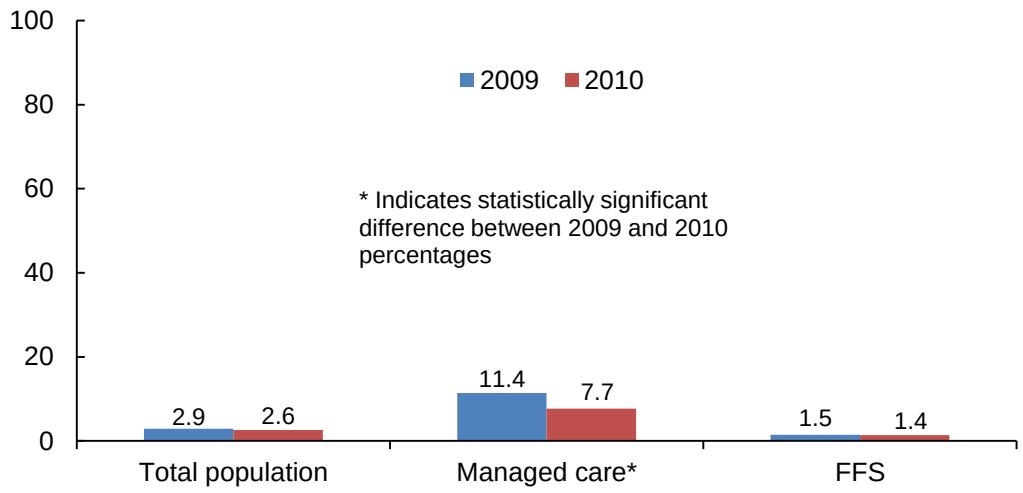
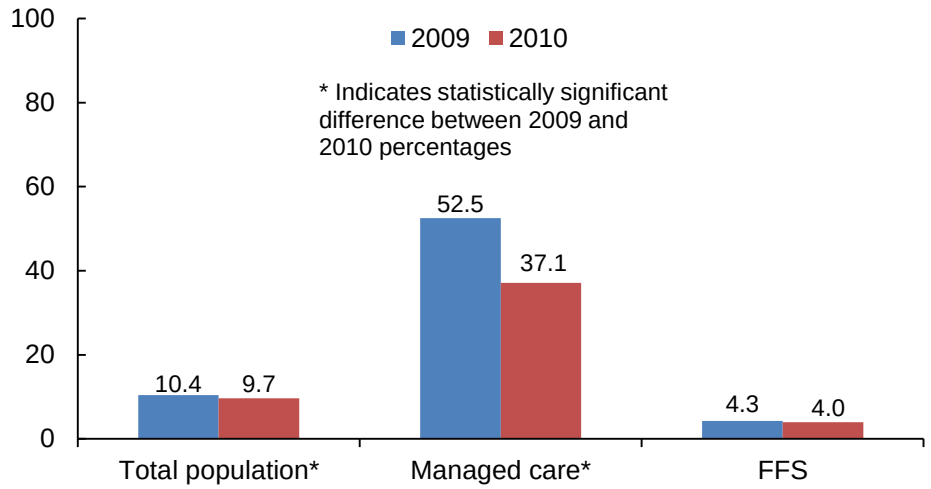


Figure 20. Asthma-related emergency room visits by population, 2009 vs. 2010.



Discussion and recommendations

Diagnoses of acute respiratory and other common infections in children, together with injuries, account for about 53% of ER visits by children aged 0 to 12 covered by Medicaid.[8] A focus on treating children's asthma in lower-cost, less resource-intensive settings that can provide a moderate intensity of care and urgent response time might lead to a substantial reduction in overall ER use.

Since ER utilization is often regarded as an indicator of success in managing patient care, the asthma study results raise concern; however, they appear compatible with recent observations in other states. A 2012 study of ER utilization in the five largest states found limited evidence that managed care sustainably reduces ER visits.[9]

To reduce rates of hospitalization and ER visits due to persistent asthma, Acumentra Health recommends that the Washington MCOs implement asthma health management strategies for their enrollees. Successful strategies might involve identifying members with asthma, targeting interventions based on severity of illness, and promoting effective communication and care coordination among providers.

Antidepressant medication management (AMM)

Depression is reported to incur the highest medical costs among all behavioral conditions. American Psychiatric Association guidelines call for treating depression with antidepressant medication and behavioral therapies.

Research has shown that nearly half of primary care patients who begin antidepressant treatment discontinue medications within the first 90 days,[10] and half of patients discontinue medications during the maintenance phase of treatment.[11] Patients who end treatment early are more likely to relapse and to incur higher medical costs, compared with patients who comply with medication management guidelines.

Acumentra Health analyzed two components of the HEDIS measure for AMM: (1) effective acute-phase treatment and (2) effective continuation-phase treatment. These components measure the percentage of adult enrollees who were diagnosed with a new episode of depression, were treated with antidepressant medication, and remained on the medication (1) for the entire three-month acute treatment phase and (2) for at least six months. The national average completion rates reported by NCQA in 2012 for Medicaid managed care enrollees were 51% for acute phase and 34% for continuation phase.

The eligible population for this study included 3,100 enrollees newly diagnosed with major depression during 2009–2010.

Study highlights

- The study population was predominantly female (69%), white (69%), English speaking (93%), and urban (89%).
- Male enrollees completed treatment in both the acute phase (44%) and the continuation phase (30%) at significantly higher rates compared with females (39% and 26%, respectively).
- For both acute and continuation phase treatment, the completion rates tended to increase as enrollees' age increased.
- In all age groups, a larger percentage of enrollees completed the acute phase than completed the continuation phase.
- Managed care enrollees completed acute phase treatment at significantly lower rates than did FFS enrollees in both urban and rural areas.
- Enrollees in Grant, Lewis, and Mason counties completed acute phase treatment at the highest rates, 52 to 54%. The lowest acute phase completion rate occurred in Snohomish County (33%).
- Completion of continuation phase treatment was highest in Mason County (42%) and lowest in Chelan, Skagit, and Yakima counties (20 to 25%).

Table 41 shows differences in completion of the acute and continuation phases based on demographic characteristics. As shown, the analysis identified significant differences among the demographic groups. Tables 42 and 43 break out the AMM measures by age range and by urban/rural residence.

Table 41. AMM measures by demographic characteristic, 2010.

		N	Effective acute phase treatment	Effective continuation phase treatment
Gender*	M	957	44%	30%
	F	2,143	39%	26%
Race*	American Indian	134	38%	24%
	Asian	74	23%	15%
	Black	280	35%	21%
	White	2,145	43%	30%
Language*	English	2,883	42%	28%
	Spanish	86	14%	8%
	Russian	35	51%	43%
Age	18 to 64	3,026	40%	27%
	65+	74	55%	34%
Urban/Rural	Urban	2,708	40%	27%
	Rural	348	44%	30%

* Indicates statistically significant difference (p<0.05).

Table 42. AMM measures by age, total eligible population (N=3,100).

Age	N	Effective acute phase treatment*	Effective continuation phase treatment*
18 to 30	986	32%	18%
30 to 40	678	37%	23%
40 to 50	702	46%	34%
50 to 65	660	50%	38%
65+	74	55%	34%

* Indicates statistically significant difference (p<0.05).

Table 43. AMM measures by urban/rural address, managed care vs. FFS.

	Effective acute phase treatment		Effective continuation phase treatment	
	Urban	Rural	Urban	Rural
Managed care	34%*	31%*	24%*	24%
FFS	45%	49%	31%	37%

* Indicates statistically significant difference (p<0.05).

Discussion and recommendations

The study results show that in 2010, completion of both acute and continuation phase treatment tended to increase as enrollees' age increased. Male enrollees completed both treatment phases at significantly higher rates compared with females. Analysis also revealed significant differences in completion rates on the basis of race and primary language. In addition, both AMM measures were lower for managed care enrollees than for FFS enrollees.

To improve rates of adherence to effective medication management, Acumentra Health recommends that HCA study the reasons for disparate rates of treatment completion between male and female enrollees, and among enrollees from different demographic groups. HCA could then work with MCOs to design interventions aimed at improving AMM rates, possibly including provider incentives for outcomes related to medication management.

Additionally, Acumentra Health recommends that HCA

- develop data quality control procedures to ensure a basic level of data integrity
- develop a system of documentation, including data dictionaries, to help give analysts and programmers a more complete understanding of the variables in each of the claims, enrollment, and demographic datasets

Addressing data completeness will improve the value of future quality-of-care studies by enhancing analysts' ability to drill down on multiple variables that affect care measurement results.

Discussion and Recommendations

This annual report summarizes the performance of Washington's MCOs and RSNs in measures of health care access, timeliness, and quality, and in meeting state and federal standards for Medicaid managed care. The synthesis of data from EQR activities is intended to help the state define QI expectations for the MCOs and RSNs and design effective incentives for improvement.

The 2012 report marks the close of an eight-year period during which Acumentra Health and TEAMonitor evaluated seven MCOs each year using consistent review criteria. The accumulated data provide a comprehensive picture of those MCOs' services for Healthy Options enrollees from 2004 through 2011. As of July 1, 2012, HCA began contracting with five MCOs (CHP, MHW, and three new contractors) to provide services for Healthy Options, Basic Health, and some Supplemental Security Income clients. Future annual reports will present results for the new roster of MCOs, and for 11 RSNs instead of the 13 evaluated in this report.

Medicaid managed care highlights

Children's mental health redesign. Children are the predominant segment of the population served by Washington Medicaid. DSHS has engaged its child-serving systems in a multi-year effort to redesign mental health care delivery. Federal grant funds will aid the state in implementing a system of community-based, child-centered, family-focused care. The redesign plan responds to commitments based on the *T.R. et al. v. Dreyfus* Interim Agreement, and to the requirements of SSHB 1088 (2007) on improving the children's mental health system and E2SBH 2536 (2011) on implementing evidence-based practices. The plan sets priorities for children's mental health services, promotes cross-system collaboration, emphasizes cultural competence, establishes performance-based outcome indicators, and implements a value base and evidence-based practices through contract and workforce development. DSHS/DBHR has finalized the 2013–2014 activity plan after gathering statewide feedback from stakeholders and tribes.[12]

Mental health care in appropriate settings. DBHR and the RSNs are partnering with ADSA's Home and Community Services Division (HCS) and the Western State Hospital (WSH) in an effort to serve mental health clients, including those with dementia, in more appropriate settings. Some activities at WSH are aimed at discharging people from decertified wards into supportive community placements. For example, WSH staff provides support or coaching for staff at community placement sites before and after placement. HCS supports the RSNs in reducing utilization of local psychiatric hospitals by prioritizing assessments for personal care and residential services for people with dementia. These combined efforts are described as part of a "learning collaborative model" that values individual staff accountability and an increased role for the RSN while the client is in the hospital.

CMS chose Washington as one of 11 states to participate in the three-year Medicaid Emergency Psychiatric Demonstration. This project expands Medicaid coverage to include emergency services for Medicaid-eligible people aged 21–64 that are provided in private psychiatric hospitals classified as Institutions for Mental Disease (IMDs). In the past, Medicaid has not paid IMDs for emergency services unless the patient is admitted to an acute-care hospital first. CMS will assess whether this expansion improves access to and quality of medically necessary care and reduces the burden of psychiatric boarding on hospital emergency departments. The state's operational plan for the demonstration focuses on IMDs within the GCBH and KCRSN service areas.

Care integration. Effective July 1, 2012, HCA's managed care contract for Basic Care and Healthy Options requires MCOs to integrate physical and behavioral health care by providing a full range of health home services for enrollees with SHCN. Each MCO must implement an intensive care

management program, in coordination with qualified community health homes or by contracting with RSNs, chemical dependency facilities, long-term care agencies, and other community organizations. Among other care integration activities, each MCO must conduct a collaborative statewide PIP on transitional healthcare services for enrollees with SHCN or at risk for reinstitutionalization, rehospitalization, or substance use disorder recidivism.

HCA, in collaboration with the Robert Bree Collaborative and the Puget Sound Health Alliance, has applied to CMS for a three-year, $34 million innovation grant to support system changes aimed at providing higher-quality care at lower cost. The innovation model would enable the state to shift from FFS to new payment methods that provide incentives for care coordination between professionals and facilities, and to develop transparent, evidence-based metrics and evaluation criteria. The project would build on work of the Robert Bree Collaborative (obstetrics/deliveries) and the Puget Sound Health Alliance (managing chronic conditions through implementation of health homes).

In 2009, DOH began a Patient-Centered Medical Home Collaborative, aimed at implementing medical homes in a variety of primary care clinics. A total of 33 clinics took part in the collaborative, which concluded in September 2011.

Access to care. The contracted MCOs generally are complying with federal and state standards related to access and timeliness. TEAMonitor's 2012 review found that all MCOs complied fully with the standards for timely access to services, and demonstrated strong compliance with other access-related standards.

The RSNs use multiple methods to monitor enrollees' access to care: reviewing enrollee grievances and appeals; conducting surveys of enrollee satisfaction; analyzing service penetration rates for enrollees by age, ethnicity, and gender; reviewing service utilization and clinical records; and performing "secret shopper" calls. To meet access and availability timelines, several RSNs' provider agencies have made significant changes, such as requiring same-day access, open access, double booking, and expanded hours to include Saturdays and evening hours.

Several pilot projects are underway to improve access to mental health care for specific Medicaid enrollee populations.

- **Mental health wraparound:** June 30, 2012, marked the end of the fourth year of operation of three state-funded Fidelity Wraparound pilot sites contracted to RSNs (NSMHA, SWRSN, and GHRSN), each serving roughly equal numbers of young enrollees. An independent evaluation by Dr. Eric Bruns and others at the University of Washington (UW) continues to show high-fidelity adherence and improved rates of serving youth in their local communities. The UW Evidence Based Practice Institute provides technical assistance and fidelity monitoring.
- **PACT services:** Ten PACT teams across the state continue to serve about 800 consumers with severe and persistent mental illness. A recent study of Washington PACT found a reduction in state hospital use of between 32 and 33 days per person per year, and related cost reductions of $17,000 to $20,000 per person per year for PACT consumers, with greatest effect on consumers who had used state hospital services at a high level before being admitted to the program.[13] Further study suggests that these outcomes varied according to each PACT team's level of fidelity to the Assertive Community Treatment model.[14]

Quality of care. TEAMonitor's 2012 review found that the MCOs, as a group, strengthened their compliance with quality-related standards compared with 2011. The MCOs met all elements of Primary Care and Coordination, Practice Guidelines, and Provider Selection, and met more than than 90% of the elements of Enrollee Rights, QA/PI Program, and Grievance Systems.

RSNs assess the quality and appropriateness of care furnished to enrollees by performing monthly and yearly chart audits, analyzing data from multiple sources, and reviewing enrollee input from forums, surveys, grievances, and appeals. As a group, the RSNs showed marked improvement in this year's review of compliance with QA/PI standards. All RSNs recognize the need to meet the needs of diverse enrollees.

Clinical care measures. The 2012 HEDIS results once again present a mixed picture of the care received by Healthy Options enrollees. The MCOs generally stabilized their performance on *immunization* measures following the significant declines reported in 2011, yet for the majority of indicators, average statewide immunization rates remain significantly below the U.S. Medicaid averages. Performance on the *diabetes care* indicators showed few significant changes, but the MCOs as a group significantly underperformed the national averages for six of nine indicators. And despite some improvement in 2012, the statewide averages for *WCC visit* rates remain significantly below the U.S. averages.

Among more positive results, the average rate of *ER visits* by Healthy Options enrollees fell significantly for the second straight year. ER utilization has remained significantly below the U.S. Medicaid average since 2006. For the two indicators of blood pressure control in diabetes care, the 2012 state averages were significantly better than the U.S. averages.

The path to future improvements: Mental health care

The RSNs generally are dedicated to serving Medicaid enrollees and have made commendable efforts to maintain their effectiveness in the face of resource limitations. DBHR should focus resources on the following opportunities to improve the mental health system.

Program evaluation. Annual internal evaluation of the RSN's QA/PI program can help identify needed improvements as well as achievements in care delivery. Although the RSNs collect and analyze data on many quality indicators, the majority of RSNs do not conduct formal year-end evaluations of their QA/PI programs. Such evaluations can provide a valuable resource by synthesizing the information the RSN collects during its contractually required review of network providers, including results of agency audits and subcontract monitoring, consumer grievances, and service verification. Evaluations also should summarize QI activities, metrics, how the RSN reached its performance goals, barriers and achievements, and ongoing improvement needs.

- ***DBHR needs to ensure that all RSNs complete end-of-year evaluations that synthesize the results of QA/PI activities defined in the RSN contract.***

Policy review. Although a few RSNs review and update their policies and procedures as often as yearly, many RSNs have not conducted such review in years. To ensure that their policies and procedures reflect current practices and regulatory and contractual requirements, the RSNs should establish schedules for frequent review and updating of policies and procedures.

- ***DBHR needs to work with the RSNs to ensure that all policies and procedures are reviewed and updated regularly.***

Program integrity. All RSNs have procedures in place to ensure that they do not to hire or contract with individuals and organizations that are excluded from participating in federal healthcare programs. However, many RSNs do not require that all RSN staff, board members, committee members, and volunteers be screened for federal exclusion. Also, many RSNs perform screening for exclusion only yearly.

- ***DBHR should ensure that the RSNs screen for federal exclusion all staff, board members, committee members, and volunteers, and that the RSNs screen more often than yearly.***

RSNs need to ensure that all program integrity issues are tracked, reviewed, investigated, and resolved timely and with as little bias as possible. Many RSNs do not have separate compliance committees but assign program integrity issues to the QA/PI committee. Many of the committees meet only on an ad-hoc basis when an issue of fraud, waste, or abuse is under investigation, usually in connection with encounter data.

- ***DBHR needs to ensure that each RSN has an independent compliance committee that meets regularly. The committee's overview should include fraud, waste, and abuse not only associated with encounter data but also related to internal financial practices, HIPAA, and other issues that might have a negative impact on the RSN, providers, and enrollees. All issues need to be tracked, reviewed, investigated and resolved in a timely manner.***

Many compliance officers at the RSNs and provider offices lack formal or adequate training on compliance and program integrity.

- ***DBHR needs to confirm that the RSNs' and contracted providers' compliance officers have the necessary training to effectively maintain program integrity.***

PIP topics. Documentation for PIPs that were in their fourth or fifth year did not thoroughly demonstrate the reasons why the RSNs changed their interventions, and did not present clear measurements or interpretations of results. None demonstrated improvement in the measure being studied. CMS recommends that PIPs address a broad selection of topics over time.

- ***DBHR needs to establish a recommended period during which a PIP should be completed.***

Validating encounter data. The 2012 EDV activity revealed that many RSNs used manual processes to collect, analyze, and record EDV data. Such processes introduce the potential for error in calculating EDV results. An electronic database system could support automatic calculation of EDV results and could improve the efficiency and reliability of data collection and management.

- ***DBHR should work with the RSNs to standardize data collection and analytical procedures for encounter data validation to improve the reliability of encounter data submitted to the state.***

Response to 2011 recommendations

The 2011 EQR report offered recommendations as to how DBHR and the RSNs could work together to improve access to mental health care and the quality and timeliness of care. Table 44 outlines DBHR's response to those recommendations to date.

Table 44. DBHR response to 2011 EQR recommendations for mental health.		
2011 recommendations	**DBHR response**	**EQRO comments**
Enrollee information needs		
Ensure that RSNs notify enrollees at least annually of their right to request information about individual practitioners in the RSN's service area.	Effective July 2012, DBHR launched an attachment to the Medicaid eligibility letter that fulfills this requirement. Content added to the annual review letter that is issued to all enrollees also fulfills this requirement. DBHR has reworded this information under the "Rights" section of its Benefits Booklet to more fully address this requirement.	The EQRO considers this action responsive.
Ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.	Five of the 13 RSNs did not track this during 2010 and were required to submit a corrective action plan to DBHR in 2011. Acumentra Health will provide follow-up review of compliance during the 2012 site reviews of those RSNs.	The RSNs continue to have difficulty monitoring requests for translation or interpretation at the provider level.
Access to culturally competent services		
Continue to work with the RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural.	DBHR commissioned a workgroup to assess the continued need for specialists, the need for practice education on delivering culturally competent services, and assessment of the current system capacity. DBHR expects a final report from this workgroup by 9/30/2012.	At the time of this annual report, the EQRO had not received the workgroup's report for review.
Seclusion and restraint		
Ensure that the RSNs require all contracted providers to follow policies and procedures on the use of seclusion and restraint, and that the RSNs review providers' use of seclusion and restraint at the time of credentialing and recredentialing.	The three RSNs that lacked policies and procedures in this area during 2010 were required to submit a corrective action plan to DBHR in 2011. Acumentra Health will provide follow-up review of compliance during the 2012 site reviews of those RSNs.	The EQRO considers this action responsive. RSNs continue to have difficulty with incorporating review of providers' use of seclusion and restraint into credentialing.
Advance directives		
Inform enrollees, or their families or surrogates, that they may file complaints with the state regarding noncompliance with advance directives.	DBHR has added this information to its Advance Directive brochure and has distributed these to all RSNs to make available to all consumers. DBHR also has revised its Benefits Booklet to more fully address the requirement by adding "medical" to the advance directive language in the "Rights" section and explaining where to call to file a complaint.	The EQRO considers this action responsive.

Table 44. DBHR response to 2011 EQR recommendations for mental health (cont.).		
2011 recommendations	**DBHR response**	**EQRO comments**
Each RSN needs to ensure ongoing community education and staff training regarding both medical and mental health advance directives. DBHR needs to ensure that RSN responsibilities related to advance directives include medical advance directives.	See response immediately above.	Adding information to the Benefits Booklet informs enrollees about medical and mental health advance directives. A few RSNs have demonstrated best practice by providing community and staff education regarding medical and mental health advance directives. More work is needed.
Tracking and analyzing enrollee grievances and complaints		
Ensure that all RSNs' QA/PI programs incorporate analysis of consumer complaints, appeals, and grievances.	DBHR developed new contract language, effective October 1, 2012, that requires RSNs to incorporate grievances and appeals into their QM plans. DBHR provided training to RSNs in 2012 on how to incorporate complaints, grievances, and appeals into their QM programs.	DBHR has addressed this issue.
Require each RSN, as part of the QA/PI process, to collect and review all complaints—not only grievances—from providers, Ombuds, and the RSN's own grievance system.	The new contract language described above requires each RSN to incorporate complaints received by Ombuds and provider agencies into the RSN's QM plan.	DBHR has addressed this issue.
Delineate in the RSN contract the difference between a complaint and a grievance, to guide the RSNs in tracking and monitoring enrollees' verbal and written expressions of dissatisfaction with quality, access, or timeliness of care and services.	The new contract language described above defines all expressions of dissatisfaction, oral or written, as grievances.	DBHR has addressed this issue.
PIP topics		
Continue to sponsor follow-up training and technical assistance related to PIPs, to support the RSNs in selecting and developing appropriate study topics and intervention strategies.	DBHR will require each RSN to participate in a PIP focusing on children's mental health and possibly in an employment PIP in the 2013 contract. DBHR will consider obtaining technical assistance for additional PIP training from the EQRO.	The EQRO considers this action responsive. However, continued work with the RSNs is needed.

The path to future improvements: Physical health care

Some recommendations presented in previous annual reports continue to apply. The following recommendations apply to the newly contracted MCOs as well as to CHP and MHW.

Care coordination. MCOs have strengthened their compliance with care coordination standards over time. However, improving care coordination and continuity across medical and mental health programs will require coordinated efforts between HCA and DBHR—especially since in July 2012, Medicaid recipients with complex medical and behavior needs were moved into managed care.

- ***HCA and DBHR should explore strategies to ensure that all eligible providers or managed care partners have access to the Predictive Risk Intelligence System (PRISM), which provides current Medicaid utilization data to help facilitate appropriate levels of treatment and coordination.***

PIP interventions. TEAMonitor's PIP reviews found that MCOs often failed to provide analysis of the effect of their interventions on subsequent performance. The reviews also cited concerns about passive interventions and the need for new or "refreshed" interventions.

- ***HCA should examine the MCOs' levels of expertise and performance gaps to help determine the level of technical assistance needed to help facilitate a successful PIP.***

Data completeness. In 2012, the MCOs as a group reported race and ethnicity as "unknown" for nearly half of all enrollees. A primary reason for gaps in reporting these data is underreporting at the state level, as these self-reported data are optional when new clients enroll in Medicaid.

- ***HCA should continue to work with state policy analysts to determine the best approach to collect reliable race and ethnicity data for Medicaid enrollees.***
- ***MCOs should continue to explore new data sources to augment the state-supplied race/ethnicity data.***

Performance measure feedback to clinics. Clinical performance reports for providers can identify Medicaid enrollees who do not have claims in the system but who need services—i.e., those without access to care.

- ***To help facilitate targeted interventions, HCA should require the MCOs to provide performance measure feedback to clinics and providers regularly and often.***

Quality-of-care studies. Acumentra Health's special study of asthma care revealed high rates of hospital and emergency room utilization by managed care enrollees with persistent asthma.

- ***Contracted MCOs should implement asthma health management strategies for their enrollees. Successful strategies might involve identifying members with asthma, targeting interventions based on severity of illness, and promoting effective communication and care coordination among providers.***

Acumentra Health's AMM study revealed that Washington Medicaid enrollees who were newly diagnosed with major depression completed effective treatment at rates somewhat below the national average rates.

- ***HCA should study the reasons for disparate rates of treatment completion among enrollees in different demographic groups. HCA could then work with MCOs to design interventions aimed at improving AMM rates, possibly including provider incentives for outcomes related to medication management.***

Response to 2011 recommendations

Table 45 outlines HCA's response to the recommendations presented in the 2011 EQR annual report.

Table 45. HCA response to 2011 EQR recommendations for physical health.		
2011 recommendations	**HCA response**	**EQRO comments**
Compliance with standards		
• *Consider providing technical assistance training in QI principles for the MCOs.*	HCA provided training in QI principles to all MCOs in 2012.	HCA has addressed this recommendation.
• *MCOs are encouraged to examine their allocation of QA/PI resources—especially for sufficient numbers of qualified staff—to ensure that they can meet the needs of a successful quality management program.*	As part of the 2012 readiness review, HCA required MCOs to examine their allocation of QA/PI resources and provide evidence of sufficient numbers of qualified staff to ensure that they can meet the needs of a successful quality management.	HCA has addressed this recommendation. Ongoing oversight will be monitored through annual TeaMonitor site visits.
Continuity and coordination		
• *Consider providing technical assistance training for MCOs in physical and behavioral health coordination.*	As part of the 2012 contract effective July 1, 2012, all MCOs are required to collaborate with peer MCOs to conduct a nonclinical PIP on transitional healthcare services. One of the outcomes of the PIP will be MCO collaboration with PCPs, RSNs, state institutions, long-term care providers, hospitals, and substance use disorder programs. HCA facilitated a meeting between the RSNs and MCO staff in July 2012.	The MCOs and RSNs will require technical assistance or structured support to conduct the nonclinical PIP on transitional healthcare services effectively.
PIP training		
• *Consider providing PIP training to help ensure a source of technical assistance for MCO staff.*	In collaboration with HCA, Acumentra Health provided PIP training to all MCOs in February 2012. HCA has also offered additional technical assistance to the MCOs on an as-needed basis.	HCA has addressed this recommendation. Depending on their levels of expertise, the new MCOs may benefit from a PIP refresher course or technical assistance to address specific PIP standards.
Data completeness		
• *Conduct a barrier analysis to identify effective ways to increase self-reporting of race/ethnicity data when new enrollees sign up for Medicaid.*	HCA will take this recommendation under consideration as time and resources allow. The intake of this information is not under HCA control.	The EQRO will continue to monitor the impact of this issue and will report status to the HCA.
Performance measure feedback to clinics		
• *Require MCOs to provide performance measure feedback to clinics and providers on a frequent and regular schedule.*	HCA will take this recommendation under advisement. We will suggest this as an intervention and consider this when the contract is being revised.	HCA cited this as best practice for two MCOs in 2012. Specific contract language may be needed to ensure that other MCOs follow this practice.

The path to future improvements: WMIP

Washington has established the goal of integrating primary care, mental health, chemical dependency, and long-term care services. As a fully integrated program, the WMIP can provide valuable lessons in integration to accelerate the state's progress toward that goal.

TEAMonitor's review of WMIP has identified deficiencies surrounding timely and complete initial intake screenings and in comprehensive assessment of high-risk enrollees. The following recommendation still applies.

- ***MHW should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.***

In addition, Acumentra Health recommends that the WMIP program

- ***ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and up-to-date to meet standards for continuity and coordination of care***
- ***explore ways to increase enrollees' engagement in alcohol and drug dependence treatment, since a high percentage of WMIP enrollees receive AOD services***

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