



2018 Annual Technical Report

Washington Apple Health
Washington Health Care Authority
Department of Social and Health Services

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

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Executive Summary

Washington's Medicaid program for physical and behavioral healthcare services provides benefits for more than 1.5 million residents. In 2018, the Washington State Health Care Authority (HCA) administered services for behavioral and physical healthcare through contracts with managed care organizations (MCOs), which facilitate delivery of physical healthcare services and behavioral health services through Integrated Managed Care (IMC) services within the integrated regions. The Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) administered services for mental healthcare and substance use disorder (SUD) treatment through contracts with Behavioral Health Organizations (BHOs), which facilitate behavioral healthcare services. In July 2018, as part of the State's continued efforts to fully integrate physical and behavioral healthcare programs and services, DBHR merged with the HCA.

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review (EQR) of healthcare services provided to enrollees, to assess the accessibility, timeliness, and quality of care they provide. As Washington's Medicaid external quality review organization (EQRO), Qualis Health conducted this 2018 review. This technical report describes the results of this review.

Information in this report was collected from MCOs and BHOs through review activities based on Centers for Medicare & Medicaid Services (CMS) protocols. Additional activities may be included as specified by contract.

Washington's Medicaid Program

Washington continues on a path to transform the way healthcare is furnished in the state through multiple initiatives connected to the State Health Care Innovation Plan, Healthier Washington. The changes resulting from Healthier Washington initiatives will ultimately include full integration of behavioral and physical healthcare services, value-based payments, greater community and consumer empowerment through Accountable Communities of Health (ACHs), and practice transformation throughout the state. Collectively, these efforts contribute to an overall program that will better meet the needs of the whole person, providing better-coordinated care for Medicaid enrollees as well as more fluid access to physical and behavioral healthcare services.

In 2018, Integrated Managed Care (IMC), which combines physical health services with mental health and substance use disorder treatment under one health plan, expanded from Southwest Washington to the North Central region, which includes Chelan, Douglas, Okanogan, and Grant Counties. IMC will be implemented in the Greater Columbia, King, Pierce, and Spokane regions in January 2019, and in the North Sound region by July 2019 (mid-adopters). In this transition, which began in 2017, behavioral health services purchased and administered by regional BHOs under contract with DSHS/DBHR are being transferred to Apple Health MCOs through IMC contracts administered by the HCA. By 2020, the remaining regions (on-time-adopters) will transition to integrated managed care and the State will have fully integrated the financing and delivery of physical health, mental health, and substance use disorder treatment services throughout the state.

In Washington, Medicaid enrollees are covered by five MCOs through the following programs:

- Apple Health Family (traditional Medicaid)
- Apple Health Adult Coverage (Medicaid expansion)
- Apple Health Blind/Disabled
- Integrated Managed Care
- State Children's Health Insurance Program (CHIP)
- Apple Health Foster Care

Description of External Quality Review Activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols. The 2018 report includes strengths, opportunities for improvement, and recommendations reflecting the results of the following:

- **MCOs**
 - audits of Healthcare Effectiveness Data and Information Set (HEDIS®¹) measures of clinical services
 - validation of performance measures
 - compliance monitoring, including follow-up of the previous year's corrective action plans
 - validation of performance improvement projects (PIPs)
- **BHOs**
 - assessment of each mid-adopter BHO's closeout status
 - compliance monitoring
 - follow-up of the previous year's corrective action plans
 - validation of PIPs
 - validation of statewide performance measures

Description of Access, Timeliness, and Quality

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

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

Access: Access to care encompasses the steps taken for obtaining needed healthcare and reflects the patient's experience before care is delivered. Access to care affects a patient's experience as well as outcomes and thus the quality of care received. Adequate access depends on many factors, including

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

availability of appointments, the patient's ability to see a specialist, adequacy of the healthcare network, and availability of transportation and translation services.

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

Physical Health

Qualis Health's review of physical healthcare services delivered by Apple Health MCOs included an assessment of the compliance review and performance improvement project validation conducted by the State interagency TEAMonitor and HCA, respectively; a validation and analysis of HEDIS performance measures reported by the MCOs; and a review of prior-year EQR recommendations.

Compliance Review

The State's MCOs are evaluated by TEAMonitor, the interagency unit of the Health Care Authority and the Department of Social and Health Services, on their compliance with federal and State regulatory and contractual standards. TEAMonitor's review assesses activities for the previous calendar year and evaluates MCOs' compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCOs' contract with HCA.

Performance Improvement Project Validation

MCOs are required to have an ongoing program of clinical and non-clinical performance improvement projects that are designed to improve processes, health outcomes, and enrollee satisfaction. HCA assesses and validates the MCOs' performance improvement projects to ensure they meet State and federal guidelines and are designed, conducted, and reported in a methodologically sound manner.

Performance Measure Validation

HEDIS is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over six domains of care; they also allow MCOs to determine where quality improvement efforts may be needed. For the 2018 reporting year (RY, measuring 2017 data), MCOs submitted data on 57 specific measures.

Qualis Health used these data to perform comparisons among MCOs and against national benchmarks, as well as to identify variations in measure performance across regions, Apple Health programs, and demographic groups. Summary results from these analyses can be found in the Performance Measure Review chapter of the Physical Healthcare section of this report. The full analyses are available in the *2018 Comparative Analysis Report* and the *2018 Regional Analysis Report*.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey assesses consumers' experiences with healthcare services and support. Developed by the U.S. Agency for Healthcare Research and Quality (AHRQ), the surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of healthcare, access to specialized services, and coordination of care.

In 2018, as part of their annual HEDIS Compliance Audit™², Apple Health MCOs conducted CAHPS 5.0H Child and/or 5.0H Adult Medicaid surveys of their memberships, via individually contracted NCQA-certified survey vendors, but were not required to provide results for EQR comparative reports as in prior years.

Additionally, as required by HCA, Coordinated Care of Washington conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions survey of the Apple Health Foster Care program. NCQA-certified survey vendor DataStat, under a subcontract with Qualis Health, administered the 5.0H Child Medicaid survey of the member households of children enrolled in the State Children's Health Insurance Program (CHIP).

Behavioral Health

Qualis Health's external quality review of the state's eight BHOs consisted of a compliance review assessing the BHOs' adherence to State and federal regulatory and contractual requirements, an evaluation of the BHOs' performance improvement projects, validation of two statewide performance measures, and a review of prior-year EQR recommendations.

Additionally, reviewers assessed each mid-adopter BHO's closeout status in transferring the administration of behavioral health services to the Apple Health MCOs under the State's IMC program.

Compliance Review

Qualis Health's compliance review assessed each BHO's compliance with federal Medicaid managed care regulations and applicable elements of the BHOs' contract with the State in three key areas: enrollee rights and protections, the grievance system, and certifications and program integrity. Each section of the compliance review protocol contains elements corresponding to relevant sections of 42 CFR Part 438, the State's contract with the BHOs, the Washington Administrative Code (WAC), and other State regulations where applicable.

Performance Improvement Project Validation

BHOs are required to have an ongoing program of performance improvement projects that are designed to assess and improve the processes and outcomes of the healthcare the BHOs provide. In 2018, BHOs were required to implement or maintain two PIPs, one clinical and one non-clinical; one of these focused on a substance use disorder treatment area and one focused on children. Performance improvement projects are evaluated and validated each year to ensure they meet State and federal standards.

Performance Measure Validation

42 CFR §438.358 requires the annual validation of performance measures for managed care entities that serve Medicaid enrollees. In 2018, Qualis Health validated statewide performance data submitted by the State for two measures assessing access to and engagement with the state's mental health and substance use disorder treatment services.

² HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Summary of Recommendations

In its assessment of the degree to which MCOs and BHOs provided Medicaid enrollees with accessible, timely, quality care, this *2018 Annual Technical Report* explains to what extent the State's managed care plans are meeting federal and State regulations, contract requirements, and statewide goals, and where they need to improve. Following are Qualis Health's recommendations to the State intended to help improve Washington's overall Medicaid system of care. Subsequent sections offer further discussion.

Physical Health

Recommendations

Performance Measure Review

Statewide rates for maternal care measures, including timeliness of prenatal care and postpartum care, dropped or remained flat in 2018 RY, and remain below the 40th percentile of national performance.

- HCA needs to examine root causes for poor performance on these measures and determine what action is needed. The State should consider requiring MCOs to have a plan in place, including timelines and deliverables, to improve performance.

Statewide rates for numerous measures, including child and adolescent access to care, adolescent well-care and well-child visits, immunizations for adolescents, women's health screenings, HbA1c control, antidepressant medication management, and follow-up care for children prescribed ADHD medication, have either dropped or remained flat since 2017 RY, yet are still below the 60th national percentile.

- To continue to improve care delivery to all Apple Health enrollees, HCA should continue to monitor these measures. To bring statewide performance above national standards, HCA should consider setting higher statewide performance goals for MCOs.

Statewide rates for adult access to care improved slightly in 2018 RY; those for child/adolescent access decreased. Overall, access rates in the eastern regions of the state continued to surpass those in the western regions of the state.

- The State should consider examining root causes of low performance rates on access measures in the western regions of the state. Performance on access to primary care for both adults and children/adolescents were all particularly low in these regions of the state compared to the state average and should be a focus of improvement. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.

Although performance on the antidepressant medication management measures improved slightly in the eastern regions of the state in 2018 RY, rates here still lag behind those in the western areas of the state.

- The State should consider examining root causes of low performance on these behavioral health measures in the eastern part of the state and determine whether focused improvement efforts may be necessary, including examining the number and types of behavioral health practitioners and provider organizations available in the underperforming regions. Success for some of the measures may require sophisticated and specialized care potentially not readily available in rural areas. Depending on the results of these analyses, HCA should consider maximizing collaboration with the behavioral health integration efforts, priorities, and resources of Healthier

Washington to better facilitate behavioral health integration across the state, particularly in the eastern regions.

Numerous measures, including most access measures and the breast cancer screening measure, showed lower performance rates for English-speaking enrollees; on other measures, performance was lower for those enrollees with a non-English-language preference.

- Language preference plays a critical role in healthcare delivery, yet currently, methods for collecting enrollees' preferred language data vary among the plans and do not collect optimally detailed data. To further understand the specific language challenges present in delivering equitable care and to ensure enrollees are obtaining care and information in language they understand, HCA should consider the following options: asking MCOs to expand options for capturing enrollees' preferred language data beyond "other" to include a variety of languages, standardizing collection of this information among the plans, and evaluating whether the language capture is accurate. Obtaining an enhanced level of enrollee data may assist in identifying regions where additional or specialized outreach may be concentrated.

Opportunities for Improvement

Compliance Review

In this year's review, MCO scores indicated that complying with the standards for coordination and continuity of care, specifically assessment and treatment plans, and coverage and authorization continues to be a challenge. HCA has prioritized these areas, providing frequent technical assistance to the plans and collaborating with the MCOs on multiple efforts to improve care coordination and transitions, especially with regard to services that span the physical and behavioral health realms.

- As the Apple Health program moves closer to a fully integrated managed care model, the state should remain focused on the areas of coordination and continuity of care and coverage and authorization, continuing to provide guidance to MCOs, supporting collaborative efforts between physical and behavioral health services, and implementing initiatives that will help ensure quality care for enrollees.

PIP Validation

MCOs showed improvement on PIP performance in 2018 RY, achieving more Met scores and fewer Not Met scores than in 2017 RY. However, numerous PIPs continued to suffer from lack of clarity and specificity in documentation, and data and results analysis was often insufficient.

- HCA's continued work with the MCOs to improve PIP design and documentation appears to be affecting a positive shift in PIP execution and outcomes; to further improve performance, particularly among MCOs that have demonstrated less improvement, the State should continue to provide trainings and technical assistance to the MCOs and their staff on PIP study design and implementation.

Behavioral Health

Recommendations

Compliance Review—On-Time-Adopters

(IMC Transition in 2020)

Not all Behavioral Health Agencies (BHAs), including both SUD treatment and Behavioral Health, are complying with informing and training their staff on enrollee rights policies and procedures at the time of hire and as rights are updated and revised.

- HCA needs to ensure that BHOs are informing and training BHA staff on enrollee rights policies and procedures at the time of hire and as rights are updated or revised. The BHOs could create a PowerPoint training on client rights and require the BHAs to submit attestations that staff have reviewed the PowerPoint training. The BHOs could also review staff personnel files for evidence of the training completion during their administrative review.

While many of the BHAs have posted the most current and up-to-date enrollee rights, some of the BHAs have not.

- The BHOs need to ensure that all BHAs have posted the most current enrollee rights in their lobbies where they are visible to enrollees.

Not all BHOs have a policy and mechanism in place to provide its staff and BHA staff with information on where to refer enrollees who are having difficulty understanding written materials or information posted on the BHO's website.

- HCA needs to ensure that all BHOs have implemented a policy and mechanism for informing enrollees of whom to contact when they are experiencing difficulties understanding benefit and client rights materials. This may include, but is not limited to, publishing this information on the BHO's website.

Not all BHOs include in their online provider directory the types of clinical specialties and languages spoken at the BHAs or whether each BHA meets ADA accessibility requirements.

- HCA needs to ensure that all BHO provider directories include the specialties, languages spoken, and whether each BHA meets ADA accessibility requirements.

Not all BHOs have mechanisms in place for tracking the grievances the BHO or BHAs receive.

- HCA needs to ensure that all BHOs develop a standardized form or spreadsheet for tracking the grievances they receive and those the BHAs receive. This form or spreadsheet should be distributed to the BHAs to ensure they are capturing all the elements the BHO needs to trend and monitor.

Not all BHOs have updated the grievance policies to reflect current CFR language and requirements regarding notice of adverse benefit determinations and grievance timelines.

- HCA needs to ensure that all BHOs' grievance policies are up to date with current language and requirements.

Although most BHOs monitor compliance with grievance system standards and requirements through an on-site process or administrative review and through the submission of quarterly grievance reports and

acknowledgment and resolutions letters, one BHO has not conducted a complete review of BHA compliance with grievance system standards.

- HCA needs to ensure that the BHOs maintain compliance with current grievance system standards at least annually or upon any change in standards and requirements.

Although most BHOs indicated that they monitor the BHAs for grievance record retention during annual administrative reviews, one BHO indicated that it has not completed monitoring for all its BHAs for several years.

- HCA needs to ensure that the BHOs routinely monitor BHAs for compliance with grievance system standards and requirements, including where and how grievance records are stored.

One BHO's notice of adverse benefit determination does not describe the process for requesting that benefits continue while an appeal or State fair hearing is pending or notify enrollees of their financial responsibility for services received while an appeal is pending if the final resolution of the appeal is adverse to the enrollee. Additionally, the BHO did not provide information indicating that it notifies enrollees of these elements through a different medium.

- The State provided a template for the notice of adverse benefit determination for the BHOs to adopt or incorporate. HCA needs to ensure that the BHOs' notice of adverse benefit determination contains all of the required elements, including the process for requesting that benefits continue while an appeal or State fair hearing is pending, and notification that enrollees may be financially responsible for services received while an appeal is pending if the final resolution of the appeal is adverse to the enrollee.

One BHO's policy on conflict of interest and the BHO's administrative tool do not include how often the conflict of interest disclosure form needs to be reviewed and attested to by BHO staff and volunteers, BHA staff, and the BHO's governing board. Conflict of interest disclosure forms should be reviewed and attested to annually.

- HCA needs to ensure that the BHOs include in both their policies on conflict of interest and administrative tools the timeframes in which all BHO and BHA staff and volunteers and BHO governing board members need to review and attest to the conflict of interest disclosure forms.

One BHO has not performed a risk assessment to identify the top three vulnerable areas and outlined action plans for mitigating risks in each of those areas since 2016. The compliance officer stated that the BHO has been actively working to address the vulnerable areas identified during the 2016 risk assessment.

- HCA needs to ensure that all BHOs are performing current risk assessments in order to identify and evaluate the most current vulnerable areas and implement action plans for mitigating risks in those areas.

Not all BHOs have an active compliance committee to review the compliance program for effectiveness. Additionally, one of the BHO's Quality Management Committee is inactive and last met in March 2017. The compliance officer stated that difficulty coordinating meeting times for BHO leadership staff has been the cause of inactivity.

- To be in compliance with both the CFR and HCA contracts, HCA needs to ensure that all BHOs convene their compliance and quality management committees to monitor the effectiveness of the compliance programs, as well as the accessibility, timeliness, and quality of care enrollees are receiving.

PIP Validation—On-Time Adopters

Some of the BHOs struggled with determining next steps after failing to achieve statistically significant improvement.

- HCA needs to ensure that when PIP interventions need course correction, the BHOs:
 - take steps to identify improvement opportunities, including but not limited to conducting barrier analyses to derive the improvement strategies to be implemented
 - undertake shorter re-measurement periods to allow adequate time for modifications to be made until the desired outcome is achieved and sustained
 - review data at least on a quarterly basis to ensure the PIP is moving in a successful direction
- HCA and the EQRO need to continue to provide technical support to ensure BHOs understand how to utilize core improvement concepts and tools when implementing PIPs.

Recommendations for Integration

The following recommendations are intended to aid in the transfer of BHO functions to the State's Apple Health MCOs.

Compliance Review—Mid-Adopters

(IMC Transition in 2019)

Many BHAs are out of compliance with standards regarding enrollee rights.

- Because many BHAs are out of compliance with standards regarding enrollee rights, HCA will need to ensure the MCOs are performing annual administrative on-site reviews of their contracted BHAs to make certain the BHAs are adhering to standards regarding enrollee rights.

All BHOs require the BHAs to review enrollee rights with each enrollee at the time of the intake assessment and to include in each client file an attestation signed by the enrollee documenting that the enrollee acknowledged and understood their rights. However, the 2018 EQR indicated that not all BHAs are complying with this requirement.

- HCA will need to ensure that the MCOs monitor the BHAs for reviewing enrollee rights with each enrollee at the time of the intake assessment and including in each client file an attestation signed by the enrollee documenting that the enrollee acknowledged and understood their rights.

Although the BHOs have policies and procedures in place for collecting logs of interpreter services requests from the BHAs and tracking the use of these services to analyze unmet enrollee needs, not all BHAs have consistently maintained these logs.

- HCA will need to ensure the MCOs have a process in place to collect information on requests for interpreter services from the BHAs and track the use of these services to analyze unmet enrollee needs.

Although many of the BHOs' online provider directories include the names of each BHA in the network, as well as the languages spoken at each agency's facility, many of the directories do not include the names of all clinicians associated with the BHAs, or each clinician's gender, specialties, languages spoken, and credentials. The directories also do not indicate whether each facility meets ADA accessibility requirements or whether clinicians are accepting new patients.

- HCA will need to ensure the MCOs provide enrollees with access to directories that include all of this information.

The BHOs monitor their contracted BHAs regarding the treatment of enrollees with respect, dignity, and consideration of privacy through on-site monitoring, administrative reviews, clinical record reviews, enrollee satisfaction surveys, and review of grievance and Ombud reports. However, the 2018 EQR discovered that the majority of grievances enrollees filed with the BHOs and BHAs were related to respect, dignity, and consideration of privacy.

- HCA will need to work with the MCOs to ensure they are educating the BHAs on the importance of treating enrollees with respect, dignity, and consideration of privacy, and monitoring them for this requirement.

All BHOs understand the importance of requiring contracted BHAs to have policies and procedures in place on the use of seclusion and restraint. Enrollees have the right to be free from seclusion and restraint at all provider out-patient and residential facilities. However, during the 2018 on-site reviews of several mental health agencies, reviewers observed several instances in which an agency utilized seclusion and restraint, primarily with children.

- HCA will need to ensure the MCOs are monitoring out-patient and residential agencies for their use of seclusion and restraint and behavioral de-escalation processes. Monitoring includes reviewing incident reports, auditing clinical records, reviewing grievances and enrollee surveys and performing on-site reviews. The MCOs need to require all out-patient and residential agencies to have policies and procedures in place on the use of seclusion and restraint.

All BHAs are required to comply with federal and State laws, such as the Civil Rights Act, Age Discrimination Act, Rehabilitation Act, Americans with Disabilities Act, and Health Insurance Portability and Accountability Act. However, reviewers noted during the 2018 EQR BHA walkthrough reviews that not all BHAs demonstrated compliance with these laws, particularly the Americans with Disabilities Act.

- To ensure the BHAs are complying with all relevant State and federal laws, HCA will need to work with the MCOs to ensure they monitor the BHAs for this requirement.

Most of the BHOs expressed concern regarding how the BHAs will effectively submit data to more than one MCO given many of the SUD treatment BHAs continue to need technical assistance to submit truthful, accurate, and timely data.

- The BHAs will continue to need monitoring and technical assistance to ensure that all submitted encounter data are truthful, accurate, and timely. MCO- and EQRO-conducted encounter data validation record reviews would help to identify continued needs and educational opportunities as well as any cases of fraud, waste, or abuse.

All BHOs require the BHAs to conduct a Washington State Patrol criminal background check prior to hiring any employee, and then continue to perform the check annually for BHA employees and volunteers who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults. However, not all BHAs have been in compliance with this requirement.

- HCA will need to ensure the MCOs have implemented methods to monitor the BHAs for routinely conducting annual background checks for BHA employees and volunteers who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

Many of the BHOs do not require BHA staff to read and sign conflict of interest attestations on a yearly basis.

- HCA should encourage the MCOs to develop mechanisms to monitor the BHAs to ensure that conflict of interest attestations are reviewed and completed annually.

All BHOs require their contracted BHAs to have written compliance plans and policies detailing mechanisms for detecting and preventing fraud, waste, and abuse. All BHAs are required to, at minimum, adhere to the seven essential elements of an effective compliance program. The BHOs also require the BHAs to perform self-assessments to identify any potential risks. Although many of the larger BHAs have these processes and plans in place, there is a lack of consistency in meeting these requirements among smaller BHAs, particularly the SUD treatment BHAs.

- HCA will need to ensure the MCOs are requiring all contracted BHAs to have written compliance plans and written policies detailing mechanisms for detecting and preventing fraud, waste, and abuse. The MCOs should also require all BHAs to, at minimum, adhere to the seven essential elements of an effective compliance program and perform self-assessments to identify any potential risks. HCA should also ensure the MCOs have in place auditing and monitoring activities to detect any fraud, waste, and abuse by the BHAs. Activities could include encounter data validation record reviews, medical record audits, clinical and administrative reviews, duplicate member reviews, utilization reviews, review of reports from licensing and Washington state disciplinary reports, and review of provider risk assessments.

PIP Validation—Mid-Adopters

Some BHOs struggled with allocating resources to continue the required PIPs.

- HCA needs to ensure that as BHOs approach closing out their business operations, they continue to fulfill the requirements of their PIHP contract.
- HCA and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.
- HCA and the EQRO need to continue to provide technical support to ensure BHOs understand how to utilize core improvement concepts and tools when implementing and continuing PIPs.

Some of the BHOs struggled with determining next steps after failing to achieve statistically significant improvement.

- HCA needs to ensure that when PIP interventions need course correction, the BHOs:
 - take steps to identify improvement opportunities, including but not limited to conducting barrier analyses to derive the improvement strategies to be implemented
 - undertake shorter re-measurement periods to allow adequate time for modifications to be made until the desired outcome is achieved and sustained
 - review data at least on a quarterly basis to ensure the PIP is moving in a successful direction

Physical Healthcare and Integrated Managed Care Provided by Apple Health Managed Care Organizations

Introduction

Throughout calendar year (CY) 2017, five managed care organizations (MCOs) delivered physical healthcare services to Apple Health managed care (Medicaid) enrollees across the State of Washington:

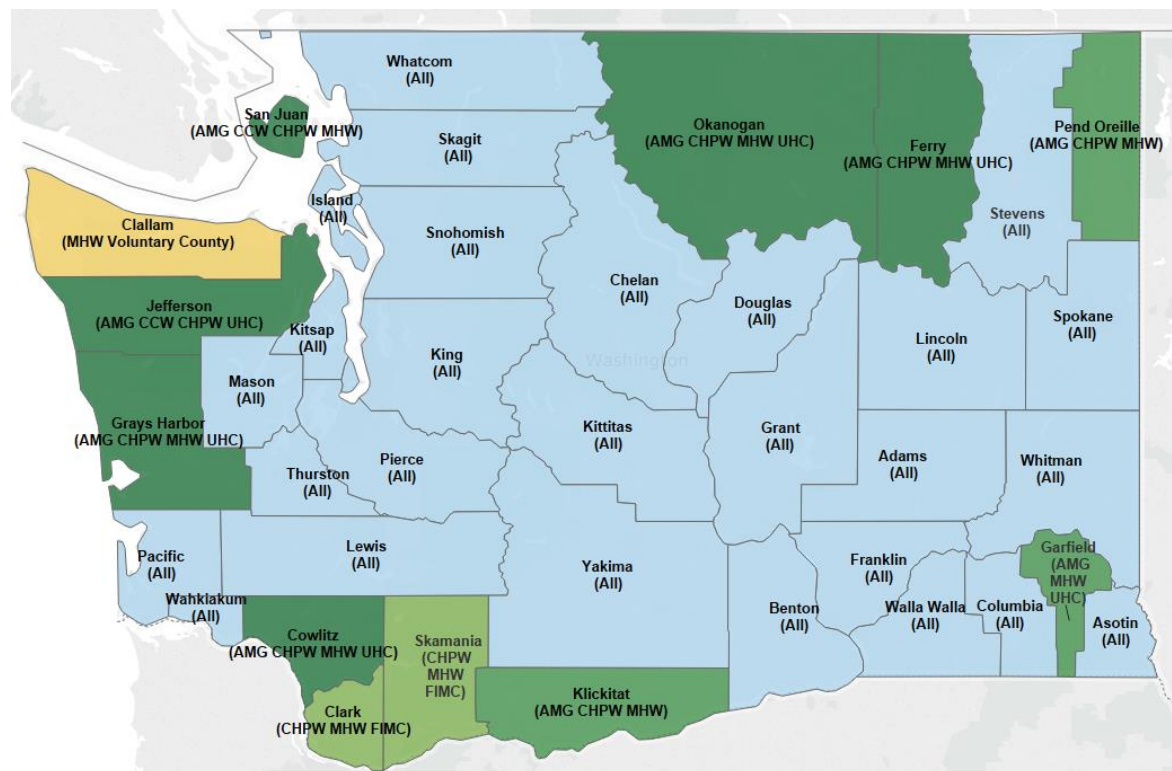
- Amerigroup Washington, Inc. (AMG)
- Community Health Plan of Washington (CHPW)
- Coordinated Care of Washington (CCW)
- Molina Healthcare of Washington (MHW)
- United Healthcare Community Plan (UHC)

For Medicaid enrollees in the Southwest Washington region (Clark and Skamania Counties), physical health, mental health, and substance use disorder treatment services were coordinated through CHPW and MHW.

Figure 1, next page, identifies the MCOs and the counties they serve, as of December 31, 2017. In Clallam County, enrollment was voluntary because only one MCO was in operation or because the contracted MCOs did not have sufficient capacity to serve all enrollees.

Note: For clarity, results of all review activities collected or reported during the 2018 calendar year are indicated with 2018 RY.

Figure 1: Washington Apple Health MCO Coverage, by County*



*Color coding indicates variation in MCO coverage in each county.

Overview of Apple Health Enrollment Trends

In Washington, Medicaid enrollees are covered by five MCOs through the following programs:

- Apple Health Family (traditional Medicaid)
- Apple Health Adult Coverage (Medicaid expansion)
- Apple Health Blind/Disabled
- Integrated Managed Care
- State Children’s Health Insurance Program (CHIP)
- Apple Health Foster Care

It is important to note that MCOs’ members are not homogenous. Most members in the Apple Health Family program (traditional Medicaid) are under the age of 20 (84.1 percent), while the majority of members in the Apple Health Adult Coverage program (Medicaid expansion) are between the ages of 20 and 50 (73.4 percent), and 32 percent of members in that program are between the ages of 20 and 30.

The IMC population served by CHPW and MHW in the southwest region of the state accounts for 7.6 percent of all Medicaid enrollees, and the age distribution for this population is relatively evenly distributed, with a higher concentration only of enrollees under the age of 10 (26.96 percent). Tables 1, 2, and 3 show the distribution of Apple Health enrollees by program, age, and both program and age. Note that these data are sourced from the member-level data submitted by MCOs and are based on the total number of enrollees.

**Table 1: 2017 RY Enrollee Population by Apple Health Program
1,318,385 Enrollees in Total**

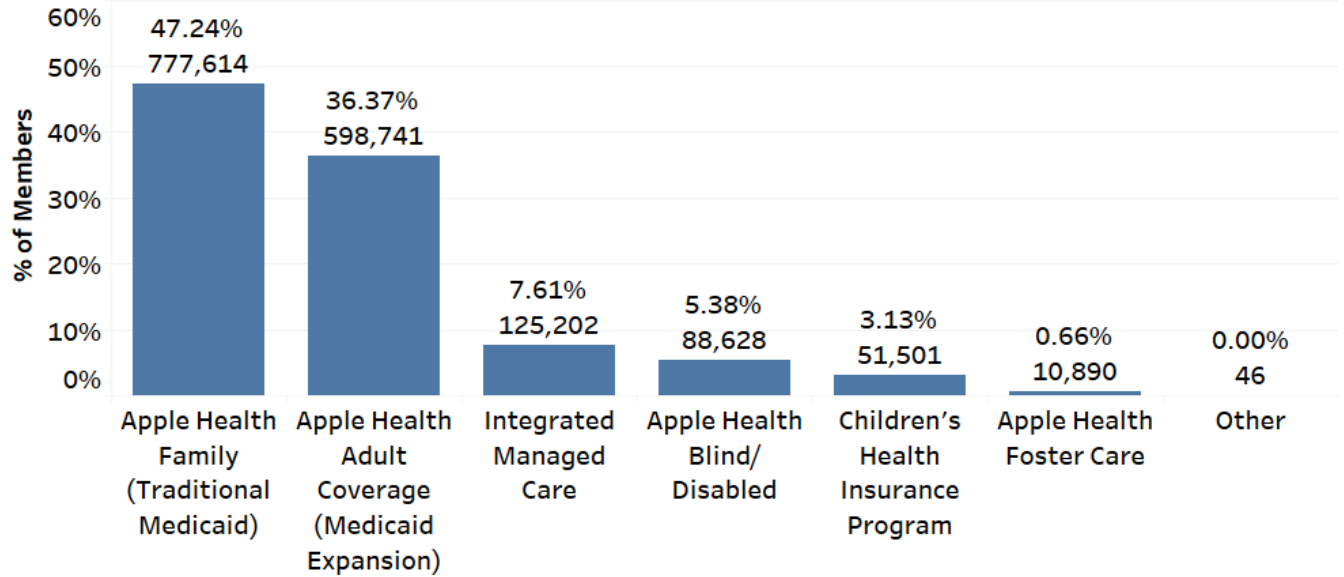


Table 2: 2017 RY Enrollee Population by Age

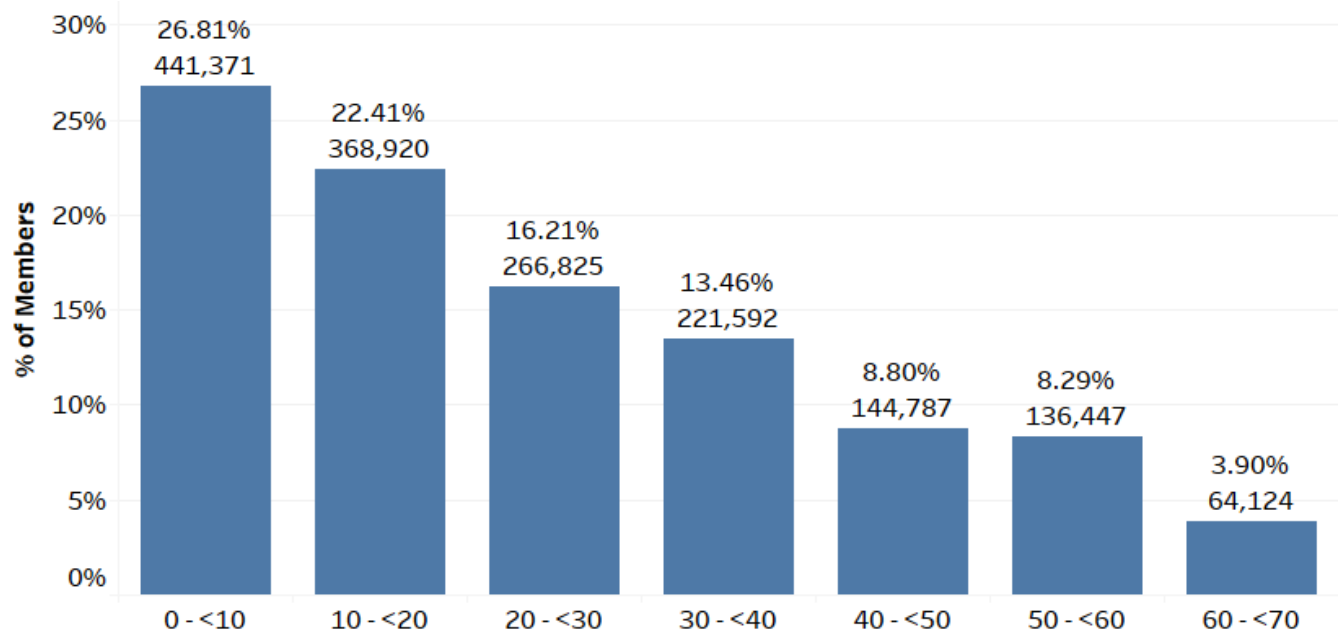


Table 3: 2017 RY Enrollee Population by Apple Health Program and Age

Program	% of Members	0 - <10	10 - <20	20 - <30	30 - <40	40 - <50	50 - <60	60 - <70
Apple Health Family (Traditional Medicaid)	100%	47.06%	37.09%					
	50%	365,981	288,448	43,081	48,882	22,494	7,350	1,245
Apple Health Adult Coverage (Medicaid Expansion)	100%			32.08%	24.48%	16.81%	16.38%	7.59%
	50%	0.79%	1.87%	192,101	146,548	100,660	98,098	45,453
Apple Health Blind/Disabled	100%							
	50%	7.82%	12.47%	13.68%	12.08%	12.39%	24.48%	15.08%
Children’s Health Insurance Program	100%	48.46%	51.53%					
	50%	24,955	26,539	2	1	2	1	1
Apple Health Foster Care	100%	61.05%	27.32%					
	50%	6,648	2,975	1,267				
Integrated Managed Care	100%	26.96%	23.89%	15.72%	13.36%	8.94%	7.66%	3.33%
	50%	33,759	29,911	19,687	16,723	11,199	9,588	4,175

It is important to note that the relative distribution of these members is not uniform across MCOs. For example, 62.2 percent of AMG’s members are enrolled in Apple Health Adult Coverage (Medicaid expansion), while only 28.6 percent of MHW members are enrolled in that program. Additionally, only CHPW and MHW administered IMC in 2017. This variation in Medicaid program mix by MCO can affect HEDIS performance outcomes, so it is important to monitor performance at both the plan level and at the plan and program level. Table 4, next page, shows Apple Health enrollee population distribution by program and plan.

Table 4: 2017 RY Member Population by Apple Health Program and Plan

	% of Members	2017 RY Member Population by Apple Health Program and Plan					
		Apple Health Family (Traditional Medicaid)	Apple Health Adult Coverage (Medicaid Expansion)	Integrated Managed Care	Apple Health Blind/Disabled	Children's Health Insurance Program	Apple Health Foster Care
Grand Total	100%	47.24%	36.37%	7.61%	5.38%	3.13%	0.66%
	50%	777,614	598,741	125,202	88,628	51,501	10,890
AMG	100%	29.33%	62.20%		6.11%	2.35%	0.00%
	50%	57,612	122,173		12,008	4,619	2
CCW	100%	49.50%	36.26%		7.05%		7.18%
	50%	75,051	54,975		10,692		10,888
CHPW	100%	49.57%	34.16%	7.44%	5.71%	3.12%	
	50%	181,479	125,078	27,253	20,904	11,424	
MHW	100%	50.93%	28.61%	12.30%	4.24%	3.92%	
	50%	422,362	237,294	101,973	35,165	32,501	
UHC	100%	42.34%	47.29%		7.78%	2.56%	
	50%	64,208	71,718		11,792	3,889	

Overall, Apple Health MCOs experienced a total growth rate of 0.10 percent from December 2016 to December 2017 CY. MHW grew by 4.54 percent during this time, while all other plans decreased in total published enrollment from 2016 to 2017 CY. Table 5 shows Apple Health enrollment by plan for the 2014, 2015, 2016, and 2017 calendar years.

Table 5: Apple Health Enrollment, December 2014, 2015, 2016, and 2017 CY³

	December 2014 CY Enrollment	December 2015 CY Enrollment	December 2016 CY Enrollment	December 2017 CY Enrollment	Percent Change	
					Dec 2015 to Dec 2016 CY	Dec 2016 to Dec 2017 CY
AMG	128,369	141,571	149,314	145,135	5.19%	-2.88%
CHPW	332,456	294,141	297,725	277,185	1.20%	-7.41%
CCW	175,353	181,801	207,342	201,006	12.31%	-3.15%
MHW	486,524	566,201	697,392	730,571	18.81%	4.54%
UHC	180,225	204,078	224,973	224,450	9.29%	-0.23%
Total	1,302,927	1,445,093	1,576,746	1,578,347	8.35%	0.10%

³ www.hca.wa.gov/about-hca/apple-health-medicaid-reports

Summary of Results

Qualis Health's review of physical healthcare delivered by Apple Health MCOs included an assessment of TEAMonitor's compliance review and corrective action plan (CAP) follow-up, HCA's performance improvement project validation, and a validation and analysis of HEDIS performance measures reported by the MCOs.

The performance measure review reflects data collected in 2018 measuring the experience of members in 2017. To be consistent with NCQA methodology, the resulting scores are indicated in this report by 2018 reporting year (RY) and 2017 calendar year (CY), respectively. For clarity, results of all other review activities collected or reported during the current calendar year, including compliance review and PIP validation, are also indicated with 2018 RY.

MCOs generally performed well in the compliance portion of the review, with scores remaining steady for most standards and showing improvement in others, including the grievance system. Areas of weakness are those that have been historically challenging, particularly coverage and authorization and coordination and continuity of care.

HCA's review of the MCOs' PIPs found that overall, plans made improvements this year on PIP design, execution, and documentation, with more PIPs achieving scores of Met and fewer PIPs receiving scores of Not Met. However, MCOs continued to struggle at times with presenting the details of study design, implementation, and data analysis clearly and in sufficient detail, or simply meeting the contractual requirements of the PIP.

Performance measure data showed improvements in several areas, including adult access to primary care, weight assessment and counseling for children/adolescents, and several appropriateness of care measures. However, performance on numerous other measures either declined or did not improve, particularly child and adolescent access to care, adolescent well-care and well-child visits, women's health screenings, antidepressant medication management, and follow-up care for children prescribed ADHD medication. Statewide rates are still below national averages for these measures.

Going forward, the State will need to prioritize these areas in its continued efforts to improve delivery of care to Washington's Medicaid population.

Compliance Review

The State interagency TEAMonitor annually evaluates Washington's managed care organizations (MCOs) on their compliance with federal and State regulatory and contractual standards, including those set forth in 42 CFR Part 438, as well as those established in the MCOs' contract with HCA. Compliance with these standards reflects accessibility, timeliness, and quality of care.

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

Methodology

The TEAMonitor review process is a combined effort by clinical and non-clinical staff and subject matter experts. Desk review includes MCO policies and procedures, program descriptions, evaluations and reports. HCA also requests individual enrollee files for review of denials, appeals, grievances, health homes and care coordination. After review, HCA staff share results with the MCOs through phone calls and on-site visits. Each MCO then receives a final report that includes requests for corrective action plans as needed for standards that are not fully met. HCA issues specific recommendations and offers ongoing technical assistance to develop and refine processes that will improve accessibility, timeliness and quality of care for Medicaid enrollees.

Scoring

TEAMonitor scores the MCOs on each compliance standard according to a metric of Met, Partially Met, and Not Met, each of which corresponds to a value on a point system of 0–3. Scores of 0 and 1 indicate Not Met (with 0 points indicating that the MCO additionally did not fulfill a corrective action plan from the previous year's review), 2 indicates Partially Met, and 3 indicates Met. Final scores for each section are denoted by a fraction indicating the points obtained (the numerator) relative to all possible points (the denominator). For example, in a section consisting of four elements in which the MCO scored a 3, or Met, in three categories and a 1, or Not Met, in one category, the total number of possible points would be 12, and the MCO's total points would be 10, yielding a score of 10/12. In the following presentation of results, total scores have been converted to percentages, which, for the above score of 10/12, would produce a score of 83 percent.

Summary of Compliance Results

Table 6 provides a summary of all MCO scores by compliance standard. Bars and percentages reflect total scores for each standard (total scores for all elements combined, converted to percentages). MCOs with elements scored as Partially Met or Not Met were required to submit CAPs to HCA. MCOs were scored on these elements in the first half of the review year. MCOs may have implemented corrective action plans since that time to address specific issues, and therefore scores may not be indicative of current performance.




Table 6: MCO Compliance with Regulatory and Contractual Standards, by Plan (General Apple Health Population)

Standard	# of Elements	MCO	# Met or NR 3 points	# Partially Met 2 points	# Not Met 1 point	# Not Met 0 points	Total Score (% of points attained)
Availability of Services	7	AMG	2	5	0	0	76
		CCW	7	0	0	0	100
		CHPW	7	0	0	0	100
		MHW	6	1	0	0	95
		UHC	7	0	0	0	100
Program Integrity Requirements	5	AMG	4	0	1	0	87
		CCW	4	1	0	0	100
		CHPW	4	1	0	0	93
		MHW	4	1	0	0	100
		UHC	4	1	0	0	100
Timely Claims Payment	5	AMG	5	0	0	0	100
		CCW	5	0	0	0	100
		CHPW	5	0	0	0	100
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Coordination and Continuity of Care	10	AMG	8	1	0	1	87
		CCW	8	1	1	0	90
		CHPW	8	0	0	2	80
		MHW	9	1	0	0	97
		UHC	8	1	1	0	80
Patient Review and Coordination	5	AMG	4	3	0	2	100
		CCW	4	4	1	0	100
		CHPW	5	1	1	2	100
		MHW	5	3	0	1	100
		UHC	4	4	0	0	100
Coverage and Authorization	9	AMG	4	3	0	2	67
		CCW	4	4	1	0	78
		CHPW	5	1	1	2	67
		MHW	5	3	0	1	78
		UHC	4	4	0	1	74
Enrollment/ Disenrollment	2	AMG	2	0	0	0	100
		CCW	2	0	0	0	100
		CHPW	2	0	0	0	100
		MHW	2	0	0	0	100
		UHC	2	0	0	0	100

Table continues on next page.

Standard	# of Elements	MCO	# Met or NR 3 points	# Partially Met 2 points	# Not Met 1 point	# Not Met 0 points	Total Score (% of points attained)
Enrollee Rights	15	AMG	12	2	0	1	89
		CCW	14	0	0	1	93
		CHPW	13	2	0	0	96
		MHW	14	1	0	0	98
		UHC	14	1	0	0	98
Grievance System	18	AMG	18	0	0	0	100
		CCW	17	0	0	0	96
		CHPW	18	0	0	0	100
		MHW	17	1	0	0	98
		UHC	18	0	0	0	100
Practice Guidelines	3	AMG	1	1	1	0	67
		CCW	3	0	0	0	100
		CHPW	2	0	1	0	78
		MHW	3	0	0	0	100
		UHC	0	2	1	0	56
Provider Selection	4	AMG	0	1	3	0	42
		CCW	4	0	0	0	100
		CHPW	3	1	0	0	92
		MHW	4	0	0	0	100
		UHC	4	0	0	0	100
QA/PI Program	5	AMG	4	1	0	0	93
		CCW	5	0	0	0	100
		CHPW	5	0	0	0	100
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Subcontractual Relationships/ Delegation	4	AMG	3	1	0	0	92
		CCW	4	0	0	0	100
		CHPW	4	0	0	0	100
		MHW	4	0	0	0	100
		UHC	4	0	0	0	100
Health Information Systems	3	AMG	3	0	0	0	100
		CCW	3	0	0	0	100
		CHPW	3	0	0	0	100
		MHW	3	0	0	0	100
		UHC	3	0	0	0	100
Health Homes	11	AMG	8	0	2	1	79
		CCW	9	0	2	0	88
		CHPW	10	0	1	0	94
		MHW	9	0	0	2	82
		UHC	8	1	0	2	79

Table 7: MCO Compliance with Regulatory and Contractual Standards, by Plan (IMC and AHFC)

Standard	# of Elements	MCO	# Met or NR 3 points	# Partially Met 2 points	# Not Met 1 point	# Not Met 0 points	Total Score (% of points attained)
Coordination and Continuity of Care—AHFC	6	AMG	NA	NA	NA	NA	NA
		CCW	4	1	1	0	 83
		CHPW	NA	NA	NA	NA	NA
		MHW	NA	NA	NA	NA	NA
		UHC	NA	NA	NA	NA	NA
Coverage and Authorization—IMC	2*	AMG	NA	NA	NA	NA	NA
		CCW	NA	NA	NA	NA	NA
		CHPW	0	1	0	0	 67
		MHW	2	0	0	0	 100
		UHC	NA	NA	NA	NA	NA

*Note: CHPW was scored only on one IMC section—authorization of services—whereas MHW was scored on two: authorization of services and outpatient mental health.

In addition to evaluating Apple Health MCO compliance with regulatory and contractual standards, this year's TEAMonitor review included assessment of the Apple Health Foster Care (administered by Coordinated Care of Washington) and Apple Health Integrated Managed Care (administered by Community Health Plan of Washington and Molina Healthcare of Washington) programs. Overall scores for MCO compliance remained relatively steady, with all MCOs fully or nearly fully meeting standards for availability of services (with two plans, CHPW and MHW, receiving distinction for best practices in this area), timely claims payment, enrollment/disenrollment, the grievance system, quality assessment and performance improvement (where UHC was noted for two best practices), sub-contractual relationships and delegation, and health information systems.

Areas of weakness cited included those that have been noted in prior years, specifically coordination and continuity of care, coverage and authorization, practice guidelines, provider credentialing, and health homes.

Program integrity: Plans fully met most elements in this category. However, none of the MCOs fully met the standard for program integrity requirements. Reasons for the findings included lack of documentation evidencing the use of the provider appeal process for program integrity activities, the process in place for the whistleblower program, and the process for reporting overpayment to HCA.

Coordination and continuity of care: While MCO scores in this category overall remained relatively steady, as in prior years the assessment and treatment plans standard related to care coordination continued to be problematic for the MCOs, with three plans partially meeting and two plans not meeting this particular element. Issues centered on lack of documentation for activities, including follow-up on issues identified, clinically appropriate care, and informed interventions. CHPW did not meet the standard for coordination between contractors and external entities, a repeat finding, while AMG did not meet the standard for care coordination oversight.

Review of the Foster Care program files showed that CCW did not meet the standard related to care coordination, and partially met the standard for direct access to specialists. The plan was recognized, however, for a best practice in showing how it identifies individuals with special health care needs, which is the first step in planning and providing appropriate services.

Coverage and authorization: MCO performance in this area, which has historically been a problem, showed little improvement, with all plans receiving findings for the authorization of services standard. Findings, among others, were related to elements missing from plans' utilization management (UM) program description and/or UM program evaluation, incomplete or outdated lists of clinical and non-clinical staff involved in UM activities, and insufficient inter-rater reliability reports.

None of the MCOs fully met the standard for notice of adverse benefit determination. Plans were cited for sending letters to enrollees that did not meet HCA criteria for readability and clarity, not including information in the notifications regarding why the requests were denied, and using outdated grievance and appeal inserts, among other reasons.

Enrollee rights: Issues within this category centered on distribution of informational materials to enrollees. Two plans did not provide adequate evidence of the distribution of information in an alternative format. Another failed to provide timely enrollee notification of terminated providers. While liability for payment improved from last year for two plans, it was a problem for another two, with one MCO receiving a score of Not Met for its process not being in compliance with the Apple Health contract or CFR 438.106(c), and for documentation that showed incomplete resolutions and inaccuracies.

Grievance system: In the 2017 review, CHPW received a number of Not Met or Partially Met scores in this category; however, this year's assessment indicated these issues have been resolved. During the current assessment, only one plan received a Not Met score, for not providing adequate evidence of the provision of information related to the grievance and appeal system to providers and subcontractors.

Practice guidelines: Three MCOs received Not Met scores in this area, one for inadequate documentation of distribution dates of new or revised practiced guidelines to all affected providers, and two for not having evidence demonstrating decision-making in the areas of utilization management or coverage determinations and other functional areas are consistent with adopted practice guidelines.

Provider selection (credentialing): Most plans fully met standards for this regulation, with the exception of AMG, which did not meet three of the elements and only partially met the fourth. For this category, MHW received best practice distinction for affirming that credentialing or recredentialing decisions follow the nondiscrimination policy.

Health homes: This year's review of the health homes standards showed that while there was slight improvement, MCOs continue to struggle with encounter data reporting. Additionally, all MCOs failed to meet the elements of the health action plan standard.

Table 8: TEAMonitor Compliance Review Summary of Issues

Compliance Area	42 CFR and Apple Health Contract Citation	Number of Plans with Findings
Availability of Services		
	438.206 (b)(1)(i-v) Delivery network 438.207(b)(1)(2) Assurances of adequate capacity and services	1
	438.206(b)(2) Direct access to a women's health specialist	1
	438.206(b)(3) Provides for a second opinion	1
	438.206(b)(4) Services out of network	1
	438.206 (b)(5) Out-of-network payment	1
	438.206(c) Furnishing of services (2) Cultural considerations	1
Program Integrity		
	438.608(a)(b) Program integrity requirements	5
Care Coordination and Continuity of Care		
	438.208(c)(26) Assessment and treatment plans and care coordination for individuals with special health care needs, 14.3	5
	438.208(c)(26) Assessment and treatment plans and care coordination for individuals with special health care needs, 14.3—AHFC	1
	Apple Health—Coordination between contractor and external entities, 14.4	1
	Apple Health—Skilled nursing facility coordination, 14.6	1
	Apple Health—Care coordination oversight, 14.10	1
	438.208(c)(4) Direct access to specialists—AHFC	1
Coverage and Authorization		
	438.210(b)(1)(2)(3) Authorization of services, 11.1, 11.3	5
	438.210(b)(1)(2)(3) Authorization of services, 11.1, 11.3—IMC	1
	438.210(c) Notice of adverse action, 11.3.4.2	5
	438.210(d) Timeframe for decisions (1) (2), 11.3.5	4
	438.114 Emergency and post-stabilization services, (a)(b)(c)(d), (e), 16.5.5 and 16.5.6	1
	Apple Health—Outpatient mental health, 16.5.13	5
	Apple Health—Second opinion for children prescribed mental health medications, 16.5.14	2
	Apple Health—Emergency contraceptives, 16.8.16.1.7.1	1
Enrollee Rights		
	438.100(a) General rule, 10.1.1	1
	438.100(d)(1)(ii) and (2) Format, alternative formats, 3.4.1 and 3.4.2	2
	438.100(f) (2–6) General information, 3.2 and 6.15.2	2
	438.100(b)(2)(i) Specific rights; 438.10(i), Information for enrollees—formulary	1
	438.106 Liability for payment, 2.13 and 10.5	2
Grievance Systems		

	438.228 Grievance systems, 3.2.5.18.2 and 13.1.1	1
	438.414 Information about the grievance system to providers and subcontractors, 9.4.12	1
Practice Guidelines		
	438.236(a)(b) Adoption of practice guidelines, 7.8.1	2
	438.236(c) Dissemination of practice guidelines, 7.8.1.5 and 7.8.1.7	2
	438.236(d) Application of practice guidelines, 7.8.1.6	2
Provider Credentialing		
	438.214(a) General Rules and 438.214(b) Credentialing and re-credentialing requirements, 9.13—file review	1
	438.214(c) Nondiscrimination and provider discrimination prohibited, 9.3—file review	1
	438.214(d) Excluded providers, 9.13.2	1
	438.214 Provider selection (e) State requirements, 9.13.2.5, 9.13.13, and 9.13.17—file review	2
Quality Assessment and Performance Improvement (QAPI)		
	438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement— assess care furnished to enrollees with special health care needs, 14.10.1	1
Subcontractual Relationships and Delegation		
	438.230(b)(3) Monitoring performance of subcontractors	1
Apple Health Contract—Health Homes		
	Health Care Authority Encounter Data Reporting Guide (Administrative), (Apple Health Contract Exhibit C 2.1.3)	3
	Health Action Plan (HAP) (Apple Health Contract Exhibit C 5.1, 5.3, 5.5 and 5.5.7)	5
	Transitional Care (Apple Health Contract Exhibit C 5.8)	3

Opportunity for Improvement

In this year’s review, MCO scores indicated that complying with the standards for coordination and continuity of care, specifically assessment and treatment plans, and coverage and authorization continues to be a challenge. HCA has prioritized these areas, providing frequent technical assistance to the plans and collaborating with the MCOs on multiple efforts to improve care coordination and transitions, especially with regard to services that span the physical and behavioral health realms.

- As the Apple Health program moves closer to a fully integrated managed care model, the state should remain focused on the areas of coordination and continuity of care and coverage and authorization, continuing to provide guidance to MCOs, supporting collaborative efforts between physical and behavioral health services, and implementing initiatives that will help ensure quality care for enrollees.

Performance Improvement Project Validation

Medicaid managed care organizations (MCOs) are federally required to design and implement a series of performance improvement projects (PIPs) intended to effect sustaining improvements in care delivery.

Apple Health MCOs were required to conduct the following PIPs in 2017 CY:

- one clinical PIP piloting a mental health intervention that is evidence-based, research-based, or a promising practice and is recognized by the Washington State Institute for Public Policy (WSIPP)
- one collaborative clinical statewide PIP, conducted in partnership between the Department of Health and the Apple Health MCOs, focused on improving well-child visit rates in infants, young children, and adolescents
- additional clinical PIPs if the MCO’s HEDIS rates were below the contractually required threshold for 2017 RY
- one non-clinical PIP of the MCO’s choosing

In addition to the PIPs referenced above, the Apple Health Foster Care plan, CCW, was required to complete the following PIPs related to that program’s population:

- one clinical or non-clinical PIP of the MCO’s choosing
- one non-clinical PIP in partnership with DSHS and HCA

Integrated Managed Care plans were required to complete the following additional PIPs for the IMC and Behavioral Health Services Only (BHSO) enrollees:

- one clinical PIP piloting a behavioral health intervention for adults that is an evidence-based, research-based, or promising practice including those recognized by the Washington State Institute for Public Policy (WSIPP)
- one clinical PIP piloting a behavioral health intervention for children, including, for example, those found in the current WSIPP reports

As a component of its review, HCA conducted a validation of the MCOs’ PIPs. Table 9 displays the MCOs’ PIP study topics. N/A in the results column indicates the MCO was not required to complete the given PIP. For a full description of HCA’s methodology for PIP validation, please see Appendix D.

Table 9: MCO PIP Study Topics

MCO	Study Topic		Result
AMG	WSIPP Clinical PIP	Clinical Mental Health Intervention Adult PIP—evidence-based collaborative effort for depression, co-morbid depression, and chronic health	Not Met
	Collaborative Clinical PIP	Improving Well-child Visit Rates in Infants, Young Children, and Adolescents	Met
	Non-clinical PIP	Improving Member Engagement and Satisfaction	Not Met
	HEDIS Clinical PIP	Childhood Immunization Status—Combo 2	Partially Met
	HEDIS Clinical PIP	Well-child Visits—0–15 months	N/A
	HEDIS Clinical PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS Clinical PIP	Adolescent Well-care Visits	Partially Met

CCW	WSIPP Clinical PIP	Improving Adherence in Adults 18-64 Years Old on Antidepressant Medications	Not Met
	Collaborative Clinical PIP	Improving Well-child Visit Rates in Infants, Young Children, and Adolescents	Met
	Non-clinical PIP	Improving Adult Male Access to Preventive/Ambulatory Health Services in Members Aged 20–64 Years	Not Met
	HEDIS Clinical PIP	Child Immunization Status—Combo 2	Met
	HEDIS Clinical PIP	Well-child visits—0–15 months	Partially Met
	HEDIS Clinical PIP	Well-child visits—3–6 years	Met
	HEDIS Clinical PIP	Adolescent Well-care Visits	Met
	AHFC PIP	Medication Management for People with Asthma	Not Met
	AHFC Non-clinical PIP	Improving Access to Assigned Primary Care Providers for AHFC Members Ages 12 Months to 19 Years Old	Partially Met
CHPW	WSIPP Clinical PIP	Proactive Prior Authorizations for Antidepressant Medication Adherence	Partially Met
	Collaborative Clinical PIP	Improving Well-child Visit Rates in Infants, Young Children, and Adolescents	Met
	Non-clinical PIP	Improving Utilization for High-risk Members through Community Care Coordination	Met
	HEDIS Clinical PIP	Childhood Immunization Status—Combo 2	Partially Met
	HEDIS Clinical PIP	Well-child Visits—0–15 months	N/A
	HEDIS Clinical PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS Clinical PIP	Adolescent Well-care Visits	Met
	IMC Clinical PIP: WSIPP Adult	Outpatient Engagement Post Psychiatric Inpatient Hospitalization	Met
	IMC Clinical PIP: WSIPP Child	Caregiver Attachment in Young Children Exposed to Trauma	Met
MHW	WSIPP Clinical PIP	Effective Provider Collaboration: Enhancing Behavioral Parent Training (BPT) for Parents of Children with Attention-Deficit/Hyperactive Disorder (ADHD)	Partially Met
	Collaborative Clinical PIP	Improving Well-child Visit Rates in Infants, Young Children, and Adolescents	Met
	Non-clinical PIP	Bridging the Gap: Level of Provider Engagement and Quality Improvement	Met
	HEDIS Clinical PIP	Child Immunization Status—Combo 2	Met
	HEDIS Clinical PIP	Well-child Visits—0–15 months	Met
	HEDIS Clinical PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS Clinical PIP	Adolescent Well-care Visits	Partially Met
	IMC Clinical PIP: WSIPP Adult	Collaborative Primary Care for Depression	Met

MHW	IMC Clinical PIP: WSIPP Child	Effective Provider Collaboration: Enhancing Behavioral Parent Training for Parents of Children with ADHD	Partially Met
UHC	WSIPP Clinical PIP	Increase Anti-Depressant Treatment Plan Compliance for Adult, Female, TANF Members Diagnosed with Depression (Anti-depressant Medication Management)	Partially Met
	Collaborative Clinical PIP	Improving Well-child Visit Rates in Infants, Young Children, and Adolescents	Met
	Non-clinical PIP	Increasing the Rate of Members Receiving Diabetic Education Services	Partially Met
	HEDIS Clinical PIP	Childhood Immunization Status—Combo 2	Met
	HEDIS Clinical PIP	Well-child Visits—0–15 months	N/A
	HEDIS Clinical PIP	Well-child Visits—3–6 years	Partially Met
	HEDIS Clinical PIP	Adolescent Well-care Visits	Partially Met

Scoring

In scoring the MCOs’ PIPs, TEAMonitor used the following criteria:

To achieve a score of Met, the PIP must demonstrate all of the following 12 elements:

- The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- Study question(s) must be measurable and stated clearly in writing.
- Relevant quantitative or qualitative measurable indicators are documented.
- There is a description of the eligible population to whom the study questions and identified indicators apply.
- A sampling method has been documented and determined prior to data collection.
- The study design and data analysis plan are proactively defined.
- Specific interventions have been undertaken to address causes/barriers identified through data analysis and QI processes (e.g., barrier analysis, focus groups, etc).
- Numerical results are reported, e.g., numerator and denominator data.
- Interpretation and analysis of the results are reported.
- Consistent measurement methods have been used over time or if changed, the rationale for the change is documented.
- Sustained improvement has been demonstrated through repeat measurements over time (baseline and at least two follow-up measurements required).
- Linkage or alignment has been demonstrated between the following: data analysis documenting need for improvement; study question(s); selected clinical or non-clinical measures or indicators; and results.

To achieve a score of Partially Met, the PIP must demonstrate all of the following seven elements:

- The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- Study question(s) must be measurable and stated clearly in writing.
- Relevant quantitative or qualitative measurable indicators are documented.
- A sampling method has been documented and determined prior to data collection.
- The study design and data analysis plan are proactively defined.
- Numerical results are reported, e.g., numerator and denominator data.

- Consistent measurement methods have been used over time or if changed the rationale for the change is documented.

A Not Met score results from demonstrating any one of the following:

- The topic of the PIP does not reflect a problem or need for Medicaid enrollees.
- Study question(s) is not measurable and/or stated clearly in writing.
- Relevant quantitative or qualitative measurable indicators are not documented.
- A sampling method is not documented and determined prior to data collection.
- The study design and data analysis plan are not proactively defined.
- Numerical results, e.g., numerator and denominator data, are not reported.
- Consistent measurement methods are not used over time, and no rationale has been provided for change in measurement methods, as appropriate.

Summary of PIP Validation Results

HCA's review of the MCOs' PIPs found that overall, plans made improvements this year on PIP design, execution, and documentation, with more PIPs achieving scores of Met and fewer PIPs receiving scores of Not Met (with MHW and CHPW making the greatest strides in improvement). In a number of areas, reviewers noted that MCOs had successfully incorporated feedback received in the previous year's review into their current-year PIP submissions. However, MCOs continued to struggle at times with presenting the details of study design, implementation, and data analysis clearly and in sufficient detail, or simply meeting the contractual requirements of the PIP.

The required clinical WSIPP PIP demonstrated the weakest performance overall, with three plans receiving a score of Partially Met and two receiving a score of Not Met. Topics centered on improving enrollee compliance with medication management, including antidepressant and attention deficit hyperactivity disorder (ADHD) medication management. Several plans received deductions for providing insufficient detail regarding the chosen intervention(s), for choosing interventions not clearly linked to research, or for lack of discussion regarding the relevance between the chosen intervention(s) and the target population. One MCO continued its prior-year PIP with a change in measurement tools without any explanation regarding the continuation or the change. Additionally, in one case the MCO did not choose an intervention recognized by WSIPP. However, in two cases, MCOs were scored down not because of insufficiencies in study design or execution but because the interventions were not effective in the measurement year.

Reviewers found more promising design and execution in the IMC WSIPP PIPs conducted by MHW and CHPW, which included improving outpatient engagement post-psychiatric inpatient hospitalization for better long-term outcomes; using child-parent psychotherapy to decrease health impacts on children exposed to trauma; implementing collaborative primary care for enrollees with depression to improve medication adherence; and employing behavioral parent training to improve attention deficit hyperactivity disorder medication adherence. All PIPs except one were scored as Met; the one PIP scored as Partially Met was scored down only because the intervention did not improve results during the measurement period.

The MCOs' non-clinical PIPs demonstrated mixed results, with two receiving scores of Met, one Partially Met, and two Not Met. PIPs that scored poorly lacked an analysis of the target issue, an identified connection between barriers and the chosen intervention(s), or a demonstration of connection between the intervention and the outcome. Additionally, for two PIPs, reviewers noted a lack of clarity around whether interventions had been designed to accommodate those members of the MCOs' populations with non-English-language needs. However, two non-clinical PIPs showed improvement from the previous year,

receiving scores of Met for their thorough design, success in applying feedback received in the previous year, and achieving quantifiable results on target measures.

For the 17 HEDIS PIPs MCOs were required to complete, HCA issued seven scores of Met, an improvement from the previous year, when reviewers identified only two HEDIS PIPs that fully met criteria. For the PIPs receiving a Met score, reviewers cited thorough analysis of interventions and results, a clearly presented data analysis plan, and an explanation of intended changes to the interventions as strong points. All PIPs receiving a Met score also demonstrated improvement in the relevant HEDIS score, which serves as the PIP indicator, even when the improvement was not statistically significant. However, a number of HEDIS PIPs were scored down to Partially Met as a result of lack of improvement in HEDIS scores, despite sound construction, modifications to the intervention(s), and thorough documentation. Other PIPs received deductions for insufficient interpretation of results or correlation of results with the chosen intervention(s), for a failure to change the intervention after the previous measurement cycle yielded no improvement, or a lack of documented planned changes for the next measurement period's intervention.

The two PIPs CCW conducted for the Apple Health Foster Care program received scores of Partially Met and Not Met. Both study topics applied HEDIS measures (medication management for people with asthma and child/adolescent access to primary care practitioners) to the Washington Apple Health Foster Care population, and reviewers found that both were lacking in design and/or execution. The clinical MMA PIP received a Partially Met score as a result of failure to demonstrate implementation of any of the interventions described in the study design; the Not Met score assigned to the CAP PIP resulted from a lack of baseline data, poor study design, and vaguely described interventions.

MCOs collectively produced good results on the collaborative PIP designed to improve well-child rates in infants, children, and adolescents. During the previous measurement year, this PIP had not yet undergone a full measurement period, but MCOs received Met scores for the PIP's clear, sound design. In mid-2017, with additional information regarding clinic challenges and available reporting, MCOs adapted their approach to focus improvement strategies on increasing partnership between clinics and MCOs. Learnings from parent focus group discussions, organized by DOH, were also used to inform additional clinic pilot design and planning for 2018. On this PIP all MCOs received a score of Met.

Opportunity for Improvement

MCOs showed improvement on PIP performance in 2018 RY, achieving more Met scores and fewer Not Met scores than in 2017 RY. However, numerous PIPs continued to suffer from lack of clarity and specificity in documentation, and data and results analysis was often insufficient.

- HCA's continued work with the MCOs to improve PIP design and documentation appears to be affecting a positive shift in PIP execution and outcomes; to further improve performance, particularly among MCOs that have demonstrated less improvement, the State should continue to provide trainings and technical assistance to the MCOs and their staff on PIP study design and implementation.

Performance Measure Review

Healthcare Effectiveness Data and Information Set (HEDIS)

The performance of Apple Health MCOs in delivering accessible, timely, quality care and services to enrollees can be measured quantitatively through the Healthcare Effectiveness Data and Information Set (HEDIS), a widely used set of healthcare performance measures reported by health plans and developed by the National Committee for Quality Assurance (NCQA). HEDIS results can be used by the public to compare plan performance over six domains of care; they also allow plans to determine where quality improvement efforts may be needed⁴. The HEDIS data are derived from provider administrative and clinical data.

Qualis Health assessed audited MCO-level HEDIS data for the 2018 reporting year (RY) (measuring enrollee experience during calendar year 2017), including up to 57 measures. Many of these measures included one or more submeasures, usually for specific age groups or other defined population groups. Of the 57 measures, 37 relate to effectiveness of care, 5 to access, 10 to utilization, and 5 to health plan descriptive measures.

The HEDIS effectiveness of care measures (broken into categories of access, preventive care, chronic care management, and appropriateness of care in the following section) are considered to be unambiguous performance indicators, whereas the utilization measures are more indicative of the overall risk profile of the population and can vary based on characteristics outside the control of the MCO.

It should be noted that the HEDIS measures are not risk adjusted and may vary from MCO to MCO because of factors that are out of a health plan's control, such as medical acuity, demographic characteristics, and other factors that may impact enrollees' interaction with healthcare providers and systems. NCQA has not developed methods for risk adjustment of these measures.

Many of the HEDIS measures are focused on a narrow eligible patient population for which the measured action is almost always appropriate, regardless of disease severity or underlying health condition.

Data Collection and Validation

In the first half of 2018, each MCO participated in an NCQA HEDIS Compliance Audit™ to validate accurate collection, calculation, and reporting of HEDIS measures for the member populations. This audit does not analyze HEDIS results; rather, it ensures the integrity of the HEDIS measurements.

Using the NCQA-standardized audit methodology, NCQA-certified auditors assessed each MCO's information systems capabilities and compliance with HEDIS specifications. HCA and each MCO received an on-site report and final report of all audit activity; all Apple Health MCOs were in compliance with HEDIS specifications.

⁴ <http://www.ncqa.org/HEDISQualityMeasurement/WhatIsHEDIS.aspx>

Administrative Versus Hybrid Data Collection

HEDIS measures draw from clinical data sources, utilizing either a fully “administrative” collection method or a “hybrid” collection method. The administrative collection method relies solely on clinical information that is collected from the electronic records generated in the normal course of business, such as claims, registration systems, or encounters, among others. In some delivery models, such as undercapitated models, healthcare providers may not have an incentive to report all patient encounters, so rates based solely on administrative data may be artificially low. For measures that are particularly sensitive to this gap in data availability, the hybrid collection method supplements administrative data with a valid sample of carefully reviewed chart data, allowing health plans to correct for biases inherent in administrative data gaps. Hybrid measures therefore allow health plans to overcome missing or erroneous administrative data by using sample-based adjustments. As a result, hybrid performance scores will nearly always be the same or better than scores based solely on administrative data.

Supplemental Data

In calculating HEDIS rates, the Apple Health MCOs used auditor-approved supplemental data, which is information generated outside of a health plan’s claims or encounter data system. This supplemental information included historical medical records, lab data, immunization registry data, and fee-for-service data on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provided to MCOs by HCA. Supplemental data was used in determining performance rates for both administrative and hybrid measures.

Member-level Data

Additionally, HCA required MCOs to submit de-identified member-level data for all administrative and hybrid measures. Member-level data enable conducting analyses related to geographic and demographic performance variation to identify quality improvement opportunities.

Calculation of the Washington Apple Health Average

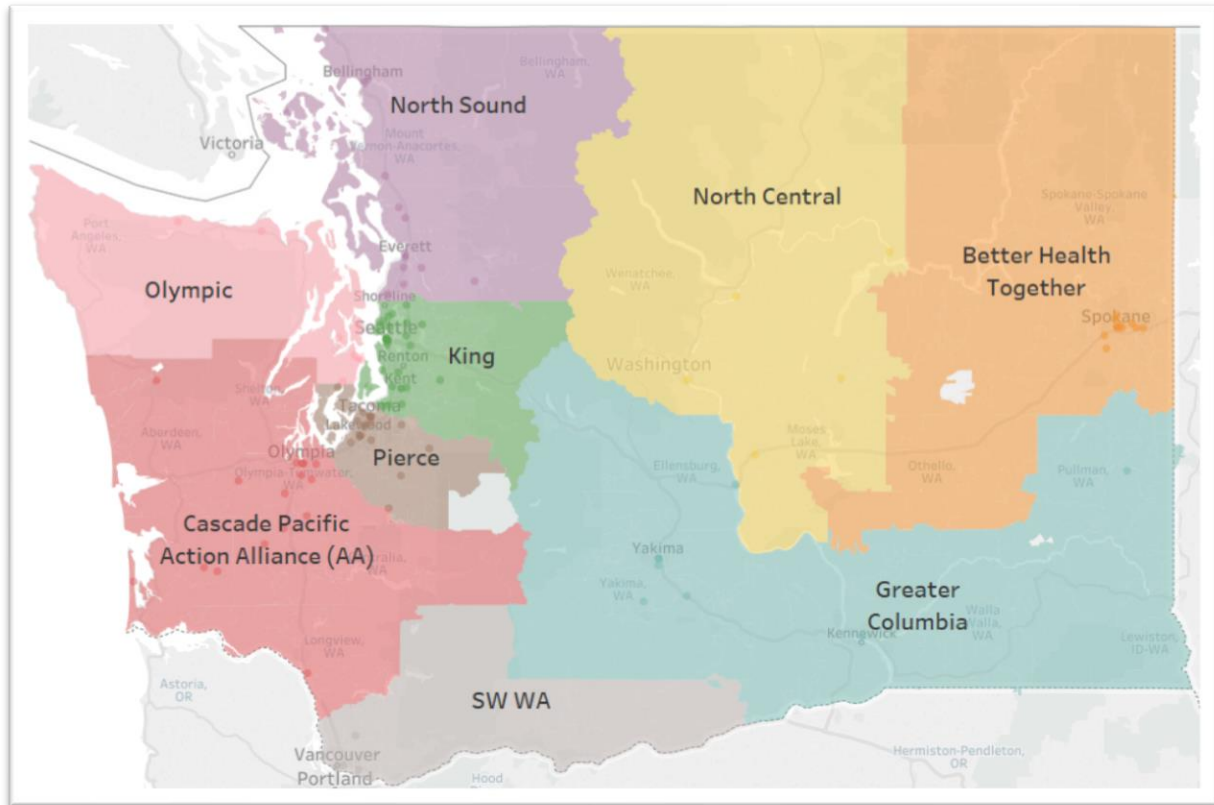
This report provides estimates of the average performance among the five Apple Health MCOs for the four most recent reporting years: 2015, 2016, 2017, and 2018 RY. The state average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five MCOs), with MCOs’ shares of the total eligible population used as the weighting factors.

Summary of HEDIS Performance Measure Results

The following results present the Apple Health average (the state rate) compared to national benchmarks, derived from the Quality Compass⁵, the NCQA’s database of HEDIS results for health plans. It also includes select results of regional and demographic analyses conducted using member-level data (described above). Further analyses based on member-level data are included in the *2018 Regional Analysis Report*. For comparative plan performance, readers may refer to the *2018 Comparative Analysis Report*. Regional results are described using the geographic designations for the state’s Accountable Communities of Health, as shown in the following map in Figure 2, next page.

⁵ Quality Compass® 2018 is used in accordance with a Data License Agreement with the NCQA.

Figure 2: Accountable Community of Health Boundaries, 2018 CY



The map above reflects boundaries defined by the HCA as of May 2018⁶. Enrollees were assigned to ACHs based on their residence ZIP code and not where care is provided. Note that the grey area near Pierce is a national park and does not contain any beneficiaries.

⁶ <https://www.hca.wa.gov/assets/program/ach-map.pdf>

Access to Care

HEDIS access to care measures relate to whether enrollees are able to access primary care providers at least annually, whether children are able to access appropriate well-child and well-care services, and whether pregnant women are able to access adequate prenatal and postpartum care. These measures reflect the accessibility and timeliness of care provided.

Statewide rates for adult access to primary care measures improved significantly at the state level between 2017 and 2018 RY. Most child and adolescent access measures, however, shifted down. Performance in this category was poorest in the area of maternal health. The statewide rate for timeliness of prenatal care declined by more than 5 percentage points and fell below the 20th percentile of national performance; the rate for postpartum care did not improve and remained below the 40th percentile nationwide.

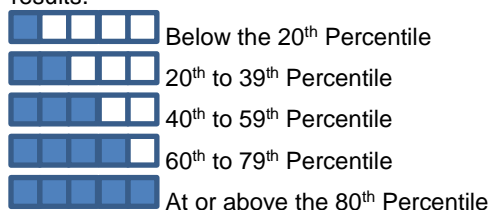
Regionally, rates for adult and child access measures were stronger in the eastern regions of the state. Analysis by identified language preference showed higher rates for non-English-speaking enrollees than for English-speaking enrollees.

Table 10 displays the statewide results of these measures for the last four reporting years.

Table 10: Access to Care HEDIS Measures, 2014–2017 RY

	2015 State Rate	2016 State Rate	2017 State Rate	2018 State Rate	2018 National Quintile*
Adults' Access to Preventive/Ambulatory Health Services					
20–44 years	77.9	71.8	71.1	72.6	
45–64 years	84.6	80.4	79.9	80.6	
Children and Adolescents' Access to Primary Care Practitioners					
12–24 months	97.5	92.7	96.7	96.7	
25 months–6 years	88.8	81.9	86.4	85.8	
7–11 years	91.9	87.5	91.2	90.4	
12–19 years	91.2	87.5	90.8	90.6	
Well-Care Visits					
0–15 months	56.8	60.3	66.3	67.7	
3–6 years	66.6	66.7	67.9	66.7	
12–21 years	42.6	43.3	45.8	48.0	
Maternal Health					
Timeliness of Prenatal Care	73.7	68.2	77.9	72.6	
Postpartum Care	51.6	52.2	58.8	58.8	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.



Preventive Care











Preventive care measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect access and quality.

Performance on many preventive care measures improved or remained steady between 2017 and 2018 RY. However, rates for children’s BMI percentile assessment, nutrition and physical activity counseling, and most women’s health screenings remain below the 40th percentile of national performance.

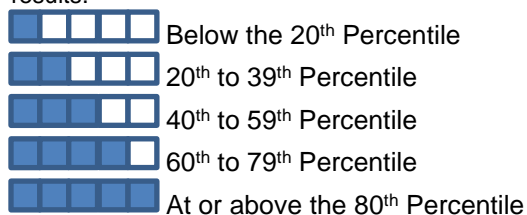
Demographic analyses showed lower breast cancer screening rates for white, English-speaking women than for all other groups.

Table 11 displays results for preventive care measures.

Table 11: Preventive Care HEDIS Measures, 2015–2018 RY

	2015 State Rate	2016 State Rate	2017 State Rate	2018 State Rate	2018 National Quintile*
Weight Assessment and Counseling					
Children’s BMI Percentile	36.7	45.8	58.0	70.9	
Children’s Nutrition Counseling	51.1	57.4	58.7	62.9	
Children’s Physical Activity Counseling	45.1	53.5	53.2	57.8	
Adult BMI Assessment	82.2	85.0	90.2	89.0	
Immunizations					
Children’s Combination 2	70.9	71.4	70.5	70.5	
Children’s Combination 10	41.6	40.8	36.9	38.1	
Adolescents’ Combination 1	73.7	74.2	76.6	76.0	
Women’s Health Screenings					
Breast Cancer Screening	54.4	52.3	53.5	55.3	
Cervical Cancer Screening	50.4	52.8	55.8	56.9	
Chlamydia Screening	51.2	54.8	54.4	55.1	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.



Chronic Care Management

Chronic care management measures relate to whether enrollees with chronic conditions are able to receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient services. These measures reflect access and quality.

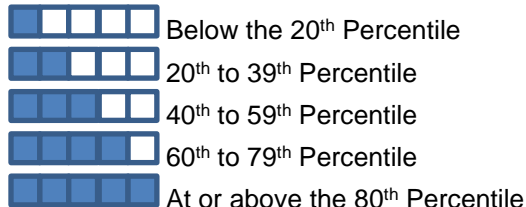
Statewide performance on most chronic care management measures remained steady in 2018 RY, as shown in Table 12.

Regional analysis showed particular variation on the antidepressant medication management measures. Rates for both submeasures were generally higher in the western regions of the state, continuing a trend identified in 2017 RY.

Table 12: Chronic Care Management HEDIS Measures, 2015–2018 RY

	2015 State Rate	2016 State Rate	2017 State Rate	2018 State Rate	2018 National Quintile*
Diabetes Care					
HbA1c Testing	90.4	88.3	89.6	89.3	
Eye Exam	54.8	55.5	59.1	59.7	
Medical Attention for Diabetic Nephropathy	83.4	88.9	90.1	89.4	
Blood Pressure Control (<140/90)	63.7	63.0	66.0	67.8	
HbA1c Control (<8.0%)	46.3	39.0	49.6	50.0	
Other Chronic Care Management					
Controlling High Blood Pressure (<140/90)	53.6	53.5	56.0	59.9	
Antidepressant Medication Management (Acute Phase)	51.7	54.2	50.8	51.6	
Antidepressant Medication Management (Continuation Phase)	37.0	39.4	35.4	35.9	
Medication Management for People with Asthma: 75% Compliance (Ages 5–11)	21.8	22.1	23.4	25.7	
Medication Management for People with Asthma: 75% Compliance (Ages 12–18)	21.3	23.2	25.7	25.4	
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	37.7	38.7	43.1	42.4	
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase)	39.1	48.2	53.5	49.1	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.



Appropriateness of Care

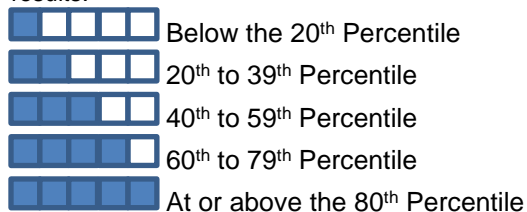
Appropriateness of care measures relate to whether enrollees receive non-medically indicated care. These measures reflect quality.

Apple Health MCOs continued to perform well on measures relating to appropriateness of care in 2018 RY. Each of the measures in Table 13 relates to the percentage of individuals who did not receive inappropriate services (meaning higher scores indicate better performance). Uniformly high performance on these measures indicates that Apple Health enrollees are not receiving potentially expensive unnecessary interventions.

Table 13: Appropriateness of Care HEDIS Measures, 2015–2018 RY

	2015 State Rate	2016 State Rate	2017 State Rate	2018 State Rate	2018 National Quintile*
Use of Imaging for Low Back Pain	77.7	76.3	74.3	75.6	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	29.3	30.3	36.1	40.4	
Appropriate Treatment for Children with Upper Respiratory Infection	92.6	93.5	93.7	93.8	

* Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.



Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS surveys assess consumers' experiences with healthcare services and support. Developed by the U.S. Agency for Healthcare Research and Quality (AHRQ), the surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of healthcare, access to specialized services, and coordination of care.

In 2018, as part of their annual HEDIS Compliance Audit^{TM7}, Apple Health MCOs conducted CAHPS 5.0H Child and/or 5.0H Adult Medicaid surveys of their memberships, via individually contracted NCQA-certified survey vendors, but were not required to provide results for EQR comparative reports as in prior years.

Additionally, as required by HCA, Coordinated Care of Washington conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions survey of the Apple Health Foster Care program. NCQA-certified survey vendor DataStat, under a subcontract with Qualis Health, administered the 5.0H Child Medicaid survey of the member households of children enrolled in the State Children's Health Insurance Program (CHIP).

Apple Health Foster Care

Respondents of the Apple Health Foster Care CAHPS survey included parents/caretakers of children under the age of 18 enrolled in the program. The survey included the general Apple Health Foster Care population as well as children with chronic conditions. NCQA-certified survey vendor DataStat, under a subcontract with Qualis Health, produced a report that summarized survey responses and identified key strengths and opportunities for improvement, based on survey questions most highly correlated to enrollees' satisfaction with their health plan.

Both the general and the chronic conditions populations reported strengths related to getting care as soon as needed for the child; customer service treating families with courtesy and respect; ease of obtaining prescriptions; ease of getting care, tests, or treatment for the child; and usually or always getting an appointment as soon as needed.

Overall opportunities for improvement included getting treatment or counseling for the child; getting special equipment or devices; getting appointments with specialists as soon as needed; customer service providing the help needed; and personal doctors being informed about care a child received from other providers.

Children's Health Insurance Program (CHIP)

Responses for the CHIP survey's five standard composites (each of which represents a domain of enrollee experience) were on par with those collected in 2016 (the last time the survey was conducted) and indicate a good level of satisfaction, with the notable exception of Getting Needed Care. This composite, which includes questions related to the ability to get care, tests, or treatment when needed, as well as an appointment with a specialist as soon as needed, demonstrated a statistically significant decline.

⁷ HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

Recommendations

Statewide rates for maternal care measures, including timeliness of prenatal care and postpartum care, dropped or remained flat in 2018 RY, and remain below the 40th percentile of national performance.

- HCA needs to examine root causes for poor performance on these measures and determine what action is needed. The State should consider requiring MCOs to have a plan in place, including timelines and deliverables, to improve performance.

Statewide rates for numerous measures, including child and adolescent access to care, adolescent well-care and well-child visits, immunizations for adolescents, women's health screenings, HbA1c control, antidepressant medication management, and follow-up care for children prescribed ADHD medication, have either dropped or remained flat since 2017 RY, yet are still below the 60th national percentile.

- To continue to improve care delivery to all Apple Health enrollees, HCA should continue to monitor these measures. To bring statewide performance above national standards, HCA should consider setting higher statewide performance goals for MCOs.

Statewide rates for adult access to care improved slightly in 2018 RY; those for child/adolescent access decreased. Overall, access rates in the eastern regions of the state continued to surpass those in the western regions of the state.

- The State should consider examining root causes of low performance rates on access measures in the western regions of the state. Performance on access to primary care for both adults and children/adolescents were all particularly low in these regions of the state compared to the state average and should be a focus of improvement. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.

Although performance on the antidepressant medication management measures improved slightly in the eastern regions of the state in 2018 RY, rates here still lag behind those in the western areas of the state.

- The State should consider examining root causes of low performance on these behavioral health measures in the eastern part of the state and determine whether focused improvement efforts may be necessary, including examining the number and types of behavioral health practitioners and provider organizations available in the underperforming regions. Success for some of the measures may require sophisticated and specialized care potentially not readily available in rural areas. Depending on the results of these analyses, HCA should consider maximizing collaboration with the behavioral health integration efforts, priorities, and resources of Healthier Washington to better facilitate behavioral health integration across the state, particularly in the eastern regions.

Numerous measures, including most access measures and the breast cancer screening measure, showed lower performance rates for English-speaking enrollees; on other measures, performance was lower for those enrollees with a non-English-language preference.

- Language preference plays a critical role in healthcare delivery, yet currently, methods for collecting enrollees' preferred language data vary among the plans and do not collect optimally detailed data. To further understand the specific language challenges present in delivering equitable care and to ensure enrollees are obtaining care and information in language they understand, HCA should consider the following options: asking MCOs to expand options for capturing enrollees' preferred language data beyond "other" to include a variety of languages, standardizing collection of this information among the plans, and evaluating whether the language capture is accurate. Obtaining an enhanced level of enrollee data may assist in identifying regions where additional or specialized outreach may be concentrated.

Review of Previous-Year EQR Recommendations

Required external quality review activities include a review of the applicable state organization’s response to previously issued EQR recommendations. Table 14 below displays Qualis Health’s 2017 recommendations and suggested opportunities for improvement, HCA’s responses to those recommendations, and Qualis Health’s subsequent response.

Overall, Qualis Health has determined that HCA is taking comprehensive steps not only to address the recommendations outlined below, but also to implement ongoing quality improvement strategies in an effort to further elevate the quality of care for enrollees.

Table 14: Review of HCA Responses to 2017 EQR Recommendations

Prior-Year Recommendation	HCA Response	EQRO Response
<p>Integration As the State continues to coordinate physical health, mental health, and substance use disorder treatment integration, collaboration and communication among service networks will be of importance in ensuring continued quality care.</p>		
<p>The State needs to ensure there is communication and collaboration between MCOs, BHOs, and BHAs to create transparency and ensure best practices for ensuring continued quality care.</p>	<p>Communication and collaboration between MCOs, BHOs, and BH providers has increased greatly this year. All MCOs have signed MOUs or working agreements with BHOs. One large BHO is regularly exchanging data with each MCO on shared members who have physical and behavioral health needs, frequent ED visits, or hospitalizations. The other BHOs are actively working on improving their data-sharing capabilities. Sharing information on members helps both responsible entities to make sure the member is connected to the services they need.</p> <p>Our contract requires that each MCO have a liaison to each of the two state hospitals. Care managers are also being designated, usually one for each BHO. The MCO that covers children in foster care has made special efforts to identify and coordinate care for those members that have used behavioral health care services.</p> <p>Cross-agency communication is taking place in many forums, including MCO participation on local behavioral health advisory boards, shared case rounds, and specific meetings such as the Co-Occurring workgroup and the High Utilizers workgroup. The Health Care Authority is</p>	<p>Response accepted.</p>

Prior-Year Recommendation	HCA Response	EQRO Response
	<p>holding “knowledge transfer” meetings to facilitate IMC implementation and has held many meetings with BHOs and SUD providers to share information and create opportunities for questions. The HCA is also actively preparing for new IMC regions and readying new BH-ASOs entities, and strategizing about how best to meet BHO communication needs during and after the transition into BH-ASOs. Additionally, HCA is working to restore the twice-yearly community and education meetings in the 2019 EQRO contract to continue the communication and collaboration about quality with MCOs, BH-ASOs, and BHOs.</p>	
<p>Quality Strategy In 2017, HCA and DBHR collaborated on a draft State quality strategy and submitted the plan to CMS for approval. However, CMS has not yet approved the plan. Having a CMS-approved State quality strategy in place is a federal regulatory requirement.</p>		
<p>Once CMS has approved the State’s quality strategy, per federal requirements the State needs to distribute the plan to MCOs and BHOs, post the plan to the State’s website, and ensure the plan is evaluated for effectiveness yearly, either by the EQRO in the EQR annual technical report, or by the State via a report submitted to CMS.</p>	<p>The HCA was informed by CMS that no approval is required for states’ quality strategies although it is required to be submitted to CMS. The quality strategy will be reviewed and approved by HCA leadership prior to finalization and posting publically as required by CFR. HCA is in the process of obtaining this internal approval of the draft. After approval, the HCA will distribute the plan to the MCOs, BHOs, and EQRO, post publically on the HCA website, and evaluate it routinely.</p>	<p>Response accepted.</p>
<p>Performance Measures The most substantive needs for improvement for MCOs that surfaced during the 2017 external quality review centered on low HEDIS measure and CAHPS survey performance. HEDIS measure results reflected low Apple Health performance on adult access to primary care, well-child visits for children ages 3–6, maternal health measures, children/adolescents’ BMI percentile and nutrition/physical activity counseling measures, and women’s health screenings. The following recommendations are intended to help identify the causes of low performance and take steps to remedy low scores.</p>		
<p>HCA needs to monitor rates of adult access to primary care, which have shown improvement but are still considerably lower than national rates. Specifically, HCA should seek root causes for low access rates for 20–44-year-olds in Apple Health Adult</p>	<p>Adult access to primary care (AAP) HEDIS rates have stayed stable or improved slightly over the last two years. All MCOs prioritized this measure. One MCO started a performance improvement project on increasing adult male access to primary care. Other MCO interventions include increased HEDIS training for providers and improved systems of calling members to</p>	<p>Response accepted.</p>

Prior-Year Recommendation	HCA Response	EQRO Response
<p>Coverage and Integrated Managed Care, which are much lower than rates for other members of the Medicaid population, and determine whether action is needed. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.</p>	<p>remind them of recommended visits and to schedule appointments. HCA directed all MCOs to conduct a root-cause analysis, evaluate trends in HEDIS performance, and determine an action plan to attain or maintain increase in the AAP rate. This measure must be addressed specifically in their 2018 quality improvement program evaluations and 2019 work plans; this will be evaluated through the TEAMonitor process and other quality-related deliverables as requested. Based on HEDIS scores and TEAMonitor reviews, HCA is requiring each individual MCO to analyze their AAP performance and create a Quality Improvement Plan if they continue to underperform. Individualized expectations will be shared with the MCOs via letters to plan leadership. Although improvement in adult access is needed across plans, the lowest performing plans are being instructed to put particular emphasis on this measure.</p>	
<p>Examine barriers to well-child visits for children ages 3–6, and determine whether statewide action is necessary. This measure did not show improvement in 2017 RY and is still below the national 50th percentile. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.</p>	<p>The state's W34 HEDIS rate has been mostly stable in reporting year 2018; two MCOs had slight increases in the measure, two had smaller decreases, and one stayed steady. All plans have done PIPs on this measure for the past three years. Recent promising interventions have included increasing incentives for both members and providers, implementing automated and live telephone reminder systems, and providing training and support to providers. The population of children in foster care has been measured separately for the first time this year, and has shown a higher rate than the general Medicaid population for this plan.</p> <p>Well-child visits for 3-6 year olds is now a value-based purchasing measure, and has been prioritized by all plans. Interventions for increasing W34 rates often apply across the HEDIS age groups, including infants and adolescents. The Health Care Authority has done extensive training on EPSDT requirements in meetings with MCOs, and</p>	<p>Response accepted.</p>

Prior-Year Recommendation	HCA Response	EQRO Response
	<p>strengthened the contract language so that the MCOs are clear on the expectation of providing all medically necessary health care to children. Some MCOs have made internal staff or work division changes which allow more concentrated effort on all HEDIS measures.</p> <p>The well-child Collaborative PIP, which has been contractually required for the past three years, has been key to identifying and implementing new strategies to get all ages of children in for well visits. All five MCOs participate in this work along with HCA and the State Department of Health. The workgroup has looked closely at ways to help provider clinics increase their rates, identifying system issues that may produce official rates that are not indicative of their actual effectiveness. The MCO representatives worked directly with clinics (1 clinic per MCO in each of the past two years) to “clean up” their patient panels, by identifying assigned patients who had not sought care and determining if they had transferred to another provider or simply needed outreach to get in for care. Although labor intensive, this work has produced improvements in a short time for most of the clinics. The partnership with DOH has allowed the collaborative project to do research, focus groups and key informant interviews to discover what works for children and families. They have put their findings into action, for instance by recommending changes in incentives and by working together to help communications come directly from providers instead of MCOs. The project is being expanded to include 37 MCO-clinic partnerships starting in late 2018. HCA, along with DOH, DSHS and the Department of Early Learning (DEL), participated in a workgroup meant to increase knowledge and importance of well-child visit rates across the state. Well visits for 3-6 year olds are being emphasized in the letters to plans requiring individualized quality improvement plans.</p>	

Prior-Year Recommendation	HCA Response	EQRO Response
<p>To sustain improvements demonstrated by plans in 2017 RY, HCA should continue to monitor and emphasize maternal health measures, weight assessment and counseling for children/adolescents measures, women’s health screenings, and antidepressant medication management.</p> <p>While performance on many of these measures improved from 2016 RY to 2017 RY, rates are all considerably below national averages, and plans should strive for continued improvement. To bring statewide performance in line with national standards, HCA should consider setting statewide performance benchmark goals for MCOs.</p>	<p>These HEDIS rates have had various rates of improvement and new interventions. Many of these measures are now defined as value-based purchasing (VBP) measures per contract, and so have statewide performance benchmarks starting in the 2018 and 2019 contracts. The VBP measures mentioned here are:</p> <ul style="list-style-type: none"> • Antidepressant medication management, acute phase • Antidepressant medication management, continuation phase • Comprehensive diabetes care, poor HbA1c control • Comprehensive diabetes care, blood pressure control • Controlling high blood pressure • Medication management for people with asthma, acute phase • Medication management for people with asthma, continuation phase <p>Maternal care and women’s health screenings are included in MCO’s plans to increase all HEDIS rates. Specific interventions include: member incentives for prenatal care, postpartum care, breast and cervical cancer screenings; live and recorded phone calls to help set appointments; and providing more frequent interim HEDIS reports to providers. One plan has collaborated with a breast cancer center to promote and offer screenings. As many MCO members use FQHCs, efforts to increase rates have also been concentrated there. From 2015 to 2017, the Washington FQHCs saw increased rates for breast cancer screening, two comprehensive diabetes care measures, well-child (W34) visits, and medication management for people with asthma.</p> <p>Weight assessment and counseling for children and adolescents: these rates increased for every plan in RY 2018. Two plans met or exceeded the national averages for both Children’s BMI Assessment and Physical Activity Counseling.</p>	<p>Response accepted.</p>

Prior-Year Recommendation	HCA Response	EQRO Response
	<p>Antidepressant medication management (AMM) is being emphasized by every MCO. Three MCOs are doing PIPs on AMM, which are showing promise in the coming year. The MCO Collaborative Health Disparities workgroup is doing an innovative project on increasing AMM for Spanish-speaking people in Washington. Interventions have included radio public service announcements, participation at Latino Health Fairs and presentations at Community Health Worker Conference. They have also done research including key informant interviews and focus groups to better understand the dynamics around antidepressant medication in this population. While not a PIP by definition, this project has the potential to make a difference in an important healthcare disparity in the state. The improvement may not be evident in statewide HEDIS rates, as this is a smaller population. Plans are also doing individual work to improve this measure.</p> <p>The State is considering setting performance benchmarks for those measures that are not VBPs. Based on each plan's HEDIS performance, HCA is requiring MCOs to evaluate their 2018 HEDIS performance specifically for these measures and to create a Quality Improvement Plan for those areas in which they are underperforming.</p>	
<p>MCOs performed below the 20th percentile nationwide for four out of eight reported CAHPS survey questions. Given the interconnectedness of the variables impacting these scores, improvement efforts directed toward one or two process measures are likely to positively impact CAHPS results as a whole.</p> <p>HCA needs to encourage MCOs to increase focus on</p>	<p>Improved results on CAHPS surveys are a priority effort for MCOs as well as HCA. In 2018, one CAHPS survey was mandated by contract in order to stay NCQA accredited; however, the HCA did not specify which survey was required. Each plan did at least one survey in order to meet this requirement, but different surveys were conducted depending on the MCO's priority, so results cannot be compared across plans. Plans have each included CAHPS improvement strategies in their quality work</p>	<p>Response accepted.</p>

Prior-Year Recommendation	HCA Response	EQRO Response
<p>improving two easily definable CAHPS measures, Getting Needed Care and Getting Care Quickly, in an effort to improve CAHPS survey results globally.</p>	<p>plans and evaluations. Interventions include:</p> <ul style="list-style-type: none"> • Member and provider education on appointment standards • Outreach to members with immediate post-service phone calls, help making appointments, and raising awareness and use of home delivery of medications • Improve provider search tools so that they are more accurate and less frustrating for members • Expanding provider networks <p>The State has contractually defined the survey the MCOs will conduct in 2019. Additionally, changes were made to the Apple Health contracts so the MCO's must specifically utilize consumer voice in their quality improvement activities. MCOs will be required to submit their complete CAHPS surveys with the annual compliance monitoring. As part of the Quality Improvement Plan, HCA also instructed each plan to analyze their 2018 CAHPS results and report on their strategies to improve the two important CAHPS measure mentioned here.</p>	
<p>Compliance In this year's review, MCOs' scores demonstrated overall slight improvement, notably with enrollee rights and coordination and continuity of care standards. However, coordination and continuity of care, coverage and authorization, and grievance system standards continue to be areas of weakness.</p>		
<p>HCA needs to consider education or training efforts to address coordination and continuity of care, and transitional care with MCOs. These areas have been historically problematic, and additional efforts may be needed to ensure adequate care for enrollees, particularly given the integration of physical and behavioral healthcare services.</p>	<p>Care coordination, continuity of care and transitions of care are areas in which contract expectations have evolved over recent years. Contract language has changed yearly, with the goal of better meeting the needs of the population and changes in the health care system, as well as increasing congruence with NCQA and other national efforts toward population-based health. HCA staff held meetings with MCO Care Coordination staff in late 2017 to discuss the contractual changes and ensure MCO understanding of the significant change upcoming in 2018 contracts. No barriers to implementation have been reported. In the 2018 annual monitoring review, MCOs' desk and file review scores</p>	<p>Response accepted.</p>

Prior-Year Recommendation	HCA Response	EQRO Response
	<p>on care coordination were improved from the previous year. The State had worked with MCOs to clarify expectations, and the MCO's clearly defined their levels of care management, so that assumptions about file review were more aligned. MCOs and HCA are also involved in multiple projects related to improving transitions of care between hospitals, SNFs and home or other placement. All MCOs are working to maintain and improve their continuity and transitions of care standards as they proceed with integration of services. Many of the interventions created for better collaboration with BHOs are helping with continuity and transition of care between the physical and behavioral health services. Collaboration and knowledge sharing is also improving with SUD providers. Plans have created internal staffing units to concentrate on care transitions and to reach out to providers who may be unfamiliar with the services of managed care. HCA continues to prioritize these areas and will continue to provide frequent technical assistance to address the changing expectations of the programs.</p>	
<p>Opportunity for Improvement: Performance Improvement Projects MCOs received scores of Partially or Not Met on the majority of the PIPs they were assigned in 2016 CY. While identified topics generally targeted important enrollee needs or gaps in service delivery, PIP design was frequently lacking in clarity and specificity, and data and results analysis was often insufficient.</p>		
<p>HCA should continue to provide trainings and possibly technical assistance to the MCOs and their staff on PIP study design and implementation.</p>	<p>HCA added a requirement to contract that MCOs submit proposals for the PIPs they are planning to carry out in calendar year 2018. All plans did so and revised a number of PIP plans based on HCA feedback and technical assistance meetings. The intention of this is to make sure the proposed PIPs meet the contract requirements, but technical assistance was also given on other aspects of PIP design and implementation if warranted. HCA also decreased the number of PIPs required in MY 2018, to allow plans to provide more focused attention and delve more deeply into fewer projects. Individual MCOs</p>	<p>Response accepted.</p>

Prior-Year Recommendation	HCA Response	EQRO Response
	<p>requested and received technical assistance calls on PIPs throughout the year. Significant technical assistance was also provided to MCOs through the bimonthly workgroup meetings between MCO quality staff, HCA Clinical Monitoring staff, and DOH staff in the collaborative PIP. HCA has seen much improvement in the overall PIP program. The 2017 contractually required PIPs submitted in 2018 for validation showed improved scores overall. Two MCOs continue to struggle with PIP programs and individual PIP scores were lower. It is thought these lower scores were the result of staff turnover without trained replacement, high number of PIPs required, and general PIP complexity. One MCO has instituted some organizational changes to address this. The HCA plans to follow up with both of these MCOs through corrective action. HCA will continue to be available for technical assistance and monitor for changes in PIP programs.</p>	

Behavioral Healthcare

Introduction

As discussed previously in this report, Washington is moving forward to integrate behavioral healthcare benefits into the Apple Health managed care program to provide enrollees with access to both physical and behavioral healthcare services through a single managed care plan. Although the integration is scheduled to be complete no later than 2020, the legislation mandating this integration allows regional county authorities to elect to move forward with the integrated managed care transition on an earlier timeline, if desired. Of the eight BHOs facilitating services in 2018, five decided to complete the transition by the end of 2018. These mid-adopter BHOs included Spokane County Regional BHO, Greater Columbia BHO, King County BHO, North Sound BHO, and Optum Pierce BHO (North Sound revised its schedule to complete the transition by July 2019). The three on-time-adopter BHOs—Great Rivers BHO, Salish BHO, and Thurston-Mason BHO—are on schedule to complete the transition by the end of 2019. Table 15 displays the BHOs facilitating services in 2018 and their service areas, and Figure 3, next page, displays the behavioral health service areas as delivered by BHOs and IMC.

Table 15: BHO Service Areas

BHO	Counties Served
Greater Columbia BHO (GCBHO)	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima
Great Rivers BHO (GRBHO)	Lewis, Pacific, Wahkiakum, Cowlitz, Grays Harbor
King County BHO (KCBHO)	King
North Sound BHO (NSBHO)	San Juan Island, Skagit, Snohomish, Whatcom
Optum Pierce BHO (OPBHO)	Pierce
Spokane County Regional BHO (SCRBHO)	Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens
Salish BHO (SBHO)	Clallam, Jefferson, Kitsap
Thurston-Mason BHO (TMBHO)	Mason, Thurston

Compliance Review

The compliance portion of Qualis Health's external quality review assesses overall performance, identifies strengths, and notes opportunities for improvement or recommendations requiring corrective action plans (CAPs) in areas where BHOs did not clearly or comprehensively meet federal and/or State requirements. In this year's review, mid-adopter BHOs and on-time-adopter BHOs were assessed differently. Because the mid-adopter BHOs ceased operations by December 31, 2018, scores were not assigned. The on-time adopters were assigned scores in keeping with previous-year scoring practices, as described on the next page. Additionally, corrective action plans were assigned to the on-time-adopter BHOs where they were found to be out of compliance with CFR or WAC standards or with contractual requirements.

On-Time-Adopter BHOs

(IMC Transition in 2020)

The compliance portion of Qualis Health's external quality review of on-time-adopter BHOs assesses overall performance, identifies strengths, and notes opportunities for improvement or recommendations requiring corrective action plans (CAPs) in areas where BHOs did not clearly or comprehensively meet federal and/or State requirements.

Methodology

Qualis Health evaluated the BHOs' performance on each element of the protocol by reviewing and performing desk audits on documentation submitted by the BHOs, conducting telephone interviews with the BHOs' contracted provider agencies; and conducting on-site interviews with the BHO staff. Qualis Health's review process is a combined effort by clinical and subject matter experts.

The procedures for conducting the review included the following:

- performing desk audits on documentation submitted by the BHOs, including but not limited to policies and procedures, program descriptions, evaluations and monitoring reports, credentialing files, and grievances and appeals
- conducting telephone interviews with one SUD treatment agency and one dual mental health/SUD treatment agency
- conducting on-site walkthroughs and interviews at two selected dual mental health/SUD treatment agencies to evaluate enrollee rights and protections, advance directives, and the grievance system
- conducting on-site interviews with BHO staff on standards related to enrollee rights and protections, the grievance system, and performance improvement projects (PIPs)
- following up on the prior year's corrective action plans (CAPs)

After the on-site interview process, the BHO has two weeks to submit additional information and/or documentation. Qualis Health then compiles and submits to the State a draft report for the BHO, which includes strengths, opportunities for improvement, and recommendations for corrective action plans for criteria not fully met. The BHO has an opportunity to comment on the draft report, after which the final report is submitted to the State. To improve accessibility, timeliness, and quality of care for Medicaid enrollees, Qualis Health is available throughout the year and during the review process to provide technical assistance to the BHO.

Scoring

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

Fully Met means all documentation listed under a regulatory provision, or component thereof, is present and BHO staff provided responses to reviewers that were consistent with each other’s responses and with the documentation.

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

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

Scoring Key

Fully Met (pass) ●	Partially Met (pass) ◎	Not Met ○
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Summary of Results

Table 16: Results of On-time-adopter BHO Compliance Review

	Enrollee Rights and Protections	Grievance System	Certifications and Program Integrity
Great Rivers (GRBHO)	◎	◎	●
Salish (SBHO)	◎	●	●
Thurston-Mason (TMBHO)	◎	◎	◎

Enrollee Rights and Protections

Table 17: Enrollee Rights and Protections Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues	Number of BHOs with Issues
Enrollee Rights	438.100 (a)	TMBHO, GRBHO, SBHO	3
Information Requirements	438.100 (b)(1)–(2)(i) 438.10 (a–b),(c)(6–7)	TMBHO	1
Information Requirements—Specific	438.100 (b)(1)–(2)(i) 438.10 (d)		0
Information Requirements—General	438.100 (b)(1)–(2)(i) 438.10 (f–g)		0
Provider Directory	438.100 (b)(1)–(2)(i) 438.10 (h),(j)	TMBHO, SBHO	2
Respect and Dignity	438.100 (b)(1)–(2)(ii)	TMBHO	1
Alternative Treatment Options	438.100 (b)(1)–(2)(iii) 438.102 (a)(1)		0
Advance Directives	438.100 (b)(1)–(2)(iv) 438.3 (j)(1),(3)	TMBHO, SBHO	2
Seclusion and Restraint	438.100 (b)(1)–(2)(v)	TMBHO	1
Medical Record Requests	438.100 (b)(1)–(2)(vi)		0
Federal and State Laws	438.100 (c–d)		0

Enrollee Rights

Strength: Access

- All three BHOs provide access on their websites to an enrollee/member handbook and enrollee rights in the languages most prevalently spoken in the BHO's service region.

Strengths: Quality

- All three BHOs require the BHAs to display in their waiting rooms an enrollee rights and responsibilities poster in eight different languages. Interviews with BHAs indicated that enrollees are routinely informed of and provided with a copy of the enrollee rights at the time of intake.
- All three BHOs ensure the BHAs provide enrollees with a copy of their rights at intake and annually thereafter. Most BHOs monitor compliance with enrollee rights through agency administrative reviews, chart reviews, on-site walkthroughs, Quality Review Team (QRT) surveys, and tracking and reviewing of enrollee grievances.
- SBHO's quality manager worked extensively with the BHAs during the 2017 and 2018 annual administrative reviews to ensure the agencies' enrollee rights were up to date and had been included in intake/assessment packets for all enrollees seeking services.

- The BHOs' Ombuds are very active in the provider community and regularly provide enrollees with education on enrollee rights and responsibilities.

Recommendations

Not all Behavioral Health Agencies (BHAs), including both SUD treatment and Behavioral Health, are complying with informing and training their staff on enrollee rights policies and procedures at the time of hire and as rights are updated and revised.

- HCA needs to ensure that BHOs are informing and training BHA staff on enrollee rights policies and procedures at the time of hire and as rights are updated or revised. The BHOs could create a PowerPoint training on client rights and require the BHAs to submit attestations that staff have reviewed the PowerPoint training. The BHOs could also review staff personnel files for evidence of the training completion during their administrative review.

While many of the BHAs have posted the most current and up-to-date enrollee rights, some of the BHAs have not.

- The BHOs need to ensure that all BHAs have posted the most current enrollee rights in their lobbies where they are visible to enrollees.

Information Requirements

Strength: Access

- All BHO and BHA staff have access to *The Language Line Quick Reference Guide*, which includes contact information for enlisting interpreter services.

Strengths: Quality

- The BHAs review enrollee rights with each enrollee at the time of the intake assessment and document this in the client's record.
- GRBHO has a well-written customer services policy and procedure, which describes the hours of GRBHO's customer service lines, the duties of the customer service staff, and procedures for assisting enrollees who may need help with interpreter services or understanding their benefits and services. GRBHO's customer service coordinators are available to assist enrollees with any questions regarding their understanding of the requirements and benefits of the services available to them.

Recommendation

Not all BHOs have a policy and mechanism in place to provide its staff and BHA staff with information on where to refer enrollees who are having difficulty understanding written materials or information posted on the BHO's website.

- HCA needs to ensure that all BHOs have implemented a policy and mechanism for informing enrollees of whom to contact when they are experiencing difficulties understanding benefit and client rights materials. This may include, but is not limited to, publishing this information on the BHO's website.

Information Requirements—Specific

Strengths: Access

- In 2013, TMBHO purchased a braille machine to translate materials for its visually impaired consumers. The BHO notified its BHAs that this device was available upon

request, and during the past year, the BHO received numerous requests for materials translated using the braille machine.

- In order to ensure that enrollees are provided with information in alternative formats when needed, SBHO includes in its BHA contracts a requirement that the agencies must either make information available through audio or video recordings in the enrollee's primary language, have an interpreter read the materials to the enrollee in the enrollee's primary language, or provide the materials in another alternative format acceptable to the enrollee. If one of these services is provided, the BHA must document the service in the enrollee's clinical record.
- SBHO provides BHAs with access to the AT&T Language Line, which provides interpretation services for more than 240 languages as well as American Sign Language. These services are available 24 hours a day and seven days a week. As part of the annual administrative review, SBHO staff also provide one-on-one guidance to BHA staff on accessing the Language Line.
- GRBHO and its BHAs make available auxiliary aids, such as sign language and TTY/TDY telephone services, and provide information in alternative formats, including large print and braille, for enrollees in need of these services.

Information Requirements—General

Strengths: Access

- TMBHO's policy *Physician Incentive Plans* clearly states that all Medicaid enrollees receiving physician and other mental health/SUD treatment services within the TMBHO service delivery system are not subject to a denial, limitation, or discontinuation of care based solely on any financial incentive or compensation arrangement (payment, reward, or benefit) to the physician or healthcare professional for limiting care.
- All three BHOs have well-documented policies describing procedures for informing the State and enrollees of the termination of a provider or agency within required timelines. If one of the BHOs issues a termination notice to a contracted BHA, the BHO will provide written notice of the termination to each enrollee affected by the termination within 15 calendar days after the termination notice has been issued.

Provider Directory

Strength: Access

- GRBHO makes provider information available on its website, including specialties, languages spoken, and whether the provider is accepting new clients. Provider entries also include whether the provider site meets ADA accessibility standards. The BHO requires its BHAs to submit all changes to provider staff, including the exit or hiring of provider staff, to the BHO monthly.

Recommendation

Not all BHOs include in their online provider directory the types of clinical specialties and languages spoken at the BHAs or whether each BHA meets ADA accessibility requirements.

- HCA needs to ensure that all BHO provider directories include the specialties, languages spoken, and whether each BHA meets ADA accessibility requirements.

Respect and Dignity

Strengths: Quality

- All BHOs require their staff and contractors to sign an oath of confidentiality, store written information with patient health information in locked cabinets, use passwords to protect electronic information, obtain information releases, and have mechanisms in place to report breaches of confidentiality.
- Most of the BHOs monitor contracted BHAs for respect, dignity, and consideration of privacy through administrative reviews, clinical record reviews, enrollee satisfaction surveys, grievance reporting, and review of Ombud reports.
- TMBHO monitors the BHAs to verify that enrollees are treated with respect and dignity by observing how BHA staff interact with enrollees, and whether enrollee rights are posted in public areas. Additionally, the Ombud reviews grievance calls from enrollees related to respect and dignity, and the Quality Review Team (QRT) enrollee survey includes questions related to respect and dignity.
- During the three-week period of October 9–27, 2017, GRBHO-contracted outpatient BHAs took part in a region-wide effort to collect a “snapshot” of ratings and comments regarding individuals’ and caregivers’ satisfaction with each agency’s services. The primary data collection tool was the CSQ-8, a client satisfaction questionnaire. Overall, 77 percent of clients agreed they had been treated with respect and dignity. Additionally, the QRT enrollee survey includes questions related to respect and dignity.

Alternate Treatment Options

Strength: Access

- Most BHOs ensure enrollees receive information on available, alternative treatment options in a manner appropriate to the enrollee’s condition and ability to understand.

Strength: Quality

- As part of their chart reviews, all three BHOs monitor for enrollee participation in care and treatment decisions by reviewing for client signatures and client voice on service plans, for client and family statements, and for discharge criteria on service plans. They also review to verify that educational materials on diagnosis and treatment options have been provided to enrollees as part of initial treatment planning.

Grievance System

Table 18: Grievance System Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues	Number of BHOs with Issues
Grievance and Appeal Systems	438.228 (a–b) 438.402 (a–b)	TMBHO, SBHO	2
Filing Requirements	438.402 (c)(1)(i)(A)		0
Filing Requirements—Timing	438.402 (c)(2–3)	TMBHO	1
Notice of Adverse Benefit Determination	438.404 (a–b)	TMBHO	1
Timing of Notice	438.404 (c) 438.210 (d)		0
Handling of Grievances and Appeals	438.406		0
Resolution and Notification—Timeframes	438.408 (a–c)	TMBHO, SBHO	2
Resolution and Notification—Format and Content of Notice	438.408 (d–e)	TMBHO	1
State Fair Hearings	438.408 (f)		0
Expedited Resolution of Appeals	438.410		0
Grievances and Appeals—Information Requirements	438.414 438.10 (g)(2)(xi)	TMBHO	1
Recordkeeping and Reporting	438.416	TMBHO	1
Continuation of Benefits	438.420	TMBHO	1
Effectuation of Reversed Appeal Resolutions	438.424		0

Grievance System

Strength: Access

- All BHOs have policies and procedures in place to inform enrollees of their right to access the grievance and appeal process and the State's fair hearing system.

Strengths: Quality

- GRBHO has provided more than 50 trainings for its contracted BHAs, including training on the grievance and appeal process.
- SBHO has provided numerous trainings on the grievance system to its SUD treatment providers through Quality Improvement Committee (QUIC) meetings and has provided individualized technical assistance upon request.

- GRBHO uses Relias to provide grievance system trainings and track participation by BHO and BHA staff.
- SBHO uses a monitoring tool to record newly hired staff orientation trainings, including trainings on the grievance and appeal processes.
- GRBHO and SBHO require their BHAs to inform enrollees about the grievance system process at the time of intake, whenever an enrollee submits an expression of dissatisfaction, and upon request.
- GRBHO has created a Grievance and Critical Incident Review Committee, which is responsible for reviewing trends among grievances and critical incident reports and ensuring the BHAs are maintaining a standard of professional and ethical practice regarding the handling of grievances and critical incident reports.

Recommendations

Not all BHOs have mechanisms in place for tracking the grievances the BHO or BHAs receive.

- HCA needs to ensure that all BHOs develop a standardized form or spreadsheet for tracking the grievances they receive and those the BHAs receive. This form or spreadsheet should be distributed to the BHAs to ensure they are capturing all the elements the BHO needs to trend and monitor.

Filing Requirements

Strength: Access

- All BHOs require their BHAs to provide enrollees with information regarding the grievance system via either the *Washington State's Behavioral Health Benefits Book* or a version of the booklet produced by the BHO.

Strength: Quality

- GRBHO's policies and procedures on the grievance, appeal, and State fair hearing systems contain all the required elements, including the specification that an enrollee cannot file the same grievance with both a BHA and the BHO.

Filing Requirements—Timing

Recommendation

Not all BHOs have updated the grievance system policies to reflect current CFR language and requirements regarding notice of adverse benefit determinations and grievance timelines.

- HCA needs to ensure that all BHOs' grievance policies are up to date with current language and requirements.

Notice of Adverse Benefit Determination

Strengths: Quality

- GRBHO does not delegate its notice of adverse benefit determination (NOABD) process to ensure the efficiency and timeliness of the authorization and notification process.

- GRBHO's notice of adverse benefit determination contains all of the required elements, including an explanation of the reasons for the action, information regarding how the enrollee can respond if they do not agree with the decision, the enrollee's right to file an appeal, the enrollee's right to request a fair hearing, an explanation of the circumstances in which an enrollee can request an expedited appeal, and the enrollee's right to have benefits continue pending the resolution of an appeal.
- SBHO has adopted the State's template for its notice of adverse benefit determination, which contains all the required elements.
- GRBHO makes the notice of adverse benefit determination available in Spanish and can translate the document into other languages as well as braille.
- SBHO has a process in place to automatically send the NOABD in Spanish if Spanish is listed as the recipient's primary language.

Timing of Notice

Strengths: Timeliness

- TMBHO authorizes requests for services within 48 hours of receiving a request unless more information is needed.
- GRBHO's and SBHO's policy and procedure on the notice of adverse benefit determination process includes timelines for mailing notices that previously authorized services will be terminated, suspended, or reduced.

Handling of Grievances and Appeals

Strengths: Access

- All BHOs inform enrollees of their right to access behavioral health Ombud services within their region.
- TMBHO ensures by policy that individuals who make decisions on grievances and appeals have not been involved in any previous level of review or decision-making and have the appropriate clinical expertise.

Strengths: Quality

- GRBHO and SBHO have a designated staff person who is responsible for tracking and monitoring all grievances received by the BHO and the BHAs. SBHO has an identified backup grievance manager.
- GRBHO and SBHO inform enrollees that behavioral health Ombuds provide free and confidential services, can help resolve service-related complaints, can assist enrollees in connecting with provider agencies in the enrollee's service area, and are available to answer questions about the behavioral health system in the state of Washington.
- GRBHO's website includes the names, phone numbers, and email addresses of GRBHO's two contracted Ombuds.

Resolution and Notification—Timeframes

Strength: Timeliness

- GRBHO requires its BHAs to submit notification of the resolution of a grievance within five business days of the date of the resolution.

Strength: Quality

- Although GRBHO has not yet received any appeals, it has created a detailed tracking system that includes noting whether an enrollee has requested to review their medical records. This tracking system will help ensure appeals are handled in an appropriate and timely manner.

Resolution and Notification—Format and Content of Notice

The BHOs met criteria.

State Fair Hearings

Strength: Quality

- All BHOs have detailed policies and procedures, consistent with WAC and contract standards, outlining the State fair hearing process for staff and enrollees.

Expedited Resolution of Appeals

Strength: Quality

- Although some BHOs have never received a request for an expedited appeal, all BHOs have a policy and procedure in place that outlines the steps and timelines necessary to address a request for an expedited resolution of an appeal.

Strength: Access

- GRBHO's and SBHO's policies includes language requiring that no punitive action be taken against a provider who requests an expedited resolution or supports an enrollee's appeal, ensuring access to such request.

Grievances and Appeals—Information Requirements

Strengths: Quality

- SBHO updated its administrative monitoring tool to include all the required elements related to the BHA grievance process and recordkeeping.
- Most BHOs monitor compliance with grievance system standards and requirements through an on-site process or administrative review and through the submission of quarterly grievance reports and acknowledgment and resolutions letters.
- Within the GRBHO region, BHAs can ask the BHO questions and clarifications using the web application Basecamp, which assists the BHO in centralizing communications between the BHO and the BHA network.
- GRBHO has conducted extensive monitoring of its BHAs' grievance system processes.

Recommendation

Although most BHOs monitor compliance with grievance system standards and requirements through an on-site process or administrative review and through the submission of quarterly grievance reports and acknowledgment and resolutions letters, one BHO has not conducted a complete review of BHA compliance with grievance system standards.

- HCA needs to ensure that the BHOs maintain compliance with current grievance system standards at least annually or upon any change in standards and requirements.

Recordkeeping and Reporting**Strengths: Quality**

- Most BHOs review grievance and appeal information for trends and use the gathered information for quality improvement, to identify gaps in service delivery, identify opportunities to provide education and training to the network BHAs, and help inform the BHO's quality plan.
- All BHOs submit quarterly grievance reports to the State for all State-funded, Medicaid, and WISE grievances and appeals.
- All BHOs require their BHAs to submit quarterly grievance reports.

Recommendation

Although most BHOs indicated that they monitor the BHAs for grievance record retention during annual administrative reviews, one BHO indicated that it has not completed monitoring for all its BHAs for several years.

- HCA needs to ensure that the BHOs routinely monitor BHAs for compliance with grievance system standards and requirements, including where and how grievance records are stored.

Continuation of Benefits: 438.420**Strength: Quality**

- All BHOs have policies and procedures that state enrollees have the right to continue services while an appeal or State fair hearing is pending, and that the enrollee may be liable for the cost of the services provided if the final resolution is not in the enrollee's favor.

Recommendation

One BHO's notice of adverse benefit determination does not describe the process for requesting that benefits continue while an appeal or State fair hearing is pending or notify enrollees of their financial responsibility for services received while an appeal is pending if the final resolution of the appeal is adverse to the enrollee. Additionally, the BHO did not provide information indicating that it notifies enrollees of these elements through a different medium.

- The State provided a template for the notice of adverse benefit determination for the BHOs to adopt or incorporate. HCA needs to ensure that the BHOs' notice of adverse benefit determination contains all of the required elements, including the process for requesting that benefits continue while an appeal or State fair hearing is pending, and notification that enrollees may be financially responsible for services received while an appeal is pending if the final resolution of the appeal is adverse to the enrollee.

Certifications and Program Integrity

Table 19: Certifications and Program Integrity Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues	Number of BHOs with Issues
Data Certification	438.600 (b) 438.602 (a) 438.604		0
Excluded Entities	438.602 (b–d) 455.106 438.610 (a–d)		0
Disclosure of Ownership	455.102 455.104		0
Conflict of Interest	438.602 (h) 438.58	SBHO	1
Source, Content, and Timing of Certification	438.600 (b) 438.606		0
Program Integrity Requirements	438.600 (b) 438.608 (a)	TMBHO	1
Recovery of Payments	438.608 (d)(1–3)	SBHO	1
Record Retention	431.107 (a),(b)(1–2)		0
Cooperation with Fraud Control Units	455.21	TMBHO	1
Suspension of Payments	455.23		0
Civil Money Penalties and Assessments	1003.200		0

Data Certification

Strengths: Quality

- Each BHO requires its BHAs to submit a certification each month attesting to having reviewed the administrative and utilization data and making any necessary corrections prior to attesting to the certification.
- When the BHOs identify errors in data received from the BHAs, the BHOs require the BHAs to correct the errors and resubmit the data.

Excluded Providers

Strength: Timeliness

- All three BHOs require their BHAs to conduct Washington State Patrol criminal background checks prior to hire and then annually for BHA employees and volunteers who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

Strengths: Quality

- SBHO delegates its monthly agency-level excluded provider screenings to the BHAs and requires the agencies to submit attestations certifying that the screenings have occurred. At each annual administrative review, the BHO verifies the BHAs have policies and procedures in place to conduct excluded provider checks and requires each BHA to demonstrate how it conducts excluded provider checks.
- GRBHO does not contract or make payments for goods or services that directly or indirectly benefit any excluded individual or entity. The BHO's policy is to immediately recover any payments for goods or services it has discovered have benefited excluded individuals and entities, and to immediately terminate any employment, contractual, or control relationship with an individual or entity it discovers to be excluded from participation in federal programs.
- TMBHO's program service contract requires all contracted entities to perform an excluded provider screening prior to hiring any individual who will perform services under the TMBHO contract. For ongoing monthly screenings, the entity may choose one of two options: the entity may perform its own monthly screenings and submit an attestation stating the screening has been conducted (in this case, the records must be kept on file for the BHO to review during administrative reviews), or the entity may submit a monthly staffing roster to TMBHO, and the BHO will conduct a monthly screening of excluded providers using the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) database. The BHO submitted attestations received from contracted entities as well as evidence that the BHO performs monthly exclusion checks.

Disclosure of Ownership**Strength: Quality**

- SBHO and GRBHO require both in-network and out-of-network BHAs to supply a list of individuals or entities with an ownership or control interest of at least five percent of the contractor's equity. The BHOs then complete an exclusion screening for those individuals.

Conflict of Interest**Strengths: Quality**

- TMBHO has a very thorough and comprehensive employee handbook, which includes the BHO's *Ethics and Conflict of Interest* policy. TMBHO's staff are required to read and sign an employee's statement of understanding that they have read and understand the policy.
- Per its conflict of interest policy, GRBHO ensures that its officers and employees do not have a fiduciary interest in any procurement process, appointments to GRBHO's governing or advisory boards, or any other interests that may have the "appearance of conflict of interest."
- GRBHO maintains a membership roster and bylaws for its governing body to demonstrate compliance with requirements related to conflict of interest. Members of GRBHO's governing board must disclose potential conflicts of interest to the chairperson of the board

and refrain from voting or having discussions on any matter in what might be perceived as a conflict of interest.

Recommendation

One BHO's policy on conflict of interest and the BHO's administrative tool do not include how often the conflict of interest disclosure form needs to be reviewed and attested to by BHO staff and volunteers, BHA staff, and the BHO's governing board. Conflict of interest disclosure forms should be reviewed and attested to annually.

- HCA needs to ensure that the BHOs include in both their policies on conflict of interest and administrative tools the timeframes in which all BHO and BHA staff and volunteers and BHO governing board members need to review and attest to the conflict of interest disclosure forms.

Source, Content, and Timing of Certification

Strength: Timeliness

- TMBHO's CEO or COO attests to the accuracy, completeness, and truthfulness of the data submitted to the State based on best knowledge, information, and belief.

Strengths: Quality

- GRBHO continuously reviews data quality with the BHAs at its Provider IS Committee meetings.
- SBHO's information systems manager is responsible for certifying the weekly data exports to the State; the BHO's administrator is responsible for attesting to the accuracy, completeness, and truthfulness of the month-end data exports to the State.

Program Integrity Requirements

Strengths: Quality

- All three BHOs' compliance officers provide training to BHO staff, governing board members, QRT members, and network providers. Each training curriculum addresses the following:
 - the BHO's commitment to compliance with all laws, regulations, and guidelines of federal and State programs
 - the elements of the BHO's compliance plan
 - an overview of what constitutes fraud and abuse in a Medicaid managed care environment
 - a review of the specific State contract requirements applicable to BHO business
 - responsibilities to report violations
 - various options for where and how to report violations
 - the consequences of failing to comply with applicable laws
- All three BHOs employ several methods for detecting and preventing fraud and abuse, which include:
 - performing BHA administrative site reviews for compliance and adherence to contract, CFR, and WAC requirements
 - profiling, analyzing, and verifying enrollee encounter data
 - reviewing inpatient and outpatient enrollee claims
 - reviewing Ombud reports and grievances
 - performing Management Information System (MIS) audits
 - investigating any reports of suspected fraud, waste, or abuse

Recommendations

One BHO has not performed a risk assessment to identify its top three vulnerable areas and outlined action plans for mitigating risks in each of those areas since 2016. The compliance officer stated that the BHO has been actively working to address the vulnerable areas identified during the 2016 risk assessment.

- HCA needs to ensure that all BHOs are performing current risk assessments in order to identify and evaluate the most current vulnerable areas and implement action plans for mitigating risks in those areas.

Not all BHOs have an active compliance committee to review the compliance program for effectiveness. Additionally, one of the BHO's Quality Management Committee is inactive and last met in March 2017. The compliance officer stated that difficulty coordinating meeting times for BHO leadership staff has been the cause of inactivity.

- To be in compliance with both the CFR and HCA contracts, HCA needs to ensure that all BHOs convene their compliance and quality management committees to monitor the effectiveness of the compliance programs, as well as the accessibility, timeliness, and quality of care enrollees are receiving.

Recovery of Payments

Strength: Quality

- GRBHO stated that if a Medicaid Fraud Control Unit (MFCU) referral resulted in a verified overpayment, the BHO would retain legal counsel to further investigate and evaluate all available legal options to recover or recoup the overpayment.

Record Retention

Strengths: Access

- Per its policy *Monitoring Clinical Records*, TMBHO monitors provider compliance by conducting administrative and clinical chart reviews, by reviewing the Quality Review Team activities and report, and by reviewing the Ombud's report for grievances regarding issues with clinical records.
- SBHO's policy on record retention provides both a definition and guidance regarding record retention. The policy requires the BHO and its BHAs to retain for 10 years any records pertaining to credentialing and re-credentialing, incident reporting, service requests and authorizations, clinical records, and referrals and outcomes for fraud, waste, and abuse.
- During its annual administrative review process, SBHO verifies that all agencies have updated record retention policies reflecting the requirement that records be retained for ten years.

Cooperation with Fraud Control Units

Strength: Timeliness

- GRBHO's policy on fraud and abuse compliance states that the BHO and its contracted providers will report suspected fraud or abuse directly to the MFCU as soon as such activity is discovered and verified as credible and that the BHO will report all information sent to the MFCU to DSHS within one business day. The policy also states that the BHO will cooperate in any investigation or prosecution conducted by the MFCU.

Suspension of Payments

Strengths: Quality

- TMBHO's policy *Suspension of Payment* outlines the steps the BHO will take if suspension of payment occurs in cases of potential fraud. The policy states that upon the decision to suspend payment, written notice will be provided to the provider/entity within five days. A tracking document will be used to indicate which steps have been taken, the quarterly certifications of the continuing investigation, and the termination of the suspension.
- SBHO's policy regarding the prevention and detection of fraud, waste, and abuse includes monitoring its vendors, subcontractors, and providers for suspension of payments in cases of fraud.

Civil Money Penalties and Assessments

Strengths: Quality

- TMBHO's policy on civil money penalties and assessments states that the BHO monitors its providers/entities for civil money penalties and assessments through receipt and review of weekly OIG updates and investigations. New providers/entities are required to disclose this information prior to receipt of a contract and then are responsible for reporting whether they receive a penalty or assessment for the duration of the contract. TMBHO has not identified any provider/entity who has received a civil penalty or assessment to date.
- SBHO's BHA administrative monitoring tool includes monitoring for civil money penalties and assessments. Additionally, the BHO performs regular monitoring of its vendors, providers, and subcontractors for civil money penalties and assessments.

BHA Walkthroughs

Table 20: Results of BHA Walkthrough Reviews

BHO	Enrollee Rights and Protections	Advance Directives	Grievance System
Great Rivers (GRBHO)	●	⊙	●
Salish (SBHO)	●	⊙	●
Thurston-Mason (TMBHO)	⊙	●	⊙

Enrollee Rights

Strengths

- All the BHAs had enrollee rights documents posted in multiple prevalently spoken languages. Several of the BHAs posted the rights in the 13 languages outlined in the *Washington State's Behavioral Health Benefits Book* (Amharic, Arabic, Cambodian, Chinese, English, Korean, Laotian, Punjabi, Russian, Somali, Spanish, Ukrainian, and Vietnamese).
- All the BHAs included language in their enrollee rights documents describing how to obtain interpreter services.
- All the BHAs distribute the *Washington State's Behavioral Health Benefits Book* to enrollees. Some of the BHAs had the booklet readily available in their lobbies in languages other than English.

Opportunity for Improvement

The EQR revealed some deficiencies across the BHAs in staff knowledge of enrollee rights and the communication of this knowledge to enrollees. Several BHAs did not have a formal enrollee rights training process in place to prepare staff to incorporate enrollee rights into their practice and into their enrollee education.

- All BHAs should institute a training process to address gaps regarding staff knowledge and understanding of policies governing enrollee rights and how to incorporate them into service delivery models. Additionally, providing staff with a foundational training in enrollee rights ensures that service recipients receive equitable and culturally competent care. Further, annual ongoing training in these rights for staff promotes adherence and consistency around organizational policies and patient-centered care.

Advance Directives

Strengths

- Most of the BHAs provided evidence of enrollee acknowledgement that staff asked the enrollee whether they had a mental health advance directive.
- Most of the BHAs provided evidence of enrollee acknowledgement of being informed of medical advance directives.

Opportunity for Improvement

Review of clinical records indicated that enrollees who turned 18 years of age while in services were not always informed of medical advance directives and mental health advance directives. Enrollees at most of the BHAs who are older than 18 at the time of intake receive and acknowledge receipt of information regarding advance directives at the time of admission. However, if an enrollee turns 18 while in services, advance directives are not discussed.

- The BHAs should install a policy to discuss advance directives with enrollees who turn 18 while in services to ensure they receive this information.

Grievance System**Strengths**

- All BHAs were in the practice of storing grievances separately from the clinical record in a location accessible only by appropriate designated persons.
- Most of the BHAs were able to demonstrate they had processes in place to monitor the resolution of grievances and appeals and ensure compliance with timeliness requirements. All BHAs typically complete grievance acknowledgements within 5 business days and resolutions within 90 days; most are resolved within 30 days.

Opportunity for Improvement

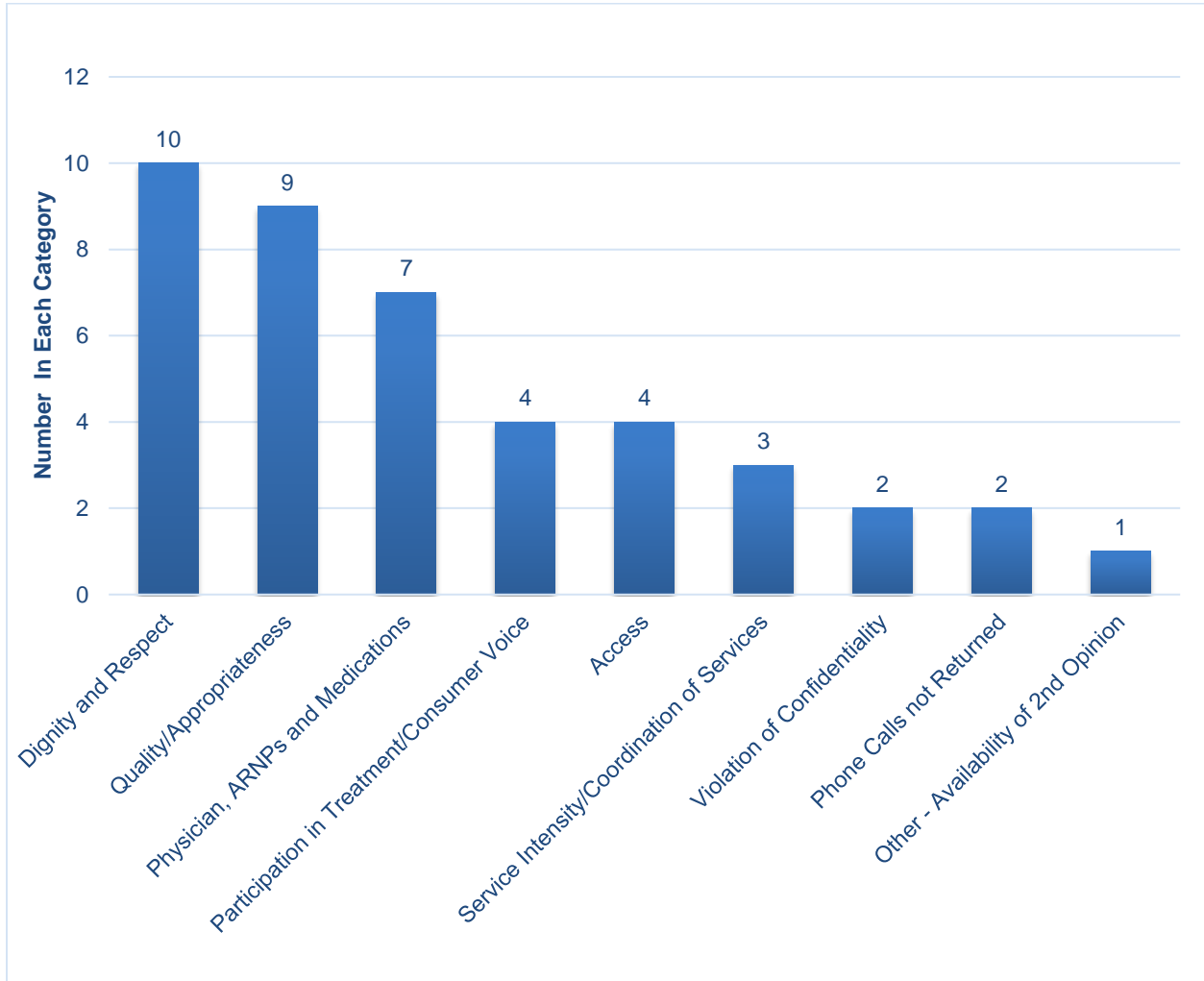
Most of the BHAs indicated they review their grievance system policy with staff within 30 days upon hire and annually thereafter. Generally, staff then sign an attestation acknowledging review of this policy. However, given the very low number of grievances reported among the BHAs, further training may be necessary to ensure staff comprehension and knowledge retention.

- All BHAs should have a mechanism in place to train staff on the grievance system to ensure an increased understanding and knowledge of its requirements.

Review of Grievances

EQR reviewers assessed a total of 26 grievances, 7 of which featured Ombud involvement at some point (either the filing of the grievance originated with the Ombud or the Ombud was brought in as part of the resolution process). The grievances fell into 9 grievance categories, involving 42 sub-classifications; a single grievance can cross multiple categories. Figure 4 displays the distribution of the reviewed grievances among these categories.

Figure 4: Distribution of BHA Grievance Review



Compliance Review

Mid-Adopter BHOs

(IMC Transition in 2019)

The compliance portion of Qualis Health's external quality review of mid-adopter BHOs assesses overall performance, identifies strengths, and notes opportunities for improvement in areas where BHOs did not clearly or comprehensively meet federal and/or State requirements. Recommendations are intended to aid in the transition of BHO functions to the State's Apple Health MCOs. As stated previously, this section was not scored.

Methodology

Qualis Health evaluated the BHOs' performance on each element of the protocol by reviewing and performing desk audits on documentation submitted by the BHOs, conducting telephone interviews with the BHOs' contracted provider agencies; and conducting on-site interviews with the BHO staff.

The procedures for conducting the review included the following:

- performing desk audits on documentation submitted by the BHOs, including but not limited to policies and procedures, program descriptions, evaluations and monitoring reports, credentialing files, close out status reports, and grievances and appeals
- conducting telephone interviews with one SUD treatment agency and one dual mental health/SUD treatment agency on standards related to enrollee rights and protections, the grievance system, and program integrity
- conducting on-site walkthroughs and interviews at four BHAs to evaluate enrollee rights and protections, advance directives, and the grievance system
- conducting on-site interviews with BHO staff on standards related to enrollee rights and protections, the grievance system, program integrity, and performance improvement projects (PIPs)
- following up on the prior year's corrective action plans (CAPs)
- following up on the status of the BHO's closeout plan

After the on-site interview process, the BHO has two weeks to submit additional information and/or documentation. Qualis Health then compiles and submits to the State a draft report for the BHO, which includes strengths, opportunities for improvement, and recommendations for corrective action plans for criteria not fully met. The BHO has an opportunity to comment on the draft report, after which the final report is submitted to the State. To improve accessibility, timeliness, and quality of care for Medicaid enrollees, Qualis Health is available throughout the year and during the review process to provide technical assistance to the BHO.

Summary of Results

Enrollee Rights and Protections

Table 21: Enrollee Rights and Protections Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues	Number of Issues
Enrollee Rights	438.100 (a)	GCBHO, NSBHO	2
Information Requirements	438.100 (b)(1)–(2)(i)		0
	438.10 (a–b),(c)(6–7)		
Information Requirements—Specific	438.100 (b)(1)–(2)(i)	SCRBHO	1
	438.10 (d)		
Information Requirements—General	438.100 (b)(1)–(2)(i)	NSBHO	1
	438.10 (f–g)		
Provider Directory	438.100 (b)(1)–(2)(i)	GCBHO, NSBHO,	4
	438.10 (h),(j)	KCBHO, OPBHO	
Respect and Dignity	438.100 (b)(1)–(2)(ii)	OPBHO	1
Alternative Treatment Options	438.100 (b)(1)–(2)(iii)	NSBHO	1
	438.102 (a)(1)		
Advance Directives	438.100 (b)(1)–(2)(iv)	KCBHO	1
	438.3 (j)(1),(3)		
Seclusion and Restraint	438.100 (b)(1)–(2)(v)		0
Medical Record Requests	438.100 (b)(1)–(2)(vi)		0
Federal and State Laws	438.100 (c–d)		0

Enrollee Rights

Strength: Access

- Several BHOs provide enrollee/member handbooks that include information on enrollee rights, obtaining services, and available treatment options, as well as provider directories.

Strength: Timeliness

- Some BHOs have provided community education using Ombud services to educate enrollees on enrollee rights, availability of services, and obtaining authorization for services.

Strengths: Quality

- Most BHOs ensure the BHAs are providing enrollees with a copy of their rights at intake and annually thereafter. Most BHOs monitor compliance with standards related to enrollee rights through agency administrative reviews, chart reviews, Quality Review Team (QRT) surveys, and tracking and reviewing of enrollee grievances.
- All BHOs monitor their BHAs for compliance with enrollee rights standards through a variety of activities, including performing clinical record reviews, reviewing data reports, reviewing enrollee survey results, reviewing the Ombud reports, performing on-site reviews, and reviewing grievances related to enrollee rights.

- NSBHO monitors for compliance with enrollee rights standards through agency administrative reviews, chart reviews, Quality Review Team (QRT) surveys, and review of enrollee grievances.
- KCBHO requires its BHAs to review enrollee rights with each enrollee at the time of the intake assessment and to include in each client file an attestation signed by the enrollee documenting that the enrollee acknowledged and understood their rights.
- OPBHO uses the Relias Learning program to offer several trainings to its BHA network: *Confidentiality of Substance Use Treatment Information, HIPAA and Behavioral Health, HIPAA Overview, and HIPAA: The Basics*. All BHAs and staff are required to take the *HIPAA: The Basics* training, according to the WAC training guidelines for substance use and mental health employees.

Recommendations for Integration

Many BHAs are out of compliance with standards regarding enrollee rights.

- Because many BHAs are out of compliance with standards regarding enrollee rights, HCA will need to ensure the MCOs are performing annual administrative on-site reviews of their contracted BHAs to make certain the BHAs are adhering to standards regarding enrollee rights.

All BHOs require the BHAs to review enrollee rights with each enrollee at the time of the intake assessment and to include in each client file an attestation signed by the enrollee documenting that the enrollee acknowledged and understood their rights. However, the 2018 EQR indicated that not all BHAs are complying with this requirement.

- HCA will need to ensure that the MCOs monitor the BHAs for reviewing enrollee rights with each enrollee at the time of the intake assessment and including in each client file an attestation signed by the enrollee documenting that the enrollee acknowledged and understood their rights.

Information Requirements

Strengths: Access

- All BHOS require the BHAs to keep a log of requests for interpreter services.
- KCBHO requires the BHAs to provide interpreter services when needed. The BHO maintains a resource page that includes information on vendors that can provide translation and interpreter services, as well as tips on providing translation and interpreter services.
- Most BHOs' websites notify enrollees of language services provided free of charge to individuals whose primary language is not English, including interpreters and written information in other languages.

Strengths: Quality

- NSBHO's PowerPoint on customer service training outlines a process for BHO staff to assist enrollees with understanding their benefits, as well as a procedure for handling requests for interpreter services.

- KCBHO's website notifies clients that written information is available in alternative formats, such as audiotape, braille or large print, and may be accessed upon request. Audio versions of the KCBHO brochure and client rights are available on compact disc from KCBHO Client Assistance Services and on KCBHO's website.
- OPBHO ensures enrollees have access to information on enrollee rights, services, and benefits by requiring its BHAs to post information on enrollee rights and the grievance and appeal processes in their lobbies in the most prevalent languages spoken in the BHO's network; by making the Language Line and Language Line reference cards available to all staff as resources; and ensuring OPBHO's customer service representative is available during business hours to provide information to enrollees and help them understand the requirements and benefits of the plan.

Recommendation for Integration

Although the BHOs have policies and procedures in place for collecting logs of interpreter services requests from the BHAs and tracking the use of these services to analyze unmet enrollee needs, not all BHAs have consistently maintained these logs.

- HCA will need to ensure the MCOs have a process in place to collect information on requests for interpreter services from the BHAs and track the use of these services to analyze unmet enrollee needs.

Information Requirements—Specific

Strengths: Access

- OPBHO's Consumer Solutions/Affairs Committee reviews and approves all enrollee materials to ensure they are written in easily understood language.
- All BHOs allow freedom of choice among the contracted BHAs in each BHO's service network.

Strengths: Quality

- Many of the BHOs' advisory committees review all written enrollee materials, including policies and procedures, for format and ease of understanding.
- GCBHO has a well-written integrated crisis system policy with clearly designed standards for the provision of crisis services, the oversight of the crisis system, and the expected outcomes of the provisions of crisis care.
- GCBHO incorporates the monitoring of the efficiencies and effectiveness of the crisis system, including the use of post-stabilization services, into its quality management improvement process.

Information Requirements—General

Strength: Access

- All BHOs have well-documented policies describing their procedure for informing the State and enrollees of the termination of a provider or agency within required timelines.

Provider Directory

Strengths: Quality

- Many BHOs make provider information available on their websites, including specialties, languages spoken, and whether the providers are accepting new clients. Provider entries also include whether the provider sites meet ADA accessibility standards.
- The BHOs' websites post the provider directories in several prevalently spoken languages.

Recommendation for Integration

Although many of the BHOs' online provider directories include the names of each BHA in the network, as well as the languages spoken at each agency's facility, many of the directories do not include the names of all clinicians associated with the BHAs, or each clinician's gender, specialties, languages spoken, and credentials. The directories also do not indicate whether each facility meets ADA accessibility requirements or whether clinicians are accepting new patients.

- HCA will need to ensure the MCOs provide enrollees with access to directories that include all of this information.

Respect and Dignity

Strengths: Quality

- All BHOs require their staff and contractors to sign an oath of confidentiality, store written information with patient health information in locked cabinets, use passwords to protect electronic information, obtain information releases, and have mechanisms in place to report breaches of confidentiality.
- All the BHOs monitor their contracted BHAs regarding respect, dignity, and consideration of privacy through on-site monitoring, administrative reviews, clinical record reviews, enrollee satisfaction surveys, and review of grievance and Ombud reports.
- SCRBHO ensures its BHA network and system of care understand and comply with confidentiality requirements for publicly funded behavioral health services through a variety of methods:
 - The BHO performs annual monitoring of the BHAs' compliance with contract requirements and applicable federal and State laws regarding confidentiality.
 - BHO staff perform ongoing technical and educational support, including assisting in coordinating clinical services across the system of care. The SCRBHO help desk provides guidance and information on data systems issues.
 - The BHO reports and addresses all known breaches of confidentiality, which helps to provide the opportunity to address immediate incidents while also allowing for education and re-training.
 - The BHO requires all delegated entities to post and make available information regarding an individual's rights regarding the confidentiality of their protected health information.

Recommendation for Integration

The BHOs monitor their contracted BHAs regarding the treatment of enrollees with respect, dignity, and consideration of privacy through on-site monitoring, administrative reviews, clinical record reviews, enrollee satisfaction surveys, and review of grievance and Ombud reports. However, the 2018 EQR

discovered that the majority of grievances enrollees filed with the BHOs and BHAs were related to respect, dignity, and consideration of privacy.

- HCA will need to work with the MCOs to ensure they are educating the BHAs on the importance of treating enrollees with respect, dignity, and consideration of privacy, and monitoring them for this requirement.

Alternate Treatment Options

Strength: Access

- Most BHOs ensure enrollees receive information on available and alternative treatment options in a manner appropriate to the enrollee's condition and ability to understand.

Strengths: Quality

- As part of the clinical chart reviews, many of the BHOs monitor for enrollee participation in care and treatment decisions by looking for the presence of consumer voice and signatures, client and family statements, and discharge criteria on service plans, as well as reviewing the educational materials on diagnosis and treatment options provided to enrollees during initial treatment planning.
- Additionally, the BHOs monitor grievance logs, customer service logs, and the Ombud reports for issues related to information enrollees have received on available treatment options and alternatives.
- The BHOs rely on the BHAs to share information on available treatment options and alternatives with enrollees. To promote and encourage this collaborative relationship, many of the BHOs have made various trainings and resources available and provided regular opportunities for collaborative community forums to discuss new or available treatment options, encouraged cross-system collaboration through established relationships with system partners, and employed integrated care coordinators to assist BHAs in connecting, communicating, and discussing treatment options.

Advance Directives

Strengths: Quality

- All BHOs have policies and procedures in place that require contracted BHAs to inform enrollees, at the time of intake, of their rights regarding mental health advance directives and medical advance directives.
- All BHOs require their BHAs to include a signed attestation in the enrollee's clinical record that the enrollee received and understands the information regarding advance directives and that the enrollee has either chosen or not chosen to execute one or both types of advance directive.
- All BHOs inform enrollees whom they should contact with any complaints concerning BHA non-compliance with advance directives.

Seclusion and Restraint

Strengths: Quality

- Most BHOs reported that they do not employ seclusion and restraint and have policies and procedures in place for that purpose. BHOs require their contracted BHAs to use no-force behavior management techniques as preventative measures, using evidence-based practices.
- Most BHOs monitor their contracted BHAs for seclusion and restraint through annual administrative reviews, annual provider chart reviews, grievance reporting, Ombud reports, enrollee satisfaction surveys, and quarterly provider performance reports.

Recommendation for Integration

All BHOs understand the importance of requiring contracted BHAs to have policies and procedures in place on the use of seclusion and restraint. Enrollees have the right to be free from seclusion and restraint at all provider out-patient and residential facilities. However, during the 2018 on-site reviews of several mental health agencies, reviewers observed several instances in which an agency utilized seclusion and restraint, primarily with children.

- HCA will need to ensure the MCOs are monitoring out-patient and residential agencies for their use of seclusion and restraint and behavioral de-escalation processes. Monitoring includes reviewing incident reports, auditing clinical records, reviewing grievances and enrollee surveys and performing on-site reviews. The MCOs need to require all out-patient and residential agencies to have policies and procedures in place on the use of seclusion and restraint.

Federal and State Laws

Strength: Quality

- OPBHO required new staff to attend a six-month training that includes education on all applicable State and federal rules and regulations.

Recommendation for Integration

All BHAs are required to comply with federal and State laws, such as the Civil Rights Act, Age Discrimination Act, Rehabilitation Act, Americans with Disabilities Act, and Health Insurance Portability and Accountability Act. However, reviewers noted during the 2018 EQR BHA walkthrough reviews that not all BHAs demonstrated compliance with these laws, particularly the Americans with Disabilities Act.

- To ensure the BHAs are complying with all relevant State and federal laws, HCA will need to work with the MCOs to ensure they monitor the BHAs for this requirement.

Grievance System

Table 22: Grievance System Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues	BHOS with issues
Grievance and Appeal Systems	438.228 (a–b) 438.402 (a–b)	GCBHO, NSBHO, KCBHO, SCRBHO	4
Filing Requirements	438.402 (c)(1)(i)(A)		0
Filing Requirements—Timing	438.402 (c)(2–3)		0
Notice of Adverse Benefit Determination	438.404 (a–b)	GCBHO	1
Timing of Notice	438.404 (c) 438.210 (d)		0
Handling of Grievances and Appeals	438.406	GCBHO	1
Resolution and Notification—Timeframes	438.408 (a–c)		0
Resolution and Notification—Format and Content of Notice	438.408 (d–e)	GCBHO, KCBHO	2
State Fair Hearings	438.408 (f)	NSBHO	1
Expedited Resolution of Appeals	438.410		0
Grievances and Appeals—Information Requirements	438.414 438.10 (g)(2)(xi)	GCBHO, NSBHO	1
Recordkeeping and Reporting	438.416	GCBHO, NSBHO, OPBHO, SCRBHO	4
Continuation of Benefits	438.420	SCRBHO	1
Effectuation of Reversed Appeal Resolutions	438.424		0

Grievance and Appeal Systems

Strength: Access

- All BHOs have policies and procedures in place to inform enrollees of their right to access the grievance and appeal process and the State’s fair hearing system.

Strengths: Quality

- NSBHO maintains a grievance portal for BHAs to submit all grievance information, which allows the BHO to track grievance trends.
- KCBHO ensures that grievances that are submitted through the BHO and promptly resolved the same day are recorded and tracked.

- OPBHO requires its contracted BHAs to inform enrollees about the grievance system process at the time of intake, whenever an enrollee submits an expression of dissatisfaction, and upon any request from an enrollee regarding grievances.
- SCRBHO uses the grievance system to teach enrollees communication and conflict resolution skills.
- SCRBHO has provided numerous trainings on the grievance, appeal and fair hearing systems, both in regionally accessible settings and at individual BHAs upon request.

Filing Requirements

Strength: Access

- All BHOs require their contracted BHAs to provide enrollees with information regarding the grievance system by furnishing either the *Washington State's Behavioral Health Benefits Book* or a version of the booklet produced by the BHO.

Strength: Quality

- After a grievance is resolved, OPBHO sends a survey to the involved enrollee to gain feedback on the quality and satisfaction of the grievance process.

Notice of Adverse Benefit Determination

Strength: Quality

- All BHOs make the notice of adverse benefit determination (NOABD) available in other languages and alternative formats.

Timing of Notice

Strengths: Timeliness

- All BHOs ensure NOABDs are mailed at least 10 days before the date of action unless an exception is permitted.
- OPBHO mails notices to enrollees the same day the BHA notifies the BHO of a termination, suspension, or reduction of a previously authorized service.

Handling of Grievances and Appeals

Strength: Access

- All BHOs inform enrollees of their right to access behavioral health Ombud' services within their region.

Strengths: Quality

- All BHOs have a designated staff member responsible for processing, recording, and monitoring all grievances filed with the BHO and the BHAs.
- NSBHO requires each BHA to have a designated grievance system contact available to answer questions or clarify grievance-related information for the BHO, Ombud, or enrollees.

Resolution and Notification—Timeframes

Strengths: Timeliness

- OPBHO maintains a two-hour standard for responding to expedited resolutions for appeals.
- SCRBHO monitors BHA grievance timelines through a quarterly desk check that occurs when BHAs submit their grievance logs. BHAs are issued corrective action when not in compliance with timeline standards.

Resolution and Notification—Format and Content of Notice

Strength: Quality

- Three of the five BHOs used either the State template for written disposition of grievances and resolution of appeals or a modified version. These templates contained all the required information in the correct format.

State Fair Hearings

Strength: Quality

- All BHOs have detailed policies and procedures, consistent with WAC and contract standards, outlining the State fair hearing process for staff and enrollees.

Expedited Resolution of Appeals

Strength: Quality

- Although some BHOs have never received a request for an expedited appeal, all BHOs have a policy and procedure in place that outlines the steps and timelines necessary to address a request for an expedited resolution of an appeal.

Strength: Access

- Many of the BHOs' policies include language requiring that no punitive action be taken against a provider who requests an expedited resolution or supports an enrollee's appeal, ensuring access to such request.

Grievances and Appeals—Information Requirements

Strengths: Quality

- All of the BHOs provide their BHAs with information on the grievance system and reported providing technical assistance annually and/or upon request.
- Most BHOs monitor compliance with grievance system standards and requirements through an on-site process or administrative review and through the submission of quarterly grievance reports and acknowledgment and resolutions letters.

Recordkeeping and Reporting

Strengths: Quality

- Most BHOs review grievance and appeal information for trends and use the gathered information for quality improvement, to identify gaps in service delivery, identify opportunities to provide education and training to the network BHAs, and help inform the BHO's quality plan.
- All BHOs submit quarterly grievance reports to the State for all State-funded, Medicaid and WISe grievances and appeals.
- All BHOs require their BHAs to submit quarterly grievance reports.

Continuation of Benefits

Strength: Quality

- All BHOs have policies and procedures that state enrollees have the right to continue services while an appeal or State fair hearing is pending, and that the enrollee may be liable for the cost of the services provided if the final resolution is not in the enrollee's favor.

Certifications and Program Integrity

Table 23: Certifications and Program Integrity Summary of Issues

Protocol Section	CFR Citation	BHOs with Issues	Number of BHOs
Data Certification	438.600 (b) 438.602 (a) 438.604	GCBHO, NSBHO, SCRBHO, KCBHO	4
Excluded Entities	438.602 (b–d) 455.106 438.610 (a–d)	GCBHO, NSBHO, KCBHO, SCRBHO	4
Disclosure of Ownership	455.102 455.104	GCBHO	4
Conflict of Interest	438.602 (h) 438.58	GCBHO, NSBHO, KCBHO, OPBHO, SCRBHO	5
Source, Content, and Timing of Certification	438.600 (b) 438.606		0
Program Integrity Requirements	438.600 (b) 438.608 (a)	KCBHO, OPBHO	2
Recovery of Payments	438.608 (d)(1–3)	GCBHO	1
Record Retention	431.107 (a),(b)(1–2)		0
Cooperation with Fraud Control Units	455.21		0
Suspension of Payments	455.23		0
Civil Money Penalties and Assessments	1003.200		0

Data Certification

Strength: Timeliness

- SCRBHO has a policy stating that the BHO and its network providers will submit data that are complete and accurate within contracted timeframes, that all data submissions by the BHAs are certified and attested to on a monthly basis by each provider agency's chief executive officer or chief financial officer, and that data submitted to the State by the BHO are certified and attested to by SCRBHO's quality and data system manager.

Strength: Quality

- All BHOs ensure data completeness via system integrity checks and encounter data record review. The BHOs also require the BHAs to submit monthly certifications to testify to the accuracy and completeness of the data.

Recommendation for Integration

Most of the BHOs expressed concern regarding how the BHAs will effectively submit data to more than one MCO given many of the SUD treatment BHAs continue to need technical assistance to submit truthful, accurate, and timely data.

- The BHAs will continue to need monitoring and technical assistance to ensure that all submitted encounter data are truthful, accurate, and timely. MCO- and EQRO-conducted encounter data validation record reviews would help to identify continued needs and educational opportunities as well as any cases of fraud, waste, or abuse.

Excluded Entities**Strengths: Quality**

- All BHOs run the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) database monthly against the human resources database for all staff, board members, agency owners and vendors for exclusion from participation in federal programs
- During OPBHO's annual on-site personnel reviews at each contracted BHA, the BHO reviews employment files to confirm BHAs conduct criminal background checks.
- SCRBHO requires the BHAs to disclose, when contracting or re-contracting with the BHO, whether any person involved in the provision of program services has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program. SCRBHO also requires all BHAs to submit a monthly contract compliance report attesting that no employees, volunteers, or owners have been debarred, suspended, or otherwise excluded from participating in federal healthcare programs.
- KCBHO checks the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) database monthly against its human resources database to verify that no staff, board members, agency owners, or vendors have been excluded from participating in federal programs.

Recommendation for Integration

All BHOs require the BHAs to conduct a Washington State Patrol criminal background check prior to hiring any employee, and then continue to perform the check annually for BHA employees and volunteers who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults. However, not all BHAs have been in compliance with this requirement.

- HCA will need to ensure the MCOs have implemented methods to monitor the BHAs for routinely conducting annual background checks for BHA employees and volunteers who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

Disclosure of Ownership**Strengths: Quality**

- Both OPBHO and NSBHO check for disclosure of ownership upon contract execution, as well as upon request, when a contract is renewed or extended.
- SCRBHO requires BHAs to disclose any ownership and control interest in which the BHA has 5 percent or more ownership or control. For corporate entities, the name of the business, address,

and tax identification number must be reported. For individuals, the name and Social Security Number must be reported. These disclosures are required at execution of the contract, annually, and within 35 days of any change.

Conflict of Interest

Strength: Quality

- Most of the BHOs maintain membership rosters and bylaws for their governing bodies to demonstrate compliance with requirements related to conflict of interest. Members of the governing boards must disclose potential conflicts of interest to the chairpersons of the boards and refrain from voting or having discussions on any matter in what might be perceived as a conflict of interest.

Recommendation for Integration

Many of the BHOs do not require BHA staff to read and sign conflict of interest attestations on a yearly basis.

- HCA should encourage the MCOs to develop mechanisms to monitor the BHAs to ensure that conflict of interest attestations are reviewed and completed annually.

Source, Content and Timing of Certification

Strengths: Timeliness

- Most of the BHOs have policies and procedures in place to ensure data submitted to the State are certified for completeness, accuracy, and truthfulness by their chief executive officer (CEO) or chief financial officer (CFO).
- NSBHO's policy and procedure titled *Certification of Utilization Information Relating to Payment* states, "Each day that utilization data is submitted by NSBHO to DSHS, NSBHO must concurrently submit a Certification of Utilization Information Relating to Payment under the Medicaid Program, which attests, based on best knowledge, information and belief, to the accuracy, completeness and truthfulness of the utilization information submitted."

Program Integrity Requirements

Strengths: Quality

- All BHOs have provided training to BHO and BHA staff on all aspects of compliance, including fraud and abuse.
- All BHOs have well-written compliance programs that contain the seven elements of an effective compliance program, including an introduction; standards of conduct policies and procedures; identification of the compliance officer and committee; and details on how the BHO is conducting effective training and education, monitoring and auditing, reporting and investigation, response and prevention, enforcement and discipline, and assessment of effectiveness.
- All BHOs have used self-assessment methodologies to conduct risk assessments and prioritize vulnerable areas for additional monitoring and or reviews.

- All BHOs have employed several methods for detecting and preventing fraud and abuse, which include:
 - performing BHA administrative site reviews for compliance and adherence to contract, CFR, and WAC requirements
 - reviewing contracted BHAs' quarterly financial information
 - profiling, analyzing, and verifying enrollee encounter data
 - reviewing inpatient and outpatient enrollee claims
 - reviewing Ombud reports and grievances
 - performing Management Information System (MIS) audits
 - investigating any reports of suspected fraud, waste, or abuse

- KCBHO's compliance committee collects information from its grievance system, finance, client services, care coordination, contract monitoring, and quality groups to discuss concerns in every aspect. The committee's subcommittee is the compliance and contract monitoring group, whose activities include clinical site reviews, facility site reviews, carve-out reviews, administrative reviews, and encounter data validation reviews.

- OPBHO regularly completes a comprehensive spectrum of auditing and monitoring activities to detect fraud, waste, and abuse. These activities include but are not limited to:
 - encounter data validation
 - annual agency reviews, including medical record audits and clinical and administrative reviews
 - duplicate member reviews
 - utilization reviews
 - review of reports from licensing and Washington state disciplinary reports
 - reviewing provider risk assessments

Recommendation for Integration

All BHOs require their contracted BHAs to have written compliance plans and policies detailing mechanisms for detecting and preventing fraud, waste, and abuse. All BHAs are required to, at minimum, adhere to the seven essential elements of an effective compliance program. The BHOs also require the BHAs to perform self-assessments to identify any potential risks. Although many of the larger BHAs have these processes and plans in place, there is a lack of consistency in meeting these requirements among smaller BHAs, particularly the SUD treatment BHAs.

- HCA will need to ensure the MCOs are requiring all contracted BHAs to have written compliance plans and written policies detailing mechanisms for detecting and preventing fraud, waste, and abuse. The MCOs should also require all BHAs to, at minimum, adhere to the seven essential elements of an effective compliance program and perform self-assessments to identify any potential risks. HCA should also ensure the MCOs have in place auditing and monitoring activities to detect any fraud, waste, and abuse by the BHAs. Activities could include encounter data validation record reviews, medical record audits, clinical and administrative reviews, duplicate member reviews, utilization reviews, review of reports from licensing and Washington state disciplinary reports, and review of provider risk assessments.

Recovery of Payments

Strength: Quality

- Most of the BHOs have developed and implemented policies on the recovery of overpayments made by the BHO to providers, including, specifically, the recovery of overpayments resulting from fraud, waste, or abuse. The policies require the BHAs to report to the BHO any overpayment a BHA may have received, return the overpayment to the BHO within 60 calendar days of the date the overpayment was identified, and to notify the BHO in writing of the reason for the overpayment.

Record Retention

Strengths: Quality

- OPBHO includes in its contracts with the BHAs the following language on record retention: “Contractor shall ensure that it has internal policies and procedures that include the requirement to retain all books, records, documents and other material relevant to this Contract for a period of not less than six (6) years after the termination hereof in compliance with Medicaid records retention standards.”
- SCRBHO has a strong fiscal monitoring process for its BHAs that includes an annual review of financial and business-related record retention policies and procedures.
- All BHOs monitor the BHAs for compliance with medical record retention.

Cooperation of Fraud Control Units

Strength: Timeliness

- Most of the BHOs have a policy and procedure to prevent and detect fraud, waste, and abuse that includes reporting all suspected cases of fraud and abuse to the Medicaid Fraud Control Unit (MFCU) as soon as they are discovered and reporting all information sent to the MFCU to DSHS.

Suspension of Payments

Strength: Quality

- Several of the BHOs have a compliance policy that includes the requirement that the BHO monitor its vendors, subcontractors, and providers for suspension of payments in cases of fraud.

Civil Money Penalties and Assessments

Strength: Quality

- As part of its excluded provider policy and procedure, GRBHO monitors its vendors, providers, and subcontractors for civil money penalties and assessments.

BHA Walkthroughs

Enrollee Rights

Strengths

- All of the BHAs had enrollee rights documents posted in multiple prevalently spoken languages. Several of the BHAs posted the rights in the 13 languages outlined in the *Washington State's Behavioral Health Benefits Book* (Amharic, Arabic, Cambodian, Chinese, English, Korean, Laotian, Punjabi, Russian, Somali, Spanish, Ukrainian, and Vietnamese).
- To assist non-English-speaking enrollees, all of the BHAs have contracts with various interpreting services in addition to using TTY relay for the hearing impaired.
- Most of the BHAs distribute the *Washington State's Behavioral Health Benefits Book* to enrollees. Some of the BHAs had the booklet readily available in their lobbies in languages other than English.
- All of the BHAs distribute enrollee rights before or at the time of intake. The BHAs that serve enrollees under the age of 13 provide those enrollees with the enrollee rights when they turn 13; the enrollee then signs an acknowledgement of receipt of the rights.

Opportunities for Improvement

The EQR revealed some deficiencies across the BHAs in staff knowledge regarding enrollee rights and the communication of this knowledge to enrollees. Several BHAs did not have a formal enrollee rights training process in place to prepare staff to incorporate enrollee rights into their practice and into their enrollee education.

- All BHAs should institute a training process to address gaps with regard to staff knowledge and understanding of policies governing enrollee rights and how to incorporate them into service delivery models. Additionally, providing staff with a foundational training in enrollee rights ensures that service recipients receive equitable and culturally competent care. Further, annual ongoing training in these rights for staff promotes adherence and consistency to organizational policies and patient-centered care.

Some of the BHAs did not appear to utilize a "point to" or "I speak" sign or poster as a means of identifying an enrollee's preferred language in order to obtain necessary assistance.

- BHAs are contracted and obligated to take reasonable steps to provide meaningful access to enrollees who may have limited English proficiency (LEP). BHAs should implement the use of such materials as a means of identifying a preferred language and potentially assisting literate individuals who are not proficient in English. These posters can be obtained from most contracted interpreter service agencies, as well as the U.S. Department of Homeland Security.

Several of the BHAs did not require the EQR reviewer to sign an oath of confidentiality before granting access to enrollee records.

- BHAs should understand and comply with their responsibility to maintain the confidentiality and security of enrollee protected health information (PHI). BHAs should provide clear direction to all staff to ensure everyone is on board and adequately prepared to safeguard enrollee PHI. The oath of confidentiality protects the BHA in an unlikely event of a staff member or an outside reviewer maliciously sharing confidential information.

Advance Directives

Strengths

- Most of the BHAs provided evidence of enrollee acknowledgement that staff asked the enrollee whether they had a mental health advance directive.
- Most of the BHAs provided evidence of enrollee acknowledgement of being informed of medical advance directives.

Opportunity for Improvement

Review of clinical records indicated that enrollees who turned 18 years of age while in services were not always informed of medical advance directives and mental health advance directives. Enrollees at most of the BHAs who are older than 18 at the time of intake receive and acknowledge receipt of information regarding advance directives at the time of admission. However, if an enrollee turns 18 while in services, advance directives are not discussed.

- The BHAs should install a policy to discuss advance directives with enrollees who turn 18 while in services to ensure they receive this information.

Grievance Systems

Strengths

- All of the BHAs were in the practice of storing grievances separately from the clinical record in a location accessible only by appropriate designated persons.
- Most of the BHAs were able to demonstrate they have processes in place to monitor the resolution of grievances and appeals and ensure compliance with timeliness requirements. All BHAs typically complete grievance acknowledgements within 5 business days and resolutions within 90 days; most are resolved within 30 days.

Opportunity for Improvement

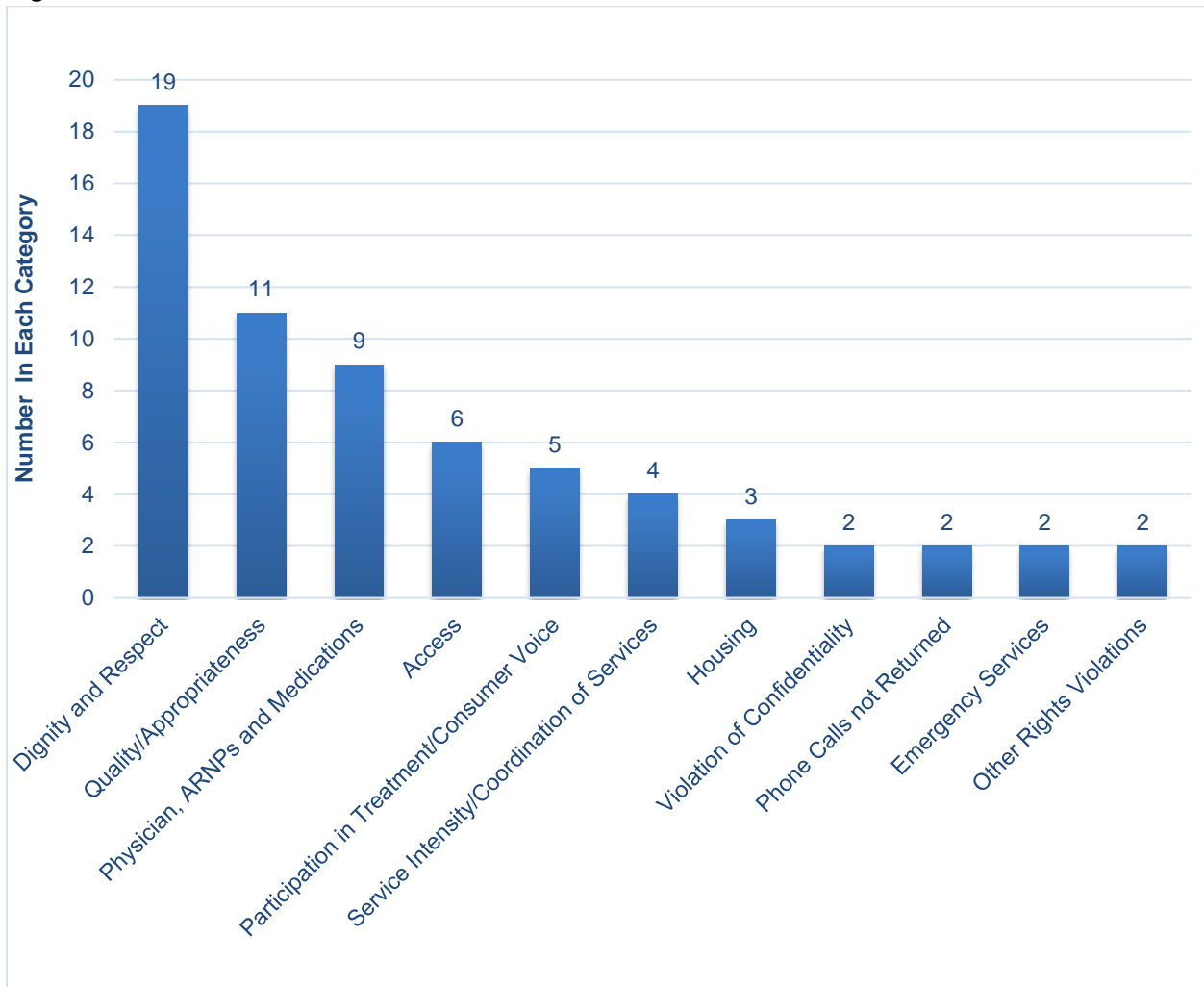
Most of the BHAs indicated they review their grievance system policy with staff within 30 days upon hire and annually thereafter. Generally, staff then sign an attestation acknowledging review of this policy. However, given the very low number of grievances reported among the BHAs, further training may be necessary to ensure staff comprehension and knowledge retention.

- All BHAs should have a mechanism in place to train staff on the grievance system to ensure an increased understanding and knowledge of its requirements.

Review of Grievances

EQR reviewers assessed a total of 46 grievances, 13 of which featured Ombud involvement at some point (either the filing of the grievance originated with the Ombud or the Ombud was brought in as part of the resolution process). The grievances fell into 11 grievance categories, involving 65 sub-classifications; a single grievance can cross multiple categories. Figure 5, next page, displays the distribution of the reviewed grievances among these categories. The majority of grievances continues to be in the category of respect and dignity.

Figure 5: Distribution of BHA Grievance Review



Performance Improvement Project Validation

Performance improvement projects (PIPs) are designed to assess and improve the processes and outcomes of the healthcare system. They represent a focused effort to address a particular problem identified by an organization. As prepaid inpatient health plans (PIHPs), Behavioral Health Organizations (BHOs) are required to have an ongoing program of PIPs that focus on clinical, non-clinical, and substance use disorder (SUD)-focused areas that involve:

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

For 2018, BHOs were required to maintain two PIPs: one clinical PIP and one non-clinical PIP; one of these PIPs was required to focus on children's mental health, and the other to focus on a substance use disorder (SUD)-related issue. Clinical PIP topics utilize outcome indicators to measure changes in behavioral health status or functional status, such as prevention and care of acute and chronic conditions for high-risk, high-volume, or high-need enrollees. Non-clinical PIPs focus on member satisfaction or process of care areas and may address coordination or continuity of care, access to care, and availability of services, as well as enrollee appeals, grievances, and satisfaction.

Methodology

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

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

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

Scoring

Qualis Health assigns a score of “Met,” “Partially Met,” or “Not Met” to each of the 10 evaluation components that are applicable to the performance improvement project being evaluated. Components may be “Not Applicable” if the performance improvement project is at an early stage of implementation. Components determined to be “Not Applicable” are not reviewed and are not included in the final scoring. Scoring is based on the answers BHOs provide in the completion of a response form, which address questions listed under each evaluation component, following a review of written documentation and in-person interviews. Opportunities for improvement, technical assistance, and recommendations requiring a corrective action plan (CAP) are provided for each standard where appropriate.

Following PIP evaluations, BHOs are offered technical assistance to aid them in improving their PIP study design, methodology, and outcomes. BHOs may resubmit their PIPs up to two weeks following the initial evaluation. PIPs are assigned a final score following the final submission. For the 2018 EQR, on-time-adopter and mid-adopter BHOs were scored in the same manner. The results of these assessments are described in the following sections.

Summary of PIP Validation Results

On-Time-Adopter BHOs

Qualis Health's review of the on-time-adopter BHOs' PIPs revealed many areas of strength as well as some opportunities for improvement. Themes within the BHOs' chosen topics this year included increasing mental health clinical outcomes for the intensive youth population, improving the grievance process among SUD treatment providers, and increasing co-occurring care for enrollees with both a mental health need and a substance use disorder treatment need. Some PIPs were still in the nascent stages and had not progressed to at least the first re-measurement of the identified study indicator. In these cases, sufficient data were not yet available to conduct thorough analysis of the study topics and Qualis Health was unable to assess for success related to real or sustained improvement. Table 24 displays the BHOs' PIP topics and validation results.

Table 24: Results of On-Time-Adopter BHO PIP Validation

BHO	Study Topic		Validation Result
Great Rivers (GRBHO)	Children's Clinical PIP	Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs	Fully Met
	SUD Non-clinical PIP	Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Services	Fully Met
Salish (SBHO)	Children's Non-clinical PIP	Increasing Child and Family Team Meetings among High-risk, High-cost, and High-need Children Served by the Mental Health System	Fully Met
	SUD Non-clinical PIP	Improving Implementation of the Grievance System among SUD Treatment Providers	Fully Met
Thurston-Mason (TMBHO)	Children's Clinical PIP	Implementing the CANS Tool at BHR to Improve Treatment Planning and Clinical Outcomes	Not Applicable
	SUD Non-clinical PIP	Increasing Concurrent and Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees	Fully Met

Greater Rivers (GRBHO)

Children’s Clinical: Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs (Fully Met)

GRBHO selected this PIP study topic in order to improve outcomes for children and youth with intensive behavioral health needs. These youth are involved with more systems, utilize more services, and are at higher risk for severely negative outcomes than the majority of child and adolescent enrollees. The PIP’s primary focus is improving Child and Adolescent Needs and Strengths (CANS) assessment scores over time, specifically the 2s and 3s in five key domains: Behavioral/Emotional Needs, Functioning, Risk Factors, Youth Strengths, and Caregiver/Family Needs and Strengths, to ultimately improve overall outcomes in service delivery. Although the BHO found some positive outcomes of care at both re-measurement points, it was not to the desired degree. GRBHO should look at BHAs’ internal processes in terms of CANS administration and data collection, entry of these data into the Behavioral Health Assessment System (BHAS), and the tracking of CANS re-assessment due dates. All of these processes are key components in understanding variances in the captured data.

SUD Non-clinical: Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Treatment Services (Fully Met)

GRBHO developed this PIP after it began contracting with SUD treatment providers on April 1, 2016. At that time, many of the providers were new to managed care regulations, and therefore were in the process of building or refining policies and procedures to meet their new contractual obligations, one of which was to implement a formal grievance system. Thus, the BHO sought to increase the number of reported grievances submitted to the BHO by the BHAs. The grievance process was new for many of the SUD treatment agencies. GRBHO recognized this gap and saw the need for improvement to ensure individual grievances were identified, reviewed, and responded to within the grievance system. In 2017, the BHO provided targeted training for each of its SUD treatment BHAs in order to increase understanding and knowledge of grievance system requirements. This training outlined clear processes to investigate, resolve, and follow up on grievances within specified time periods and demonstrated how to document grievance information for analysis and utilization in quality improvement. Although this PIP is still in the infancy stages of implementation, GRBHO has made great strides to effect change, including providing training, testing BHA knowledge around grievance processes and policies, following up with BHAs, and monitoring grievance reporting (which includes ensuring that all grievances are properly documented and resolved) on an ongoing basis. At the time of the EQR, the second re-measurement was not conducted because of the lack of improvement seen in the first re-measurement period. It was recommended that the BHO re-group and devise a revised intervention. As this PIP moves forward and the BHO works to adjust the intervention, all elements of the PIP study design should be taken into consideration to ensure all aspects of the PIP are realistic and obtainable.

Salish (SBHO)

Salish Behavioral Health Organization had two non-clinical PIPs, as these projects were well underway prior to the Division of Behavioral Health and Recovery contract amendment that outlined the new PIP requirements.

Children’s Non-clinical: Increasing Child and Family Team Meetings among High-Risk, High-Cost, and High-Need Children Served by the Mental Health System (Fully Met)

SBHO completed the first phase of this PIP in December 2016, which focused on improving the identification of intensive needs for children and youth and demonstrated sustained improvement over time. As a result of the outcomes obtained from the first phase, the BHO decided to expand the scope of

the PIP to a second phase, focused on improving the frequency of child and family team (CFT) meetings for children who are identified as high risk, high need, and high cost based on either meeting criteria for SBHO's CIS Program or WISE eligibility. Since the inception of this PIP, SBHO has made great strides in collecting data, adjusting the intervention (including additional updated training for the BHAs), and implementing appropriate improvement strategies. For an intervention to be considered robust it must be based on the results of a root cause analysis as well as target population, provider, and system-level factors, all of which SBHO has applied to this PIP.

SUD Non-clinical: Improving Implementation of the Grievance System among SUD Treatment Providers (Fully Met)

SBHO developed this PIP after it began contracting with SUD treatment BHAs on April 1, 2016. At that time, many of the providers were new to managed care regulations, and therefore were in the process of building or refining policies and procedures to align with new contractual and Washington Administrative Code (WAC) requirements. The BHO's selection of this SUD PIP topic was the result of its review of preliminary data indicating low numbers of reported grievances among its BHAs. The low numbers suggest the possibility that all types of grievances may not have been included in the formalized system, or that awareness and use of the formal grievance process could be improved. SBHO is still in the early stages of this PIP. The intervention is training the SUD treatment BHAs on the grievance system (including reporting requirements) and then measuring the increase in reported grievances, assuming it will increase as BHA staff knowledge increases. This study topic has the potential to impact enrollee satisfaction, health, and functional status by improving the grievance system and ensuring a formal means for enrollees to voice their dissatisfaction and an opportunity to reach a resolution of that dissatisfaction. At the time of the EQR, SBHO had not reached the point of data analysis and interpretation for either of the identified study indicators.

Thurston-Mason (TMBHO)

Children's Clinical: Implementing the CANS Tool at BHR to Improve Treatment Planning and Clinical Outcomes (Not Applicable)

Thurston-Mason BHO (TMBHO) is seeking to improve clinical outcomes for youth and adolescent enrollees receiving traditional outpatient treatment services at Behavioral Health Resources (BHR), a BHA in the TMBHO network. The BHO intends to collaborate with BHR to implement the use of the Washington State Child and Adolescent Needs and Strengths (CANS) assessment at intake and at 90-day intervals. The CANS tool is used to guide treatment planning throughout the course of treatment. CANS scores are numerical and provide a means of measuring progress in addressing "actionable items" (outcomes) over time. At the time of the EQR, the BHO was working to clarify its topic as it did not have initial data demonstrating that BHR treatment targets were not being met. It was recommended that the BHO examine data or indicators demonstrating BHR is struggling with treatment planning and achieving positive clinical outcomes in its child/youth population. TMBHO should continue to look at child mental health data to identify trends, needs, gaps, and barriers in order to select a PIP topic reflecting an issue that is truly in need of improvement.

SUD Non-clinical: Increasing Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees (Fully Met)

TMBHO noted that there is a disparity within its network between the number of individuals who meet the criteria for having both a mental health diagnosis and a substance use disorder diagnosis and those who have actually received co-occurring services or standalone services for both of their diagnoses. Thus, the BHO is seeking to increase availability of co-occurring mental health and substance use disorder treatment services for adult enrollees who meet the criteria for medical necessity for both mental health

and substance use disorder services. TMBHO laid out a strong foundation for this PIP, but had not progressed to the point of capturing data for re-measurement at the time of the EQR. It was recommended that the BHO conduct six-month re-measurement periods for this PIP to allow time to make course corrections if no improvement is noted. TMBHO reported that its intent is to draw attention to the baseline performance measure, track at the provider level whether or not a referral is made, and identify any barriers or reasons for the SUD assessment being delayed or not completed. The BHO plans to use this information, as well as periodic re-measurement data, to make course corrections as needed throughout the study period to work toward the final goal.

Strengths

- Over the course of 2018, the State improved upon the coordination and collaboration of the approval process as well as enhanced the tracking mechanisms that were implemented as a means to ensure BHOs have approved working PIPs underway.
- The State remains strong in its communication and collaboration with the EQR team to make certain that clear, concise, and consistent feedback as well as technical assistance is provided to the BHOs regarding study topic submissions.
- The majority of PIPs that had reached the point of data analysis received overall scores of fully met, with high confidence in reported results.
- Most BHOs were able to use qualitative and quantitative data to inform assessments of their projects' effectiveness and, if needed, implement modifications to improve outcomes.
- Several BHOs were able to identify and assess change ideas that might help solve complex quality issues in behavioral healthcare.
- PIPs demonstrated an overall commitment to improving the processes and outcomes of behavioral healthcare for all enrollees.
- All of the on-time-adopter BHOs have staff who are familiar with the PIP process and CMS protocol for conducting performance improvement projects.
- All the BHOs were receptive and responsive to feedback and technical assistance regarding the formulation and implementation of PIPs as well as next steps.

Recommendations

Some of the BHOs struggled with determining next steps after failing to achieve statistically significant improvement.

- HCA needs to ensure that when PIP interventions need course correction, the BHOs:
 - take steps to identify improvement opportunities, including but not limited to conducting barrier analyses to derive the improvement strategies to be implemented
 - undertake shorter re-measurement periods to allow adequate time for modifications to be made until the desired outcome is achieved and sustained
 - review data at least on a quarterly basis to ensure the PIP is moving in a successful direction
- HCA and the EQRO need to continue to provide technical support to ensure BHOs understand how to utilize core improvement concepts and tools when implementing PIPs.

Mid-Adopter BHOs

Qualis Health’s review of the mid-adopter BHOs’ PIPs revealed many areas of strength as well as some opportunities for improvement. Themes within the BHOs’ chosen topics included continuity and coordination of care, increasing enrollee engagement in services, and improved identification of enrollees with co-occurring disorders. Many PIPs were still in the initial phases of study. In these cases, sufficient data were not yet available to conduct thorough analysis of the study topics and Qualis Health was unable to assess for success related to real or sustained improvement. One BHO scored Not Met on both of its PIPs for failure to submit any PIP documents prior to the 2018 EQR or within the two-week resubmission period after the EQR on-site visit. That BHO’s overall score is a result of non-compliance with proceeding with the clinical and non-clinical PIPs. Table 25 displays the BHOs’ PIP topics and validation results.

Table 25: Results of Mid-Adopter BHO PIP Validation

BHO	Study Topic		Validation Result
Greater Columbia (GCBHO)	Children’s Clinical PIP	Promoting Medication Adherence in Youth	Not Met
	SUD Non-clinical PIP	Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs	Not Met
King County (KCBHO)	Children’s Clinical PIP	Improved Coordination with Primary Care for Children and Youth	Partially Met
	SUD Non-clinical PIP	SUD Treatment Patient Engagement	Partially Met
North Sound (NSBHO)	Children’s Clinical PIP	EPSDT and the Effects of Care Coordination on Level of Care	Fully Met
	SUD Non-clinical PIP	SUD Golden Thread	Fully Met
Optum Pierce (OPBHO)	Children’s Clinical PIP	Increasing the Use of Natural Supports in WISE	Fully Met
	SUD Non-clinical PIP	The Use of the GAIN-SS in a Clinical Referral for Mental Health Services	Fully Met
Spokane (SCRBHO)	Children’s Clinical PIP	WISE Crisis Prevention and Service Enhancement	Fully Met
	SUD Non-clinical PIP	SUD Treatment Continuity of Care	Fully Met

Greater Columbia (GCBHO)

GCBHO scored Not Met on both of its PIPs for failure to submit any PIP documents prior to the 2018 EQR or within the two-week resubmission period after the EQR on-site visit. Its overall score is a result of non-compliance with proceeding with the clinical and non-clinical PIPs.

Children's Clinical: Promoting Medication Adherence in Youth (Not Met)

GCBHO selected this PIP study topic in order to increase medication compliance among Medicaid-enrolled youth. The BHO presented this topic during the 2016 EQR, but at that time a root cause analysis (RCA) had not been conducted. Between the 2016 and 2017 reviews, the BHO completed an RCA, which included a survey that was completed by WISE-enrolled youth and families in July 2017. The results revealed that the families of youth enrolled in WISE did not understand the importance of medication adherence. Additionally, it was discovered that many of these youth had missed dosages as a result of forgetting to take the medication. Because the BHO was able to drill down and understand the causes and barriers of medication non-adherence, an intervention(s) and a study question should have been developed.

SUD Non-clinical: Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs (Not Met)

GCBHO selected this SUD PIP topic as a means to develop strategies for increasing engagement in detox facilities prior to discharge, with the end goal of reducing recidivism rates. This topic was presented during the 2016 EQR, but at that time GCBHO had not conducted research to identify the root causes of detox recidivism rates. When this PIP was first proposed, GCBHO intended to develop strategies to increase engagement prior to discharge with the aim of reducing recidivism rates. In 2017, the BHO was in the process of administering surveys to glean more information about the reasons for enrollee readmission into detox programs. During the 2017 EQR on-site visit, GCBHO explained its intent to gain a thorough understanding of the drivers of high readmission rates in order to develop an intervention to augment engagement in treatment and improve length of detox stays. There have not been any developments on this PIP since the 2017 EQR.

King County (KCBHO)

Children's Clinical: Improved Coordination with Primary Care for Children and Youth (Partially Met)

KCBHO continued its clinical PIP focused on improving coordination with primary care providers for Medicaid-enrolled children and adolescents. This PIP is in its fifth year, as KCBHO previously sought to conduct this PIP utilizing data from the five Apple Health managed care organizations (MCOs); however, the BHO experienced difficulty obtaining data from all of the MCOs. Because of KCBHO's difficulty in obtaining data, this PIP remained in a very early stage for several years. The BHO again decided to pursue another iteration of this PIP with a new focus on foster care youth, using some of the same basic principles and tenets originally identified while seeking to test whether implementation of a joint care coordination intervention that could include Wraparound with Intensive Services (WISE) or the Children's Crisis Outreach Response System (CCORS) would significantly reduce psychiatrically related emergency department (ED) use for Medicaid-enrolled children/youth identified as having prior psychiatrically related ED use and who are continuously enrolled in BHO outpatient or other mental health services and have Coordinated Care Apple Health Core Connections coverage. Coordinated Care oversees healthcare services for foster children and youth by addressing issues related to healthcare and ensuring adequate access. Thus, the partnership between KCBHO and Coordinated Care should enhance overall enrollee outcomes of care.

SUD Non-clinical: SUD Treatment Patient Engagement (Partially Met)

This was a new PIP for KCBHO, focusing on enrollees receiving medication-assisted treatment (MAT) at a BHO-contracted BHA. MAT is an evidence-based practice that combines pharmacological interventions with substance abuse counseling and social support. In order for MAT to be successful, an enrollee must be engaged in treatment at the onset, which allows providers to monitor the standard and overall quality of care as it is associated with subsequent SUD re-admissions. The purpose of this PIP was to increase MAT dose days and retention rates of enrollees in outpatient MAT by piloting an enrollee engagement program in which enrollees work with a peer engagement specialist in the first few weeks of treatment at Evergreen Treatment Services' (ETS) Seattle clinic. The intervention involved an engagement specialist, who would educate the enrollee about the initial dosing process, monitor dosing attendance, coach or conduct motivational interviewing to assist with reducing barriers to treatment access, provide community referrals and information, conduct outreach following missed doses, provide peer emotional support, and administer a contingency management incentive program for successful engagement. ETS hired an engagement specialist at the end of August 2018; however, the BHO reported at the time of the EQR that it was unclear if this individual would remain employed with ETS as the peer engagement specialist. Nevertheless, if the intervention for this PIP had been successful, it would be advisable for the BHO and/or ETS to consider additional phases or iterations to keep enrollees engaged after they met the standards for the identified incentives. Further, it would be advisable for the BHO to target enrollee populations that have a higher risk of low engagement, such as a specific gender and/or more severe substance abuse users.

North Sound (NSBHO)**Children's Clinical: EPSDT and the Effects of Care Coordination on Level of Care (Fully Met)**

NSBHO began this clinical PIP after determining that qualifying EPSDT referrals were either not being documented at the BHA level or not being transmitted to the BHO. Subsequent reviews found a continuing disconnect in the reporting of EPSDT referrals and the use of care coordination processes to enhance communication with the medical providers and the overall service delivery to enrollees. This PIP had five re-measurement periods as of the 2018 EQR; strides toward improvement occurred in one quarter, but the following quarter those gains appeared to have diminished. Nonetheless, during the first quarter of 2018, overall improvement was seen again, although not to the degree the BHO anticipated. It was recommended that NSBHO continue to measure and review the outcomes of this PIP and, through the knowledge transfer process, seek to determine whether the MCOs in the region would be interested in continuing or adapting this project. Care coordination processes should be continuously monitored to ensure the methods utilized are as efficient as possible, by eliminating duplication of efforts, redundancy, and cumbersome procedures. Overall, this will help to promote smooth transitions for enrollees and providers as enrollees move between levels of care.

SUD Non-clinical: SUD Golden Thread (Fully Met)

This PIP topic was developed as a result of findings and deficiencies the BHO noted during clinical utilization reviews it conducted at the SUD treatment BHAs. The BHO annually evaluates the quality of documentation for enrollee treatment, among other review elements. The review is also a means of determining the level and type of services enrollees are receiving and whether or not those services follow best practices. This includes ensuring that all elements are properly documented and that the progress notes accurately depict the needs of the individuals. The BHO recognized that fidelity to the "golden thread" concept is a key component of helping an enrollee progress through treatment. NSBHO made great strides to ensure baseline data supported the issue described by the PIP. It was recommended that the BHO continue to focus on ensuring there was a correlation between the data obtained from these reviews and overall enrollee care. It was also suggested that NSBHO continue to

focus on areas that consistently fall below 80 percent and provide specific emphasis and training on those areas.

Optum Pierce (OPBHO)

Children’s Clinical: Increasing the Use of Natural Supports in WISE (Fully Met)

OPBHO chose the study topic for this PIP in the fall of 2017 after completing an analysis and follow-up discussion regarding how well the service needs of Wraparound with Intensive Services (WISE)-eligible children, youth, and their families were being met. The BHO’s study indicator was based on data collected by the Child and Adolescent Needs and Strengths (CANS) tool, which was selected by the State expressly to provide quantitative measures of outcomes for WISE program participants across Washington. The BHO initiated the PIP with the intention of affecting outcomes of care as measured by the CANS, which is used as part of the screening process to help determine eligibility and assess the needs and strengths of children/youth receiving WISE services. Using the indicator of natural supports, OPBHO and BHA WISE teams were able to capture a layer of support that is necessary for the success of the family long after BHA supports are no longer necessary or approved. As an enrollee transitions out of this highest-intensity program to a lower level of care, natural supports are the individuals who continue to provide informal support through the process. OPBHO asserted that helping staff understand how to define and identify natural supports would help the youth and families receiving WISE services evaluate their current support system and make adjustments as necessary. Overall, the BHO demonstrated a substantial amount of work and effort regarding WISE and the full implementation of this program. The PIP’s focus on improving CANS assessment scores over time, specifically the 2s and 3s in one key domain, could result in improved overall service delivery.

SUD Non-clinical: The Use of the GAIN-SS in a Clinical Referral for Mental Health Services (Fully Met)

Since the integration of mental health and SUD treatment, the BHO emphasized the concept of “no wrong door” with its treatment providers. This concept of every door being the right door laid a foundation for behavioral health providers to offer friendly assistance to help individuals requesting services make a successful connection with another service provider when the assessing agency didn’t provide the service an individual was requesting or had been assessed as needing. OPBHO previously considered use of the GAIN-SS in the referral process as a potential study topic and for this PIP decided to focus on the process as it relates to SUD treatment providers referring or offering a referral for mental health treatment to enrollees who met the criteria as indicated by their GAIN-SS scores. This tool is used to identify those who would benefit from further assessment or referral for one or more potentially identified behavioral health disorders. Although not a comprehensive bio/psycho/social assessment, when used in conjunction with the intake assessment, it can help to identify issues early on and prevent or mitigate their progression. The BHO expected that as a result, cross-system clinical referrals would improve and individuals in the community would receive the appropriate level of care at the appropriate time.

Spokane (SCRBHO)

Children’s Clinical: WISE Crisis Prevention and Service Enhancement (Fully Met)

SCRBHO’s clinical children’s PIP was still in its nascent stages at the time of the EQR. The BHO conducted a thorough and comprehensive analysis that assessed the needs of enrollees receiving WISE services. According to the Washington State WISE Program Policy and Procedure Manual, successfully implemented WISE programs should help keep children and youth safe and promote recovery. In addition to the components that make up the program model, the service requirements include crisis planning and the use of proactive interventions to minimize the occurrence and intensity of crises. Crisis services are

available for WISE children and youth on a 24-hour basis and are intended to stabilize, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to the needs of the individual. SCRBHO articulated that this PIP would address significant aspects of enrollee care by changing how providers employ intervention strategies, moving from a reactionary to a more responsive approach. Additionally, the BHO provided various tools to support this PIP, including providing crisis prevention and intervention training for all WISE team staff, organizing and distributing the Crisis Prevention Resource Guide for WISE-enrolled families, and offering medication lock boxes and WISE response kits that include a variety of wellness tools and educational handouts.

SUD Non-clinical: SUD Treatment Continuity of Care (Fully Met)

With this PIP, SCRBHO sought to ensure coordination of care and discharge planning to allow for a seamless transition from inpatient to outpatient services and vice versa. As part of its continuity of care plan, the BHO sought to improve engagement and retention and reduce recidivism. Thus, this PIP focused on the provision of concurrent open episodes for both outpatient and inpatient residential substance use disorder treatment providers by supporting coordination and discharge planning between the outpatient and inpatient treatment providers. During the last EQR, the BHO presented data indicating that its projected results were not achieved and did not demonstrate statistical significance. Consequently, the BHO set out to conduct a failure mode analysis as a means to discover potential barriers or flaws within the intervention implementation. Since the last EQR, SCRBHO had the opportunity to conduct an intervention follow-up training, the failure mode analysis, and a second re-measurement period (with a third re-measurement scheduled for late fall). The revised approach still featured a strong emphasis on increasing service intensity and care coordination during an enrollee's wait for a residential placement to help that enrollee achieve or maintain treatment gains to support overall recovery.

Strengths

- Over the course of 2018, the State improved upon the coordination and collaboration of the approval process as well as enhanced the tracking mechanisms that were implemented as a means to ensure BHOs have approved working PIPs underway.
- The State remains strong in its communication and collaboration with the EQR team to make certain that clear, concise, and consistent feedback as well as technical assistance is provided to the BHOs regarding study topic submissions.
- Most BHOs were able to use qualitative and quantitative data to inform assessments of their projects' effectiveness and, if needed, implement modifications to improve outcomes.
- Most of the BHOs were able to identify and assess change ideas that might help solve complex quality issues in behavioral healthcare.
- PIPs demonstrated an overall commitment to improving the processes and outcomes of behavioral healthcare for all enrollees.

Recommendations for Integration

Some BHOs struggled with allocating resources to continue the required PIPs.

- HCA needs to ensure that as BHOs approach closing out their business operations, they fulfill the requirements of their PIHP contract.
- HCA and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.
- HCA and the EQRO need to continue to provide technical support to ensure BHOs understand how to utilize core improvement concepts and tools when implementing and continuing PIPs.

Some of the BHOs struggled with determining next steps after failing to achieve statistically significant improvement.

- HCA needs to ensure that when PIP interventions need course correction, the BHOs:
 - take steps to identify improvement opportunities, including but not limited to conducting barrier analyses to derive the improvement strategies to be implemented
 - undertake shorter re-measurement periods to allow adequate time for modifications to be made until the desired outcome is achieved and sustained
 - review data at least on a quarterly basis to ensure the PIP is moving in a successful direction

Performance Measure Validation

As part of its 2018 EQR of behavioral health services, Qualis Health validated two performance measures, reflecting care BHOs provided to enrollees in 2017. For validation, the State chose the following two measures for EQR, both reflecting care delivered across BHOs on a statewide level:

- Behavioral Health Access Monitoring (BHAM)
- Substance Use Disorder Treatment Initiation and Engagement (SUD IET)

Validation for a third measure, Mental Health Treatment Initiation and Engagement Penetration, was conducted by the State.

Methodology

Qualis Health conducted performance measure validation for these measures based on the CMS protocol for this activity, adapted as necessary to validate performance measures at the state level.

The validation involves assessing the accuracy of performance measures reported by the State, and determining the extent to which performance measures calculated follow State specifications and reporting requirements.

In validating the performance measures, Qualis Health conducted the following activities:

- requested all relevant documents from the State regarding the processes used in calculating the required performance measures
- reviewed the relevant materials and identified questions for further review
- met with relevant State staff to review the preliminary findings and ask any additional questions required to complete the review
- assigned compliance ratings for each performance measure based on the information provided by the State, summarizing areas of strength and weakness, and identifying opportunities for improvement

Documentation requested from the State included the following:

- measurement plans and programming specifications, including specifications of data sources, programming logic, and computer source codes
- calculation specifications for all components of the denominator and numerator of the performance measures (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, DRGs, member months calculation, member years calculation, and specified time parameters)
- documentation showing that sampling was unbiased, treated all measures independently, and size and replacement methodologies met specifications
- the frozen data set used for the performance measure calculation

Qualis Health used the following logic model to perform validation checks for the two performance measures:

- integrity checks for encounter data files (data completeness and timeliness of data received)
- validation of data received: consistency checks and verification that critical fields contained values in the correct format and were consistent across fields, erroneous or missing values of data fields, out-of-range values, etc.

- analysis and interpretation of data on submitted fields, including the volume and consistency of encounter data utilization rates
- validation of attribution methodology
- review and analysis of the appropriateness of reporting tools

Scoring

Qualis Health used CMS’s three-point scoring system in validating the performance measures. The three-point scale allows for credit when a requirement is partially met, and the level of performance is determined to be acceptable.

Scoring Key

Fully Met (pass) ●	Partially Met (pass) ◐	Not Met ○
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Met means the State’s measurement and reporting process was fully compliant with specifications.

Partially Met means the State’s measurement and reporting process was partially compliant with specifications.

Not Met means the State’s measurement and reporting process was not compliant with specifications.

N/A means the element was not applicable to the State’s measurement and reporting process.

Summary of Performance Measure Validation Results

Behavioral Health Access Monitoring (BHAM) Measure

This measure reflects all members (adults and youth) in the BHO catchment area who received mental health or substance use disorder treatment services in the reporting period, regardless of the funding source, coverage, or benefit package.

Table 26: Results for Review of Behavioral Health Access Monitoring Measure (BHAM)

Standard	Description	Result
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	⦿ Partially Met (pass)
Denominator	Data sources used to calculate the denominator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the denominator.	N/A
Numerator	Data sources used to calculate the numerator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the numerator.	⦿ Partially Met (pass)
Sampling	Sampling was unbiased. Sampling treated all measures independently. Sample size and replacement methodologies met specifications.	N/A
Reporting	State specifications for reporting performance measures were followed.	● Fully Met (pass)

Documentation

The documentation used for the BHAM measure partially met requirements.

The State provided a description of the behavioral health access monitoring measure, as well as technical specifications, computer source codes, the data dictionary, and programmer logic for the calculation of the measure.

Data sources for this measure included encounters for Medicaid-funded mental health and substance use disorder treatment services. The State utilizes two systems to collect data from the BHOs and for reporting: the Behavioral Health Data System (BHDS) and ProviderOne. BHDS is the primary data repository for reporting behavioral healthcare activity and monitoring the BHOs. Encounter and eligibility data are received from ProviderOne, the primary source for encounter data. ProviderOne is owned by the HCA and supported and maintained by Client Network Services, Inc. (CNSI). The BHOs submit their encounter data directly to ProviderOne via HIPAA-standard electronic data interchange (EDI). ProviderOne performs a series of pre-adjudication file-level edits and adjudication edits that reflect industry standards. Data format and validity checks are performed on standard coded fields found in the 837-transaction set (837I and 837P). There are minimal data quality edits in place for encounter data in order to maximize the amount of data collected. Some of the edits produce warning messages instead of rejecting the encounters. The BHOs receive a report of transactions and errors in return. An extract of accepted encounters is sent weekly to each BHO to compare to its own systems.

The State monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. The BHOs receive data quality and completeness reports from the State biweekly, and ProviderOne returns encounter transaction results reports weekly. BHOs are contractually required to conduct encounter data validation (EDV) reviews for each of their contracted behavioral health agencies (BHAs) annually.

The State-level ISCA Qualis Health conducted as part of the 2017 EQR indicated that the State did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for (e.g., batch control sheets, data validation or data completeness studies, reconciliation procedures). Qualis Health also identified in this assessment that the Department of Social and Health Services (DSHS) had not completed a comprehensive penetration test of its network since 2012. As of that review, HCA was continuing to work on issues discovered during the last penetration test. These include obtaining tools to routinely scan applications for vulnerabilities, which is required by the State Office of the Chief Information Officer (OCIO) in published standards.

Procedures for submitting data to BHDS and ProviderOne are well documented. HCA publishes the service encounter reporting Instructions (SERI), which specifies eligibility requirements for public health services, types of services, Medicaid and non-Medicaid eligibility criteria, updates to Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, encounter reporting requirements, coding instructions, clinical documentation, and mental health service modalities for the BHOs. HCA also publishes the Washington Apple Health Encounter Data Reporting Guide, which describes the encounter data reporting process and the required reporting elements.

Strengths

- The State provided the technical specifications, computer source codes, data dictionary, and programmer logic used for calculating this measure.
- Procedures for submitting data to BHDS and ProviderOne are well documented.
- The State monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. HCA provides the BHOs with data quality and completeness reports biweekly. ProviderOne returns encounter transaction results reports weekly.

Opportunities for Improvement

There are minimal data quality edits in place for encounter data in order to maximize the amount of data collected. Some of the edits produce warning messages instead of rejecting the encounters. Data quality could be improved if more edits were applied by the State.

- To ensure the appropriateness and accuracy of behavioral health encounter data, HCA should develop and implement additional data quality edits in ProviderOne.

The State-level ISCA Qualis Health conducted as part of the 2017 EQR indicated that the State did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for.

- The State should install controls to ensure behavioral health encounter data entered into the system are fully accounted for (e.g., batch control sheets, data validation or data completeness studies, reconciliation procedures).

Denominator

Per measure specifications, there is no denominator for this measure.

Numerator

The data sources used to calculate the numerator for the BHAM measure partially met requirements.

Data are extracted from ProviderOne/BHDS using a comprehensive SAS program called Qualis Access Monitoring that includes programmatic logic and computer source code for creating the analytic extract for the access monitoring measure. The SAS program is used to develop an integrated table called Behavioral Health Service Summary (BHSS), which includes data from multiple sources: mental health (MH) outpatient (OP) encounters, MH community hospital encounters from contracted providers, MH evaluation and treatment (E&T) encounters, and all SUD encounters. The BHSS is created through the consolidation of multiple data feeds into the BHDS. The primary data source is identified by Research and Data Analysis (RDA).

The State shared its SAS program with Qualis Health, enabling the EQRO to verify that critical fields and values were in the correct format and that consistency existed across fields. The program features edit checks to catch erroneous, missing, or out-of-range values. State Hospital and Children's Long-term Inpatient Program (CLIP) encounters were excluded from the original source per the final version of the measure specifications. SUD treatment includes all modalities except detoxification, housing support services, and inactivated modalities. Note that some BHOs have not reliably reported admissions (especially residential and detoxification encounters) or submitted native transactions as required.

Calculation of the BHAM measure adhered to the specifications for all components of the numerator (e.g., clinical codes to include inpatient and outpatient modalities per BHAM technical specifications, dates services were provided, adherence to specified time parameters, number or type of provider).

The State shared two datasets that were used to calculate this measure. Qualis Health found these data sets reasonable and well documented and did not find any inconsistencies in their structure or values. Qualis Health validated the programmatic logic used to calculate these datasets and did not find any deficiencies.

Strengths

- Data are extracted from ProviderOne/BHDS using a comprehensive SAS program called Qualis Access Monitoring, which includes programmatic logic and computer source code for creating the analytic extract for the access monitoring measure.
- The State shared its SAS program with Qualis Health, enabling the EQRO to verify that critical fields and values were in the correct format and that consistency existed across fields. The program featured edit checks to catch erroneous, missing values, or out-of-range values.
- The State shared two datasets that were used to calculate this measure. Qualis Health found these data sets reasonable and did not find any inconsistencies in their structure or values.
- The datasets were well documented and followed the data dictionary provided by the State. Qualis Health validated the programmatic logic used to calculate these datasets and did not find any deficiencies.
- Calculation of the BHAM measure adhered to the specifications for all components of the numerator (e.g., clinical codes to include inpatient and outpatient modalities per BHAM technical specifications, dates services were provided, adherence to specified time parameters, number or type of provider).

Opportunities for Improvement

The SUD treatment component of the State's SAS program did not include modalities identified in the technical specifications referenced in the BH Access Monitoring measure definition. Note that some BHOs have not reliably reported admissions (especially residential and detoxification encounters) or submitted native transactions as required.

- The State should ensure that all treatment modalities are included in the SAS program.

To ensure the accuracy and completeness of the performance measure queries and reports, HCA should initiate the following reconciliation and validation processes:

- comparison of results against historical trend
- subject matter expert review of results
- comparison of data samples in the repository to transaction files to verify completeness of data elements captured

Sampling

Per measure specifications, no sampling was used.

Reporting

The reporting processes used for the BHAM measure fully met requirements.

Decision Support and Evaluation (DSE) is the end-user reporting unit within HCA responsible for all reports used and distributed by HCA. This includes block grant application data and reporting, data and reports for rate setting, and other reports to support monitoring and compliance functions. DSE's primary sources of data are BHDS and ProviderOne. The unit has its own copy of BHDS, which is refreshed nightly. DSE runs bi-weekly reports for each of the BHOs, which summarize data quality, timeliness, and completeness. These reports are also discussed at the monthly BHO data group meetings.

The State requires the BHOs to monitor two performance measures but has not set performance goals or targets. The State generates and monitors other measures but has not shared the data with the BHOs. However, it shares the measures, in aggregate, with the public via its website.

Strengths

- Decision Support and Evaluation (DSE), a specialized unit within HCA, analyzes data and provides reports to meet the State's needs.
- DSE runs bi-weekly reports for each of the BHOs, which summarize data quality, timeliness, and completeness. These reports are also discussed at the monthly BHO data group meetings.

Opportunities for Improvement

The State requires the BHOs to monitor two performance measures but has not set performance goals or targets, which could be used to improve client outcomes.

- HCA should set benchmarks and targets for each of the required performance measures and use these benchmarks to measure the BHOs' outcomes.

The State generates and monitors other measures but has not shared the data with the BHOs. However, it shares the measures, in aggregate, with the public via its website.

- HCA should share the performance measure data it collects with the BHOs.

Substance Use Disorder Treatment Initiation and Engagement (SUD IET) Measure

This measure describes SUD treatment initiation and engagement, with initiation of SUD treatment defined as the percentage of adult and youth SUD outpatient service episodes in which the client received at least one face-to-face treatment encounter or one medication-assisted treatment (MAT) dispensing event within the 14 days following the start of an SUD outpatient (OP) service episode.

The State adapted the definition of the measure as defined by the Washington Circle (WC), a group focused on developing and disseminating performance measures for substance abuse services.

Table 27: Results for Review of Substance Use Disorder Treatment Initiation and Engagement (SUD IET) Measure

Standard	Description	Result
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.	⦿ Partially Met (pass)
Denominator	Data sources used to calculate the denominator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	● Fully Met (pass)
Numerator	Data sources used to calculate the numerator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measure.	⦿ Partially Met (pass)
Sampling	Sampling was unbiased. Sampling treated all measures independently. Sample size and replacement methodologies met specifications.	N/A
Reporting	State specifications for reporting performance measures were followed.	● Fully Met (pass)

Documentation

The documentation used for the SUD IET measure partially met requirements.

The State provided a detailed description of this measure.

Data sources for this measure included encounters for mental health and substance use disorder treatment services funded through HCA. HCA utilizes two systems to collect data from the BHOs and for reporting: the Behavioral Health Data System (BHDS) and ProviderOne. BHDS is the primary data repository for reporting behavioral healthcare activity and monitoring the BHOs. Encounter and eligibility data are received from ProviderOne, the primary source for encounter data. ProviderOne is owned by the HCA and supported and maintained by Client Network Services, Inc. (CNSI). The BHOs submit their encounter data directly to ProviderOne via HIPAA-standard electronic data interchange (EDI). ProviderOne performs a series of pre-adjudication file-level edits and adjudication edits that reflect industry standards. Data format and validity checks are performed on standard coded fields found in the 837-transaction set (837I and 837P). There are minimal data quality edits in place for encounter data in order to maximize the amount of data collected. Some of the edits produce warning messages instead of

rejecting the encounters. The BHOs receive a report of transactions and errors in return. An extract of accepted encounters is sent weekly to each BHO to compare to its own systems.

The State monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. The BHOs receive data quality and completeness reports from the State biweekly, and ProviderOne returns encounter transaction results reports weekly. BHOs are contractually required to conduct encounter data validation (EDV) reviews for each of their contracted behavioral health agencies (BHAs) annually.

The State-level ISCA Qualis Health conducted as part of the 2017 EQR indicated that the State did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for (e.g., batch control sheets, data validation or data completeness studies, reconciliation procedures). Qualis Health also identified in this assessment that the Department of Social and Health Services (DSHS) had not completed a comprehensive penetration test of its network since 2012. HCA continues to work on issues discovered during the last penetration test. These include obtaining tools to routinely scan applications for vulnerabilities, which is required by the State Office of the Chief Information Officer (OCIO) in published standards.

Procedures for submitting data to BHDS and ProviderOne are well documented. HCA publishes the service encounter reporting Instructions (SERI), which specifies eligibility requirements for public health services, types of services, Medicaid and non-Medicaid eligibility criteria, updates to Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, encounter reporting requirements, coding instructions, clinical documentation, and mental health service modalities for the BHOs. HCA also publishes the Washington Apple Health Encounter Data Reporting Guide, which describes the encounter data reporting process and the required reporting elements.

Strengths

- The State provided the technical specifications, computer source codes, data dictionary, and programmer logic for calculating this measure.
- Procedures for submitting data to BHDS and ProviderOne are well documented.
- The State monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. HCA provides the BHOs with data quality and completeness reports biweekly. ProviderOne returns encounter transaction results reports weekly.

Opportunities for Improvement

There are minimal data quality edits in place for encounter data in order to maximize the amount of data collected. Some of the edits produce warning messages instead of rejecting the encounters. Data quality could be improved if more edits were applied by the State.

- To ensure the appropriateness and accuracy of behavioral health encounter data, HCA should develop and implement additional data quality edits in ProviderOne.

The State-level ISCA Qualis Health conducted as part of the 2017 EQR indicated that the State did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for.

- The State should install controls to ensure behavioral health encounter data entered into the system are fully accounted for (e.g., batch control sheets, data validation or data completeness studies, reconciliation procedures).

Denominator

The data sources used to calculate the denominator for the SUD IET measure fully met requirements.

The State has well-established processes to collect all needed data. Data are extracted from ProviderOne/BHDS using a SAS program called Qualis Init_Engage v.2 . The State shared its SAS program with Qualis Health, enabling the EQRO to verify that critical fields and values were in the correct format and that consistency existed across fields.

The SAS program contains the source code for the production of the SUD IET measure and describes a logic model for how this measure is calculated. Encounters are extracted for the Integrated Managed Care (IMC) regions using a dataset maintained by RDA, for clients in the BHO service areas using BHDS's "outpatient encounter" table, for recipients of MAT using ProviderOne and ProviderOne eligibility history (client-by-month).

The State provided the full SAS code for the review, but because of the size of the data a full extract of all data sources was not provided. However, the State provided an event-level dataset and a detailed code used to produce it. Two reference files and an eligibility months table were also provided to allow Qualis Health to re-run a portion of the SAS code and calculate denominators and initiation and engagement rates by BHO and statewide.

The SAS program used for the calculation of this measure has all necessary logic checks in place to ensure the integrity of the data. Critical data fields contain values in the correct format and are consistent across fields. Program edit checks are in place to catch erroneous, missing, or out-of-range values. The program defined the eligible population for this measure and includes steps to meet continuous enrollment criteria for the denominator calculation. Source codes use appropriate State-developed clinical codes and SUD service modalities: HCPCS and CPT modifiers.

The State shared two datasets that were used to calculate this measure and provided reference tables for Recovery Audit Contractors (RACs) and eligibility. Qualis Health analyzed these datasets and did not find any inconsistencies in their structure or values. The datasets were well documented. Qualis Health validated the programmatic logic used to calculate these datasets and did not find any deficiencies.

Calculation of the SUD IET measure adhered to the specifications for all components of the denominator (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, member months calculation, member years calculation, and adherence to specified time parameters).

Strengths

- The State has well-established processes to collect all needed data.
- Data are extracted from ProviderOne/BHDS using a SAS program to calculate performance measures based on approved measure definitions.
- HCA provided the SAS program that contains the source code for the production of the SUD IET measure and describes a logic model for how this measure was calculated.
- The SAS program used for the calculation of this measure features all necessary logic to ensure the integrity of the data used to calculate the measure.
- Calculation of the SUD IET measure adhered to the specifications for all components of the denominator (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such

as ICD-9 or ICD-10, CPT-4, member months calculation, member years calculation, and adherence to specified time parameters).

Weakness

- The full SAS code was provided for the review; however, because of the size of the data, a full extract of all data sources was not provided. Instead, the State provided an event-level dataset and a detailed code used to produce it. Two reference files and an eligibility months table the State provided enabled Qualis Health to re-run a portion of the SAS code and calculate denominators and initiation and engagement rates by BHO and statewide.

Numerator

The data sources used to calculate the numerator for the SUD IET measure partially met requirements.

Qualis Health identified that the SUD IET partially met the requirements because of the State's direction that "QH should not be calculating the IET for the episode starting on or after 4/1/2018 because of the incomplete encounter data for ITE services received after 4/1/2018." Per state direction, the data submitted for calculation of SUD IET was for calculation of the measure through the quarter ending 3/31/2018 that was not reflected in the SAS programs provided to Quails Health.

Calculation of the SUD IET measure adhered to the specifications for all components of the numerator (e.g., clinical codes such as ICD-9 or ICD-10, CPT-4, relevant time parameters such as initiation or start episode dates and treatment start and stop dates, adherence to specified time parameters, number or type of provider).

Strength

- Calculation of the SUD performance measure adhered to the specifications for all components of the numerator (e.g., clinical codes such as ICD-9 or ICD-10, CPT-4, relevant time parameters such as initiation or start episode dates and treatment start and stop dates, adherence to specified time parameters, number or type of provider).

Sampling

Per measure specifications, no sampling was used.

Reporting

The reporting processes used for the SUD IET measure fully met requirements.

The State provided a dashboard for this measure at the state and BHO levels, featuring clear classification of reporting categories and rates. The SUD dashboard includes the following categories:

- SUD: Treatment Initiation—Adults
- SUD: Treatment Initiation—Youth ^
- SUD: Treatment Engagement—Adults
- SUD: Treatment Engagement—Youth ^
- SUD: Adults Receiving Treatment Services (Access Monitoring)
- SUD: Youth Receiving Treatment Services (Access Monitoring)
- MH: Adults Receiving Treatment Services (Access Monitoring)

- MH: Youth Receiving Treatment Services (Access Monitoring)

^ Youth includes individuals age 17 and younger at the date of admission to SUD treatment.

% Change = (most recent data point [numerator]/baseline data point [denominator]) -1

Qualis Health reviewed the dashboard and determined that it would be beneficial for the State to add denominators to the dashboard as a reference to estimate the impact of initiation and engagement services provided.

Decision Support and Evaluation (DSE) is the end-user reporting unit within HCA responsible for all reports used and distributed by HCA. This includes block grant application data and reporting, data and reports for rate setting, and other reports to support monitoring and compliance functions. DSE's primary sources of data are BHDS and ProviderOne. The unit has its own copy of BHDS, which is refreshed nightly. DSE runs bi-weekly reports for each of the BHOs, which summarize data quality, timeliness, and completeness. These reports are also discussed at the monthly BHO data group meetings.

The State requires the BHOs to monitor two performance measures but has not set performance goals or targets. The State generates and monitors other measures but has not shared the data with the BHOs. However, it shares the measures, in aggregate, with the public via its website.

Strengths

- Decision Support and Evaluation (DSE), a specialized unit within HCA, analyzes data and provides reports to meet the State's needs.
- DSE runs bi-weekly reports for each of the BHOs, which summarize data quality, timeliness, and completeness. These reports are also discussed at the monthly BHO data group meetings.

Opportunities for Improvement

The State provided a dashboard for the SUD IET measure at the state and BHO levels with clear classification of reporting categories and rates.

- The State should add denominators to the dashboard as a reference in order to estimate the impact of initiation and engagement services provided.

The State requires the BHOs to monitor two performance measures but has not set performance goals or targets, which could be used to improve client outcomes.

- HCA should set benchmarks and targets for each of the required performance measures and use these benchmarks to measure the BHOs' outcomes.

The State generates and monitors other measures but has not shared the data with the BHOs. However, it shares the measures, in aggregate, with the public via its website.

- HCA should share the performance measure data it collects with the BHOs.

Review of Previous-Year EQR Recommendations

Required external quality review activities include a review of the applicable state organization’s responses to previously issued EQR recommendations. The table below displays Qualis Health’s 2017 recommendations to DBHR and HCA’s responses to those recommendations.

Table 28: Review of HCA Responses to 2017 EQR Recommendations

Prior-Year Recommendation	DBHR Response	EQRO Response
Availability of Services		
<p>DBHR needs to include in its BHO contracts a requirement that BHOs and develop policies and procedures for verifying that out-of-network providers are appropriately credentialed and that the BHA requesting out-of-network services is verifying and retaining documentation evidencing that the out-of-network provider has the credentials necessary to provide the services and that the provider is not debarred/excluded from receiving federal funds.</p>	<p>The HCA contract management team responsible for oversight and monitoring of the BHO contracts ensured that BHOs addressed and resolved any corrective action plans directly related to this recommendation, including ensuring proper policies and procedures were in place to maintain this requirement going forward. DBHR quality administrator and supporting staff emphasized monitoring of out-of-network providers, specifically SUD residential, at the BHO Quality Leads meeting in November of 2017.</p>	<p>Resolved.</p>
Coordination and Continuity of Care		
<p>The BHOs need to continue their efforts to train, educate, and monitor the BHAs on coordination of care and services to ensure enrollees are receiving appropriate and medically necessary services and that documentation of these services is present in the progress notes.</p>	<p>The HCA contract management team responsible for oversight and monitoring of the BHO contracts ensured that BHOs addressed and resolved any corrective action plans directly related to this recommendation, including ensuring BHOs monitor and provide ongoing technical assistance/training. Note that care coordination and documentation will be a focus of the MCO/BHO quality forum in May of this year.</p> <p>In vetting BHO corrective action plans, the contract managers require the BHO to provide supporting documentation to demonstrate that the finding has been remedied and that</p>	<p>Resolved.</p>

	<p>there are processes in place to ensure maintaining the requirement moving forward. Supporting documentation can include copies of BHO monitoring tools, results of recent BHA reviews, BHA review schedule to demonstrate monitoring, BHA training schedule and curriculum, attestations or sign in sheets showing that trainings occurred, etc. Contract managers do not duplicate BHO auditing of BHAs, rather require that the BHO demonstrate and show that monitoring is occurring as required in the contract.</p>	
<p>To ensure BHAs are meeting all WAC, State contract, and CFR requirements and that the care furnished to enrollees is appropriate, the State needs to ensure that BHOs are monitoring out-of-network providers in cases when the BHO has not received a monitoring report from the BHO in whose region the provider is located.</p>	<p>The HCA contract management team responsible for oversight and monitoring of the BHO contracts ensured that BHOs addressed and resolved any corrective action plan directly related to this recommendation. At the BHO Quality Leads meetings in November of 2017, DBHR quality administrator and supporting staff emphasized the BHOs' responsibility to ensure that SUD residential providers contracted throughout the state undergo regular provider monitoring as required per contract (PIHP 10.9).</p>	<p>Informing BHOs that they need to ensure that SUD residential treatment providers undergo regular provider monitoring as required per contract is not monitoring the BHOs. HCA needs to request and review the BHOs' out-of-network provider monitoring results.</p> <p>Recommendation stands, pending further information.</p>
<p>The BHOs are ultimately responsible for ensuring their contracted BHAs maintain accessible facilities, including providing physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. The BHOs need to conduct thorough assessments of all contracted providers at the time of initial contracting and re-contracting to ensure adequate access is</p>	<p>HCA has included this in contract. Per required provisions subsection 10.4.3 of the PIHP contract, "Subcontracts must require adherence to the American Disabilities Act. This includes providing physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities." DBHR/HCA has also coordinated with DOH to inform them that per EQRO reviews, this appears to be an area of concern that requires increased scrutiny. DBHR certification and licensing team transferred to DOH as of July 2018, and DOH is in the process of improving their monitoring policies and procedures.</p>	<p>Resolved.</p>

provided.		
Coverage and Authorization of Services		
<p>DBHR needs to ensure that all BHOs have a policy and procedure that describes a formal process for conducting inter-rater reliability monitoring to ensure there is consistent application of review criteria pertaining to the initial and continuing authorization of services.</p>	<p>The HCA contract management team responsible for oversight and monitoring of the BHO contracts ensured that BHOs addressed and resolved any corrective action plan directly related to this recommendation. PIHP contract, section 6.12.2, requires BHOs to ensure consistent application of initial and continuing authorization of services. As of January 2019, inter-rater reliability for initial authorizations is no longer a concern for routine outpatient services due to mental health parity requirements. As of January 2019, BHOs are no longer requiring prior authorization of routine services.</p>	<p>Resolved.</p>
Provider Selection		
<p>DBHR needs to make sure that all BHOs have implemented a process for ensuring that the BHAs are consistently conducting, for all staff, a Washington State Patrol background check and excluded provider check before hire, as well as monthly excluded provider checks.</p>	<p>PIHP contract sections 10.6 and 8.9 require the BHOs to ensure subcontractors conduct both background checks and excluded provider checks on staff upon hire with excluded provider checks required monthly. BHOs monitor this requirement during the personnel records review portion of the administrative monitoring process. DBHR/HCA has also coordinated with DOH to inform them that per EQRO reviews, this appears to be an area of concern that requires increased scrutiny. DBHR certification and licensing team transferred to DOH as of July 2018, and DOH is in the process of improving their monitoring policies and procedures.</p>	<p>Excluded provider checks need to be performed monthly and going forward it will still be HCA's responsibility to ensure that all providers are performing excluded provider checks.</p> <p>Recommendation stands.</p>
<p>The State needs to enforce the BHOs' completion of CAPs related to ensuring the BHOs are all monitoring and verifying their contracted BHAs' credentialing and re-credentialing processes.</p>	<p>The HCA contract management team responsible for oversight and monitoring of the BHO contracts ensured that BHOs addressed and resolved any corrective action plans directly related to this recommendation.</p>	<p>Resolved.</p>

	<p>In vetting BHO corrective action plans, the contract managers require the BHO to provide supporting documentation to demonstrate that the finding has been remedied and that there are processes in place to ensure maintaining the requirement moving forward. Supporting documentation can include copies of BHO monitoring tools, results of recent BHA reviews, BHA review schedule to demonstrate monitoring, BHA training schedule and curriculum, attestations or sign in sheets showing that trainings occurred, etc. Contract managers do not duplicate BHO auditing of BHAs, rather require that the BHO demonstrate and show that monitoring is occurring as required in the contract.</p>	
<p>Subcontractual Relationships and Delegation</p>		
<p>DBHR needs to ensure that all BHOs are monitoring their BHAs' delegation agreements with subcontractors to ensure the delegates are following the same CFR criteria required of the BHAs.</p>	<p>Section 10.2.5 of the PIHP contract requires BHOs to have monitoring plans in place for all delegation agreements/relationships within their contracted network.</p>	<p>Resolved.</p>
<p>Practice Guidelines</p>		
<p>The State needs to make sure the BHOs are choosing practice guidelines based on valid and reliable clinical data in order to meet the needs of their enrollees. The BHOs then need to include in their QAPI program how the practice guidelines are incorporated into the administration and monitoring of services.</p>	<p>BHOs will be closed out by the end of 2019 and all regions will be transitioned to integrated managed care. Prior to transition, HCA sponsors a series of knowledge transfer sessions between BHOs and MCOs. Data-informed practice guidelines will be a topic in this series. HCA will encourage the on-time adopter BHOs to share their annual QAPI evaluation with the MCO plans transitioning into their region. HCA monitoring and quality teams will collaborate with the MCO plans to ensure data is used in developing practice guidelines for each region.</p>	<p>Resolved.</p>
<p>Quality Assessment and Performance Improvement</p>		

<p>DBHR needs to ensure that all BHOs have and follow policies and procedures for identifying, monitoring, and detecting underutilization and overutilization of services.</p>	<p>PIHP contract section 6.12 requires BHOs to develop criteria and monitoring processes to identify over- and under-utilization. Additional technical assistance and training was provided on this topic at the last quality forum.</p>	<p>Resolved.</p>
<p>Once the State receives CMS's approval for the quality strategy plan and distributes the final plan to the BHOs, DBHR will need to ensure the BHOs comply with the quality strategy plan.</p>	<p>HCA has recently learned that the quality strategy plan does not require formal approval by CMS. Prior to the merge with HCA, DBHR shared the quality strategy plan with the BHOs so that the BHOs could begin alignment. This was also discussed at the BHO Quality Leads meetings. HCA anticipates posting the quality strategy on the public website, per CMS request, by end of February. Note that given the transition to managed care and the integration of physical and behavioral health by 2020, HCA will revise and update the quality strategy plan for 2020.</p>	<p>Resolved.</p>
<p>Health Information Systems</p>		
<p>DBHR needs to make sure all BHOs have a policy and procedure to ensure BHAs are checking their data for quality and integrity before submitting them to the BHO.</p>	<p>Sections 10.10 and 10.11 of the PIHP contract require the BHOs to have mechanisms in place to verify that data submitted by their subcontractors are complete, accurate, and timely. Contract requires the BHOs to conduct encounter data validation checks, as well as certify via attestation that data are accurate/complete. Upon initial integration of SUD providers in 2016, data were identified as an area of needed improvement. Since 2016, DBHR has provided ongoing technical assistance via the joint BHO-DBHR data and SERI workgroups, as well as provided the BHOs with ongoing feedback via the data completeness report. BHOs also provided significant technical support to their networks, with many BHOs investing in electronic health records for struggling providers. By 2020, all BHO regions will transition to integrated managed care, and HCA is continuing to funnel</p>	<p>Resolved.</p>

	resources into improving data completeness and integrity across the state.	
Performance Improvement Project Validation		
DBHR needs to continually develop procedures to ensure the BHOs are able to receive reliable historical SUD treatment service data.	Per contract, BHOs are responsible to develop and implement data collection systems that work for their region, to ensure that they are receiving accurate and reliable data from their subcontracted providers. Per contract, DBHR has provided and developed procedures on how the BHOs are to submit data (PIHP section 13.1). Additional technical guidance and procedures are provided via the Service Encounter Reporting Instructions (SERI), Data Dictionary, and Encounter Data Reporting Guide. DBHR has provided ongoing technical assistance to the BHOs in the monthly data and SERI workgroups. DBHR has provided data completeness, quality, and error reports on an ongoing routine basis to assist BHOs in improving data integrity and identifying problem areas. Since the initial integration of SUD providers in 2016, DBHR has seen a marked improvement in SUD treatment data completeness.	Resolved.
DBHR needs to ensure that input from enrollees, family members, peers, and/or advocates are considered during the selection of the BHOs' PIPs.	EQRO contract manager has partnered with Qualis Health staff and DBHR contract managers to review all PIP study topics using the study topic approval form. This process requires DBHR and Qualis Health to jointly vet whether the BHO has adequately included input from enrollees, family members, peers, etc.	Resolved.
DBHR needs to ensure that when selecting a PIP study topic, the BHOs: <ul style="list-style-type: none"> ensure there are data that can be collected and analyzed to support the focus of the PIP as an area 	EQRO contract manager has partnered with Qualis Health staff and DBHR contract managers to review all PIP study topics using the study topic approval form. This process requires DBHR and Qualis Health staff to jointly ensure that the BHO has reviewed data to support the PIP focus, can	Resolved.

<p>that truly needs improvement</p> <ul style="list-style-type: none"> do not attempt to create a PIP around a program or process that does not show evidence of needing improvement. PIPs are meant to improve the care and treatment of enrollees in areas that are in need of advancement, not highlight programs or processes that are successful. fully and clearly define the intended intervention(s) 	<p>support the need for improvement, and has clearly identified intervention(s).</p>	
<p>DBHR needs to ensure that the BHOs' PIP measurement periods are clearly stated and appropriate in length. Data need to be reviewed at least on a quarterly basis to ensure the PIP is moving in a successful direction. Any changes in the study periods need to be clearly documented with thorough and valid explanations of deviations from the initial plan.</p>	<p>EQRO contract manager, in conjunction with Qualis and DBHR quality administrator, has worked with quality leads of the BHOs to provide technical assistance. For mid-adopter BHOs, technical assistance has been provided to assist BHOs in choosing shorter timeframes and appropriately concluding PIPs as the BHOs prepare to close out in December 2018. For BHOs that are on-time adopters, technical assistance has focused on appropriate timeframes that carry them into 2019.</p>	<p>Resolved.</p>
<p>DBHR and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.</p>	<p>EQRO contract manager, DBHR contract managers, and Qualis Health have partnered to provide ongoing technical assistance. Targeted technical assistance has been consistently offered to new BHO staff. Periodic training and reminders have been offered during the BHO Quality Leads meetings, with an open invitation for the quality leads to use these bi-monthly meetings to bring up questions or concerns.</p>	<p>Resolved.</p>
<p>DBHR and the EQRO need to continue to provide technical support to ensure BHOs</p>	<p>Same as above.</p>	<p>Resolved.</p>

<p>understand how to utilize core improvement concepts and tools when implementing PIPs.</p>		
<p>Information Systems Capabilities Assessment—State Assessment</p>		
<p>DBHR needs to continue to work with the SDC to establish an off-site disaster recovery location for BHDS in the event of a catastrophic outage.</p>	<p>As of July 1, 2018, DBHR merged with HCA. The data for Behavioral Health Data System (BHDS) has been moved to HCA. HCA is currently storing these databases in an AWS cloud solution that addresses this concern.</p>	<p>Resolved.</p>
<p>DSHS needs to complete work on the corrective action plan created as a result of findings identified in the last penetration test in 2012. DSHS needs to re-institute routine penetration testing on the DSHS network.</p>	<p>As stated above, the system has been moved over to HCA. While HCA has done penetration testing in the past, HCA is currently not doing penetration testing. HCA has started looking into penetration testing; however, this is in the early stages. The State’s goal is to do annual penetration testing; however, successful implementation of these goals will be dependent upon the funding the State can obtain.</p>	<p>Resolved.</p>
<p>DBHR needs coordinate with HCA to implement processes for creating edits in ProviderOne to reject encounters that are submitted incorrectly to the State.</p>	<p>ProviderOne does apply program-specific edits to behavioral health encounters as defined by program and policy directives. Specifically, ProviderOne edits behavioral health encounters at multiple levels. Prior to acceptance, every encounter file received is validated against HIPAA transaction standards to ensure that files are constructed in a compliant manner and adhere to the use of standard code sets. Once files are accepted, all behavioral health encounters are then adjudicated against the edits defined by program and policy staff. Although not all adjudicative edits available in ProviderOne are applied to Behavioral Health encounters, the editing is not minimal and goes beyond ensuring use of standard codes (please refer to the BHO Encounter Error Code List within the EDRG [www.hca.wa.gov/assets/billers-and-providers/encounter-data-reporting-guide.pdf]).</p>	<p>Resolved.</p>

	<p>Behavioral health encounter processing has already begun to undergo changes and will continue to do so as Integrated Managed Care is rolled out across all regions by January 2020. With the phased IMC implementation behavioral health encounters, except for those administered by an administrative services organization for crisis services, ProviderOne will be adjudicated using managed care encounter edits. This transition will help to remedy this concern.</p> <p>Moving forward, HCA will continue to review and monitor data completeness and integrity. ProviderOne has the capability and functionality to apply edits to behavioral health encounters at a level deemed appropriate by program and policy staff. If a change to the level of editing required for behavioral health encounters is required, the State will participate in the evaluation and implementation of appropriate changes.</p>	
<p>DBHR needs to set benchmarks for each of the required performance measures and measure the BHOs' outcomes. DBHR needs to share the performance measure data it collects with each of the BHOs.</p>	<p>BHOs began in April 2016, with the integration of substance use treatment and mental health treatment. As there were no historical data, meaningful benchmarks or targets could not be determined. Data are published online at www.dshs.wa.gov/node/28697, and results have been reviewed at the BHO Administrator's meetings and performance measure stakeholder workgroups. With the BHOs closing out within the next year, HCA is evaluating the data collected and how to standardize and improve data submission processes for providers, ASOs, and MCOs. Performance measures and data quality are a part of this discussion. The new data guide and processes as a result of this project will help standardize data collection and help facilitate</p>	<p>Resolved.</p>

	benchmarks and performance measures for the data.	
Information Systems Capabilities Assessment—BHO Assessment		
DBHR needs to work with and monitor the BHOs to ensure that all of the BHOs and their contracted BHAs have written BC/DR plans. The BHOs should collect the BC/DR plans from the agencies and ensure that the plans are updated and tested annually.	Per PIHP contract, section 13.2, this is an annual deliverable required by contract. The DBHR/HCA contract management team overseeing the BHO contracts received and reviewed this deliverable from all BHOs in 2018. Section 10.9.3 requires BHOs to monitor subcontractors' BC/DR plans to ensure they are updated and tested.	Resolved.
DBHR needs to work with the BHOs to ensure that all of the corrective action plans from the 2017 ISCA related to security and privacy are completed as soon as possible.	The DBHR/HCA contract management team worked with each BHO to ensure that all corrective action plans related to 2017 recommendations were addressed within a 60-day timeframe from receiving the corrective action plan.	Resolved.
Encounter Data Validation		
In order to improve the reliability of encounter data submitted to the State, DBHR needs to continue to work with the BHOs to standardize data collection and analytical procedures for encounter data validation.	For the past several years, BHOs have been required to conduct annual encounter data validation using standard guidelines that mirror CMS protocols. As BHOs close out and all regions transition IMC, the State will need to ensure an ongoing EDV process. The Program Integrity team within HCA's Medicaid Programs Operations Integrity division is coordinating with CMS and other third-party contractors to further develop and inform policies and procedures, as well as contract requirements, regarding this key area.	Resolved.
DBHR needs to provide guidance to the BHOs on how to bundle services correctly, review the numerous errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians. DBHR also needs to ensure the BHOs know and understand the content of the	HCA continues to provide guidance and trainings on the SERI requirements, recently making revisions that are appropriate for both the BHO and integrated care regions. Guidance and technical assistance will be ongoing. In 2019, this will be a key topic for the knowledge transfer meetings that will occur between BHO on-time adopters and the MCOs transitioning to these regions.	Resolved.

<p>State contract, SERI, and standards for documentation. DBHR may consider providing further training on the contract, SERI, and documentation to the BHOs and/or the BHAs, in particular, the SUD treatment BHAs.</p>		
<p>DBHR needs to create expectations or protocols for BHOs on how to address errors identified in encounters.</p>	<p>ProviderOne does apply program-specific edits to behavioral health encounters as defined by program and policy directives. Specifically, ProviderOne edits behavioral health encounters at multiple levels. Prior to acceptance, every encounter file received is validated against HIPAA transaction standards to ensure that files are constructed in a compliant manner and adhere to the use of standard code sets. Once files are accepted, all behavioral health encounters are then adjudicated against the edits defined by program and policy staff. Although not all adjudicative edits available in ProviderOne are applied to behavioral health encounters, the editing is not minimal and goes beyond ensuring use of standard codes (please refer to the BHO Encounter Error Code List within the EDRG [https://www.hca.wa.gov/assets/billers-and-providers/encounter-data-reporting-guide.pdf]).</p>	<p>Resolved.</p>

Mid-Adopter Closeout Status

As discussed earlier in this report, the State requested that Qualis Health focus its 2018 external quality reviews for the five BHOs closing operations at the end of 2018 (the mid-adopter BHOs) on the BHOs' status in coordinating closeout activities with the BHAs and knowledge transfers with the MCOs in conjunction with HCA. (Note that North Sound BHO delayed its closing until July 2019.) The EQR included an assessment and evaluation of the BHOs' closeout plans submitted to the State, as well as the BHOs' status in transferring the provision of behavioral healthcare services to the MCOs.

At the time of the external quality reviews, the BHOs had submitted their mid-adopter closeout activities summaries. Qualis Health reviewed the summaries with the BHOs to ascertain their status in completing the activities.

During the transition, the BHOs experienced several challenges with regard to the programs they facilitate and the services their BHAs provide. The BHAs will continue to experience many of these challenges after the BHOs cease operations. Examples include the following:

- insufficient clinicians and staff to meet demand for WISe services
- inadequate numbers of inpatient beds at evaluation and treatment (E&T) facilities
- continually rising number of single-bed certifications
- decreasing provider capacity
- lack of culturally appropriate mental health and substance use disorder treatment services for transition-age youth (18–21 years old)
- increase in youth and adult suicides
- lack of affordable stable housing for enrollees

Throughout the year, knowledge transfer meetings occurred with the BHOs, the MCOs, and HCA. The following summaries describe each mid-adopter's closeout status as of the external quality review.

GCBHO Closeout Status

The following content describes GCBHO's closeout status as a BHO of July 19, 2018, as it transitions into a regional behavioral health administrative services organization (BH-ASO).

Personnel

- On the same day the board announced it would close the BHO, GCBHO's attorney met with the entire BHO staff. Staff were informed that the BHO would cease operations and that all BHO staff would be released from their positions on December 31, 2018.
- GCBHO's governing board and the BHO's administrator conducted a review of the post-closeout staffing needs and projects that would need to be taken into consideration.
- Final performance evaluations were to begin in mid-December 2018, and each member of the staff was to undergo a final performance review prior to their release in December.
- GCBHO approved a retention package to help ensure staff remained on board through the completion of the BHO contract.
- BHO administrative functions were to be assumed by the Greater Columbia Behavioral Health BH-ASO (GCBH BH-ASO) staff after January 1, 2019, using an administrative chargeback system.

Office Space/Inventory

- GCBHO's board elected to transfer ownership of all remaining BHO general fixed assets purchased prior to April 2016 to the new GCBH ASO.
- GCBHO had not made any capital purchases since April 2016.
- GCBHO utilities were to be notified by December 31, 2018, of the BHO's closure.

Financial

- The BHO's financial staff were to continue to manage and administer financial activities and perform on-site monitoring of service providers through December 31, 2018.
- All financial closeout activities occurring after December 31, 2018, were to be managed by the GCBH BH-ASO fiscal staff.
- GCBH BH-ASO fiscal staff were to manage the BHO's general ledger and prepare the final fiscal year 2019 financial statements for the BHO.
- GCBH BH-ASO staff were to compile and submit revenue and expense reports on behalf of the BHO in February, May, and July of 2019.
- The BHO's final financial audit with the Washington State Auditor's Office was to be represented by the GCBH BH-ASO staff.

Contracts and Service Agreements

- On July 1, 2018, the BHO provided all contracted providers with written notification of the BHO closure and planned to send out an updated notification in October 2018, which would address final timelines for submission of service data and final billing instructions.

Mental Health Inpatient Hospitalization/SUD Residential Treatment

- GCBHO's staff were to continue to administer mental health inpatient and SUD residential treatment through the end of December 2018.

Other BHO Vendors and Contracts

- The BHO was notifying all other contracted vendors of its closeout, including notifications to HCA, the Washington State Department of Commerce, and any other State agency contracting with the BHO.

Clinical Services Activities

- The BHO's provider network was to continue to provide clinical services for enrollees throughout the closeout. The BHO expected that all of its providers would maintain similar service contracts with the MCOs and GCBH BH-ASO with little to no interruption in clinical service for enrollees.

Enrollee Notification

- The BHO stated that notification to enrollees regarding the transfer of service delivery to the MCO/GCBH BH-ASO network would be issued by HCA. At the time of the review, the Consumer Engagement Workgroup of the IMC Advisory Board was in the process of developing the communications.

Continuity of Care

- GCBHO was to provide HCA with a final list of open authorizations for all mental health and evaluation treatment centers, SUD residential facilities, and withdrawal management programs.

CLIP

- GCBHO was to maintain oversight of the Children's Long-term Inpatient Program (CLIP) through the end of 2018 and provide HCA with a list of CLIP placements at the time of transition.

Service Data

- BHO staff were to process data submissions through the end of December 2018.
- GCBHO contracted with an outside company to perform oversight and process data submissions after January 1, 2019.

Record Retention and Data Sharing

- GCBHO staff were to document the transfer of pertinent information to the GCBH BH-ASO. Destruction of hard drives and any hard copy information was also to be documented.
- The BHO shared historical service data with the MCOs and planned to continue to provide all information needed for the transition of services.

At the time of the EQR, the BHO had not addressed many of its recommendations from the previous year or continued with its performance improvement projects. The BHO stated it was allocating its resources for BHO closeout activities and its transition to an ASO. Prior to the EQR, Qualis Health notified DSHS of this status.

NSBHO Closeout Status

The following content describes NSBHO's closeout status as a BHO as of August 7, 2018, as it transitions into a regional BH-ASO. Note that NSBHO has delayed its closeout until July 2019.

Personnel

- The BHO's human resources manager and executive director met with legal counsel early in the planning phase to discuss retention, reduction in workforce, and severance packages.
- The governing board and administrator were involved in early discussions regarding review and analysis of needs beyond the closeout date, which included consideration of how to maintain staff through the transition.
- Retention guidelines were communicated to staff members. Notification of layoffs were planned for the first quarter of 2019.
- The BHO planned to provide staff members with a final performance review within the 12 months prior to separation.
- In March 2018, the governing board approved a retention package for staff continuously employed through June 30, 2019.
- Identification of contingency plans to continue required functions should staff not be available included discussion of contract work for positions vacated prior to June 30, 2019. Additionally, discussions ensued on reprioritizing work to fulfill the BHO's closeout needs during the transition year.
- Discussions about integration and impacts to the BHO occurred monthly at the Executive Committee meetings.

Office Space/Inventory

- As NSBHO transitions to an ASO, the BHO was to provide notifications to the leasing agent, vendors, and utilities dependent on how the BHO would sub-lease the building.

- The BHO was to complete an inventory of assets and property that were purchased with Medicaid and/or State dollars during the BHO contracting period starting April 1, 2016.

Financial

- The BHO's financial staff were to continue to manage and administer financial activities and perform on-site monitoring of service providers through December 31, 2018.
- The BHO intended to allocate 25 percent of its accounting staff time and costs in 2019 to the closure of the BHO. The plan included using two separate special revenue accounts: a fund for the BHO and a second fund for the ASO. The North Sound BH-ASO board would have two separate approval processes, one for BHO expenses and one for ASO expenses.
- All financial closeout activities occurring after December 31, 2018, were to be managed by the North Sound BH-ASO fiscal staff.
- North Sound BH-ASO fiscal staff were to compile and submit financial statements and file them with the Washington State Auditor's Office at the end of May 2019.
- The BHO's final financial audit with the Washington State Auditor's Office would be represented by the North Sound BH-ASO staff.
- The spend-down plan had been submitted to the State and was awaiting approval.

Contracts and Service Agreements

- The BHO was to send 30-day termination for convenience notifications to all contract and agreement entities 30–45 days in advance of contract terminations between October and November 2018.
- New contracts were to be sent out for review prior to termination of the existing contracts from September to November 2018. The new provider contracts were to be in place on January 1, 2019, for transition-year services.
- New memorandums of understanding (MOUs)/inter-local agreements/professional service contracts (PSCs) were to be developed between September and November 2018 for transition-year needs.

Mental Health Inpatient Hospitalization/SUD Residential Treatment

- NSBHO's staff were to continue to administer mental health inpatient and SUD residential treatment through the end of December 2018.

Other BHO Vendors and Contracts

- The BHO was notifying all other contracted vendors as required by contract, including HCA, the Department of Commerce, and any other State agency contracting with the BHO.

Clinical Services Activities

- The BHO's provider network was to continue to provide clinical services for enrollees throughout the closeout. The BHO expected that all of its providers would maintain similar service contracts with the MCOs and the North Sound BH-ASO with little to no interruption in clinical service for enrollees.

Enrollee Notification

- The BHO stated that the formal notification to enrollees regarding the transfer of service delivery to the MCO/North Sound BH-ASO network was to be issued by HCA. These documents were under development in the Consumer Engagement Workgroup.

- NSBHO was in the process of building a new website. The website was to feature all required information necessary for individuals/families seeking help or information on integrated care, as well as other pertinent information about other current healthcare-related changes. The website was also to feature a separate section for organizational providers.

Continuity of Care

- NSBHO's staff were to be providing requested continuity of care data for the MCOs.
- The BHO was to provide HCA with a final list of open authorizations for all mental health and evaluation and treatment centers, SUD residential treatment facilities, and withdrawal management programs.

CLIP

- NSBHO was to maintain oversight of the Children's Long-term Inpatient Program (CLIP) through the end of 2018 and providing each MCO with a list of clients in CLIP facilities, date of entry, next treatment plan review scheduled, and discharge plans.

Service Data

- Data submissions were to be handled by BHO staff through the end of December 2018.
- A review of the expiring contracts was to occur in the third quarter of 2018. Notifications were to be sent to providers outlining reporting deadlines. Services were to continue through 2019, and there was to be no disruption of data submission during the BHO's transition to an ASO.

Record Retention and Data Sharing

- NSBHO staff were to document the transfer of pertinent information to the North Sound BH-ASO. Destruction of hard drives and any BHO hard copy information were also to be documented.
- The BHO shared historical service data with the MCOs and was to continue to provide all information needed for the transition of services.

KCBHO Closeout Status

The following content describes KCBHO's closeout status as a BHO of September 25, 2018, as it transitions into the regional behavioral health administrative services organization (BH-ASO).

Personnel

- KCBHO was to continue to employ the majority of its current workforce in current or revised roles to administer the responsibilities required of the new organization. Any adjustments to staffing levels and employee deployment were to be decided by October 31, 2018. Appropriate notices were to be given to employees regarding retention and/or notification of layoffs.

Office Space/Inventory

- Because KCBHO will continue to administer behavioral health programs under the BH-ASO structure and will contract with the five MCOs to carry out other negotiated functions under the King County Independent Practice Association (IPA), termination of office space, professional services, equipment leases, and other business agreements was not to occur.
- The new King County BH-ASO was to continue to administer behavioral health programs after December 31, 2018 and retain all assets and property. The BHO had no plans to liquidate inventory and was not planning to inventory its assets and property. Any contracts related to

assets and property that were issued through the BHO were to be amended effective January 2019 to reflect the organization's new status as a BH-ASO or IPA.

Financial

- As KCBHO will continue to fully operate as a BH-ASO and/or the IPA in 2019, King County's Department of Community and Human Services (DCHS) financial administration was to maintain oversight of behavioral health programs and funding through 2019 and beyond.
- Closeout activities were to be consistent with the BHO's submitted spend-down plan.

Contracts and Service Agreements

- The BHO's contracted providers had been notified via the current contract that contracts would end at the close of 2018.
- Contractors received a new 2019 contract by August 1, 2018, for King County BH-ASO or MCO subcontract work.
- The BHO was not closing out any memorandums of understanding (MOUs) or service agreements at the time.

Mental Health Inpatient Hospitalization/SUD Residential Treatment

- The BHO had not finalized a decision regarding whether the responsibility for care management and hospital liaison functions would remain with the BH-ASO or IPA or be transferred to the MCOs.
- The BHO had recently created an internal hospital and mental health residential section, to include a section manager, a hospital placement and diversion supervisor, a "peer bridger" program specialist, five hospital liaisons, and three Western State Hospital peer bridgers.
- The BHO submitted two alternate plans related to SUD treatment and withdrawal management services (WMS) providers, which were still under negotiation.

Clinical Services Activities

- The BHO's provider network was to continue to provide clinical services for enrollees throughout the closeout. The BHO expected that all of its providers would maintain similar service contracts with the MCOs and the King County BH-ASO with little to no interruption in clinical service for enrollees.
- The BHO was receiving daily requests for service authorizations and sending notices of adverse benefit determination and authorization information on a daily basis. The BHO planned to continue to authorize care and send notices of adverse benefit determination until December 31, 2018.
- Because the BHO intended to contract with the MCOs as a BHO-ASO, new contracts and working agreements with MCOs were to specify the client transition and authorization processes.

Enrollee Notification

- The BHO stated that notification to enrollees regarding the transfer of service delivery to the MCO/King County BH-ASO network would be issued by the HCA.
- Details of the behavioral health services transition were to be provided on the BHO's website in mid-October 2018, including information on the BHO's closeout, the role of the new BH-ASO, and the role of MCOs in King County. The BHO website was to indicate the client transfer details and provide ongoing contact information for all MCOs, the new King County BH-ASO, and the HCA.

Continuity of Care

- During the last quarter of 2018, the BHO planned to coordinate with the HCA to collect information on clients in active treatment with open treatment authorizations.
- By November 30, 2018, the BHO was to utilize templates developed by the HCA to provide continuity of care data to allow HCA to match the clients to their January 1, 2019, MCO and then share the authorization data with the appropriate MCO by January 2019. The information was to include all clients expected to have a continued episode of care after the BHO's closeout date.
- The BHO planned to provide current treatment information to the HCA and obtain the appropriate consent to share SUD treatment information and to record which clients had signed a consent form.

CLIP

- The BHO was to maintain oversight of Children's Long-term Inpatient Program (CLIP) application activities as the BH-ASO.

Service Data

- The BHO's information system (IS) captured all authorizations processed for behavioral health outpatient services, residential, and inpatient services. Providers were to continue to request authorizations through the KCBHO system until December 31, 2018.
- Beginning in October 2018, the BHO was to develop a report identifying the clients currently receiving services within the BHO, their level of care, provider agency, and MCO. The last data for 2018 were to be run on January 15, 2019, to ensure clients were assigned to an MCO.

Record Retention and Data Sharing

- KCBHO had secure storage and HIPAA-compliant filing practices for physical and electronic records. Archived paper records were transported and stored securely in the King County Records Center.
- The new King County entities were to retain the same records in the data system, and plans were in place to align the new data submission structure with the business requirements of the MCOs and the HCA.

OPBHO Closeout Status

The following content describes OPBHO's closeout status as of October 9, 2018. The BHO ceased operations on December 31, 2018.

Personnel

- OPBHO began consultation with its human resources department and legal counsel in the early planning phase.
- The BHO was in the process of providing employees with information regarding retention guidelines and/or formal notification of layoffs.
- The BHO was in the process of developing contingency plans to continue required functions should staff not be available up to the closeout date.
- The BHO was to provide final severance paperwork to impacted employees on December 31, 2018. Any employees remaining thereafter to close out tasks were to receive final paperwork two weeks prior to their last day.

Office Space/Inventory

- The BHO planned to vacate its office space once operations ceased. The office was to be closed to the public after December 31, 2018, and open to staff completing the final closeout operations through February 2019.
- Closeout staff were to be transitioned to telecommuter status in February 2019. Corporate staff were to physically inspect the staff members' homes prior to transition to ensure HIPAA standards were met. They also planned to set up computer equipment, including installing any necessary wiring and other items.
- The BHO informally notified the building's landlord of its departure and was to provide official notification in December 2018.
- No capital purchases were made during the BHO contracting period starting April 1, 2016. Assets and property not leased were to be returned to Optum. All leased assets and property were to be returned to the vendors.

Financial

- Closeout activities were to be consistent with OPBHO's spend-down plan.
- The BHO's financial staff were to continue to manage and administer financial activities and perform on-site monitoring of service providers through December 31, 2018.
- All financial closeout activities occurring after December 31, 2018, were to be managed by a finance manager or designee to finalize fiscal reports, ensure accuracy, and complete final payments/reconciliations into the early period of the transition, after the end of the contract.
- The BHO's final financial audit with the Washington State Auditor's Office was to be represented by Optum staff to be determined.

Contracts and Service Agreements

- The BHO was to formally notify DBHR of termination of its contract per the "termination for convenience" requirements outlined in the contract's general terms and conditions.
- The BHO was to follow termination and notification requirements, including formal notification timelines, for all contracts, subcontracts, memorandums of understanding (MOUs), and other agreements.

Mental Health Inpatient Hospitalization/SUD Residential Treatment

- OPBHO was to provide a copy of the BHO-State hospital written agreement to the MCOs and the contracted BH-ASO in order for them to develop similar agreements.
- The BHO was to adhere to BHO-State hospital agreements for admissions and discharges leading up to the BHO closeout.
- The BHO was to determine the number of people in the BHO service area who were ready for discharge, including demographic information and current discharge plan, and provide this information to the MCOs and BH-ASO.
- The BHO was to compile a final list of open authorizations for SUD residential treatment for coordination of continuing service.

Clinical Services Activities

- The BHO's provider network was to continue to provide clinical services for enrollees throughout the closeout. The BHO expected that all of its providers would maintain similar service contracts with the MCOs and the BH-ASO with little to no interruption in clinical service for enrollees.

Enrollee Notification

- The BHO stated that notification to enrollees regarding the transfer of service delivery to the MCO/BH-ASO network would be issued by the HCA.
- Details of the behavioral health transition were to be provided on the OPBHO website in November 2018 and would include information on the BHO's closeout and the role of MCOs in Pierce County. It was also to provide client transfer details and ongoing contact information for the contracted MCOs, BH-ASO, third-party administrator, the HCA, behavioral health service providers, and others as needed.

Continuity of Care

- During the last quarter of 2018, the BHO was to coordinate with HCA to collect information on clients in active treatment with open authorizations.

CLIP

- OPBHO was to maintain oversight of the Children's Long-term Inpatient Program (CLIP) through the end of 2018 and provide HCA with a list of CLIP placements at the time of transition.

Service Data

- The BHO's information system (IS) captured all authorizations processed for behavioral health outpatient, residential, and inpatient services. Providers were to continue to request authorizations through the Optum Pierce system until December 31, 2018.
- The BHO was to provide individualized service data extracts to all BHAs during January/February 2019.
- The BHO was to ensure that all contractual obligations in data submission and data certification were met through the BHO closeout date.

Record Retention and Data Sharing

- OPBHO was in the process of developing a plan for identifying records necessary to retain, and ensuring the secure maintenance, secure transport, and storage of physical records.
- Destruction of hard drive, server, and other hardware was to be arranged upon completion of necessary use.
- OPBHO was reviewing contracts to determine data requirements with regard to closeout, data retention, data transfer, EDV reports, etc.

SCRBHO Closeout Status

The following content describes SCRBHO's closeout status as a BHO of October 25, 2018, as it transitions into a regional behavioral health administrative services organization (BH-ASO).

Personnel

- Since November 2017, the Spokane Board of County Commissioners (BoCC), which served as SCRBHO's governing board, Spokane County executive leadership, the Spokane County human resources department, and associated bargaining unit leadership had participated in regular meetings with SCRBHO's administrative leadership to plan and communicate with employees regarding the personnel plan for closing SCRBHO and its transition into a BH-ASO. Monthly meetings and/or communications with employees were to continue throughout the transition and closeout period.

- SCRBHO administrative leadership reviewed and analyzed SCRBHO's needs during the transition period and drafted an employee retention plan and associated employee retention agreement for the Spokane County HR department to finalize, in accordance with the bargaining unit agreement requirements. This document was shared with employees in June 2018.
- SCRBHO planned to follow Spokane County HR policies regarding completing final performance evaluations for terminated employees.

Office Space/Inventory

- The BHO had delivered notification to all leasing agents and vendors of termination and/or non-renewal of unnecessary space, office services, and behavioral health services within contract- and lease-required timeframes.
- The Spokane County Community Services, Housing, and Community Development (CSHCD) department, of which the BHO was a division, was to retain many of the existing services and some of the existing space to support the operations of the SCR BH-ASO.
- SCRBHO was to terminate funded leases and contracts in accordance with the SCRBHO reserve spend-down plan and SCRBHO budgeting processes and verify that services and space needed for the BH-ASO were appropriately associated with the BH-ASO and no longer with the BHO.

Financial

- SCRBHO Administration, Fiscal, and Contracts staff were to maintain oversight of contractual requirements through expiration and termination. Additional payment activities will occur for up to six months through the closeout date of June 30, 2019.
- The BHO submitted its BHO reserve spend-down plan to DSHS/DBHR on March 29, 2018, and received approval for the conditions, framework, and methodology within the plan on April 20, 2018. SCRBHO received full approval for its spend-down plan from DSHS/DBHR on June 20, 2018.

Contracts and Service Agreements

- SCRBHO planned to follow termination and notification requirements for all contracts, subcontracts, memorandums of understanding (MOUs)/Allied System Coordination Plans (ASCPs), and other agreements. Formal notification timelines were to be followed.
- Notices of non-renewal to network providers were to include a summary of final closeout expectations.
- SCRBHO planned to formally notify DSHS/DBHR and/or HCA of termination of its SCRBHO-related contracts, per the "termination for convenience" requirements outlined in the contract's general terms and conditions.

Mental Health Inpatient Hospitalization/SUD Residential Treatment

- SCRBHO intended to provide the MCOs with a final open authorization list for inpatient mental health services in December 2018, and again by January 4, 2019, if any inpatient authorizations were completed December 29–31, 2018.
- SCRBHO was to compile a final list of open authorizations for SUD residential treatment for coordination of continuing services and cost projection, associated with both in-region and out-of-region providers.

Clinical Services Activities

- The BHO's provider network was to continue to provide clinical services for enrollees throughout the closeout. The BHO expected that all of its providers would maintain similar service contracts with the MCOs and SCR BH-ASO with little to no interruption in clinical services.
- SCR BHO met with its service authorization subcontractor to notify it of the BHO's intent to terminate services and planned to schedule future meetings to outline steps for transfer of information. The BHO had been meeting with its third-party administrator, Behavioral Health Options to review termination of that contract and outline steps for transfer of information.
- The BHO was to receive final submissions of authorizations, copies of notice of adverse benefit determination letters, and final open authorization information January 2–4, 2019.

Enrollee Notification

- Formal notification of the regional transfer of behavioral health services to the MCO network was to be completed by HCA. These documents were under development in the Consumer Engagement Workgroup. SCR BHO intended to ensure providers, all SCR BHO staff, the Spokane BoCC, the Consumer Consultation Panel, and the Behavioral Health Advisory Board were all aware of information relayed to assist in answering questions as needed.
- The SCR BHO website was to be updated to indicate the transfer of services and provide ongoing contact information for all contracted MCOs, the SCR BH-ASO, third-party administrator, HCA, behavioral health service providers, and others as needed. Updates were to begin by December 15, 2018, and continue until June 30, 2019, when the SCR BHO closeout period ends. Contact information for access to historical records was also to be published.

Continuity of Care

- SCR BHO had been meeting with MCOs for knowledge transfer prior to May 22, 2018. Additionally, the SCR BHO staff had been discussing state hospital discharge processes with the MCOs. With the identification of the apparently successful bidders for the Spokane County Regional Service Area, continued meetings were to occur for transition.
- MCOs were to be notified of members in high-intensity services, Medicaid Personal Care (MPC), residential care, and other services modalities via the BHO's Continuity of Care Workbook Process.

CLIP

- Upon identification of the entity(ies) that will maintain oversight of Children's Long-term Inpatient Program (CLIP) application activities, SCR BHO intended to make efforts to coordinate a transfer of Spokane County Youth Task Force, CLIP Review Committee, and care management activities (treatment plan reviews and discharge planning). A list of placements, as of December 31, 2018, were also to be provided.

Record Retention and Data Sharing

- SCR BHO intended to ensure that all contractual obligations in data submission and data certification were met through the SCR BHO closeout date of December 31, 2018, for providers and SCR BHO, and that data were submitted in a timely manner from January 1, 2019, through June 30, 2019, for SCR BHO and provider data effective through December 31, 2018.
- SCR BHO providers utilized the Raintree system for BHO-required data entry and electronic data interchange (EDI) purposes only. SCR BHO providers had their own electronic health record (EHR) or data systems for storing their specific provider data for clinical and data collection

purposes, and the SCRBHO providers were not reliant on the Raintree system for storing provider data and clinical documentation for provider purposes.

- SCRBHO was to develop a plan for identifying necessary records and ensuring secure maintenance, secure transport, and storage of physical records. SCRBHO had contracted with an archiving vendor for both hard copy and electronic data storage and planned to work with these vendors to ensure SCRBHO's contract-required storage and archiving requirements were met.
- SCRBHO was to arrange and complete the contract and HIPAA compliance purging or de-identification of all SCRBHO data, after being properly stored and archived, from the Raintree SCRBHO database and CSHCD data warehouse database, upon completion of necessary use no later than June 30, 2019.

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Great Rivers Behavioral Health Organization (GRBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score		
Enrollee Rights and Protections	●		
Grievance System	●		
Certifications and Program Integrity	●		
Strengths		Opportunities for Improvement	
<p>GRBHO makes provider information available on its website, including specialties, languages spoken, and whether the provider is accepting new clients. Provider entries also include whether the provider site meets ADA accessibility standards.</p> <p>GRBHO has provided more than 50 trainings for its contracted BHAs, including training on the grievance and appeal process.</p> <p>The BHO's website provides instruction for reporting suspected cases of fraud, waste, or abuse to the BHO or the State.</p>		<p>GRBHO requires its BHAs to post enrollee information, including rights and responsibilities, in their lobbies. However, on one on-site walkthrough of a network provider, EQR reviewers noted that enrollee rights and responsibilities were not located in the public area/lobby but in a hallway only accessible to enrollees who are accompanied by a member of the provider staff. This specific agency resolved this issue, but GRBHO should verify that all of its BHAs have enrollee rights posted in their agency lobbies where they are visible to all enrollees.</p> <p>GRBHO indicated that the Grievance and Critical Incident Review Committee has not met in six months. GRBHO should ensure this committee meets on a regular schedule.</p>	
Performance Improvement Projects			
Children's Clinical PIP	Score	Strengths	Recommendations
Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs	●	This PIP addresses children and youth GRBHO identified as high need and high risk. This study topic is intended to address children who are receiving intensive Medicaid-funded services. The intervention focuses on improving functional outcomes as measured by improvement in needs and strengths during the initial phases of participation in WISe services.	N/A
SUD Non-Clinical PIP			
Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Treatment Services	●	This study topic is intended to increase grievance reporting and resolution, which is a right of enrollees receiving Medicaid behavioral health services and is a key aspect of enrollee care. This PIP also addresses a high-risk population.	N/A
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	1		1
Coordination and Continuity of Care	2		2
Encounter Data Validation	1		0
Scoring Key: Fully Met ● Partially Met ◎ Not Met ○			

Salish Behavioral Health Organization (SBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score		
Enrollee Rights and Protections	⊙		
Grievance System	⊙		
Certifications and Program Integrity	⊙		
Strengths		Recommendations	
<p>SBHO analyzes its network for prevalent spoken languages by aggregating and reviewing the native encounter transactions submitted by the BHAs, which include each enrollee’s preferred language.</p> <p>SBHO reviews its BHAs’ clinical record documentation to verify that providers have shared information on available treatment options and alternatives with enrollees in a manner appropriate to each enrollee’s condition and ability to understand.</p> <p>SBHO has provided numerous trainings on the grievance system to its SUD treatment providers through Quality Improvement Committee (QUIC) meetings and provides individualized technical assistance upon request.</p>		<p>Review of two BHAs’ clinical records indicated that enrollees who turned 18 years of age while in services were not informed of medical advance directives and/or mental health advance directives. SBHO needs to inform and monitor the BHAs to ensure they discuss advance directives with enrollees who turn 18 while in services to ensure those enrollees receive this information.</p> <p>SBHO’s policy on conflict of interest and the BHO’s administrative tool do not include how often the conflict of interest disclosure form needs to be reviewed and attested to by BHO staff and volunteers, BHA staff, and the BHO’s governing board. Conflict of interest disclosure forms should be reviewed and attested to annually. SBHO needs to include in both its policy on conflict of interest and administrative tool the timeframe in which all BHO and BHA staff and volunteers and the governing board need to review and attest to the conflict of interest disclosure form.</p>	
Performance Improvement Projects			
Clinical PIP	Score	Strengths	Recommendations
Increasing Child and Family Team Meetings among High-Risk, High-Cost, and High-Need Children Served by the Mental Health System	●	Since the inception of this PIP, SBHO has made great strides in collecting data, adjusting the intervention (including additional updated training for the BHAs), and implementing appropriate improvement strategies.	N/A
SUD PIP			
Improving Implementation of the Grievance System among SUD Treatment Providers	●	The BHO’s data collection principles and concepts are sound, and SBHO has assessed what data is needed and developed a data inventory to ensure all relevant data can be captured.	N/A
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	1		1
Provider Selection	3		3
Practice Guidelines	1		1
Health Information Systems	2		2
Quality Assessment and Performance Improvement Program	1		1
Encounter Data Validation	1		1
Scoring Key: Fully Met ● Partially Met ⊙ Not Met ○			

Thurston-Mason Behavioral Health Organization (TMBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score		
Enrollee Rights and Protections	⊙		
Grievance System	⊙		
Certifications and Program Integrity	⊙		
Strengths		Recommendations	
<p>TMBHO’s Ombud regularly visits the network BHAs to provide information and answer questions for enrollees on mental health advance directives.</p> <p>TMBHO submits to each of its BHAs a well-written and thorough report summarizing the observations and findings noted during its administrative reviews.</p> <p>In 2013, TMRSN (now TMBHO) purchased a braille machine to translate materials for its visually impaired consumers. The BHO notified its BHAs that this device was available upon request, and during the past year, the BHO received numerous requests for materials translated using the braille machine.</p>		<p>TMBHO stated that it monitors the BHAs for grievance record retention during its administrative review; however, the BHO also indicated that it has not completed monitoring for all of its BHAs for several years. TMBHO needs to consistently monitor all of its BHAs for the retention of grievance records.</p> <p>TMBHO stated that BHAs receive training on the grievance system during Quality Management meetings; however, the BHO has not held a Quality Management meeting since March 2017. TMBHO needs to reinstate its Quality Management meetings to ensure a coordinated process for quality management is in place as well as to ensure BHAs receive continual training on the grievance process.</p>	
Performance Improvement Projects			
Clinical PIP	Score	Strengths	Recommendations
Implementing CANS at BHR to Improve Treatment Planning and Clinical Outcomes	NA	Overall, utilization of a core assessment tool is essential to an organization’s effective and sustainable service provision.	N/A
SUD PIP			
Increasing Concurrent and Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees	●	This PIP focuses on key aspects of enrollee care and services. The topic touches on access to care, coordination of care, and healthcare integration for individuals who are high risk and high need.	N/A
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	4		3
Coordination and Continuity of Care	5		4
Coverage and Authorization of Services	4		1
Provider Selection	3		2
Practice Guidelines	1		0
Quality Assessment and Performance Improvement Program	1		0
Encounter Data Validation	1		1
Information Systems Capabilities Assessment	4		3
Scoring Key: Fully Met ● Partially Met ⊙ Not Met ○			

Greater Columbia Behavioral Health Organization (GCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score*		
Enrollee Rights and Protections	NS		
Grievance System	NS		
Certifications and Program Integrity	NS		
Strengths		Recommendations	
<p>In order to ensure that enrollee input drives the treatment planning process, the BHAs are required to document in the clinical record the enrollee’s understanding of the process verbatim and obtain the enrollee’s signature approving the treatment plan.</p> <p>GCBHO requires a stricter timeline for grievance resolutions than what State and federal regulations require. GCBHO policy <i>Consumer Grievances</i> requires network providers to resolve grievances as quickly as possible, but not to exceed 30 days.</p> <p>GRBHO’s compliance officer provides training to the BHO’s staff, the BHAs, and its governing board using a PowerPoint presentation that is very informative and includes all aspects of compliance, including fraud and abuse.</p>		<p>Although the BHO performed administrative BHA audits during the past year, including monitoring to verify that enrollee rights documents were posted in all BHA lobbies, Qualis Health’s walkthrough at a provider site found that the posted enrollee rights were out of date. In the future, the MCOs will need to ensure that the BHAs are posting and informing enrollees of the most current enrollee rights.</p> <p>The BHO expressed concerns that after it closes operations, the MCOs will not support the BHAs by providing technical assistance on compliance or fraud, waste, and abuse. After the transition, the MCOs will need to develop and implement a mechanism for reviewing and monitoring the BHAs’ compliance and program integrity programs.</p>	
Performance Improvement Projects			
Clinical PIP	Score	Strengths	Weaknesses
Promoting Medication Adherence in Youth	○	NA	This PIP has been in a nascent stage for a few years with no forward progression.
SUD PIP			
Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs	○	N/A	This PIP has been in its beginning stages for a few years with no forward progression.
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	4		1
Coordination and Continuity of Care	2		0
Coverage and Authorization of Services	1		0
Subcontractual Relationships and Delegation	1		0
Health Information Systems	1		0
Quality Assessment and Performance Improvement Program	2		1
Encounter Data Validation	1		0
Information Systems Capabilities Assessment	2		1
Scoring Key: Fully Met ● Partially Met ◎ Not Met ○			

*This section was not scored

King County Behavioral Health Organization (KCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score*		
Enrollee Rights and Protections	NS		
Grievance System	NS		
Certifications and Program Integrity	NS		
Strengths		Recommendations to the State	
<p>KCBHO provided a training this August to its coordinated care and recovery staff on standards for answering customer service calls regarding client rights.</p> <p>KCBHO monitors the BHAs to ensure consumer voice is present in the treatment planning process via contract compliance audits, review of BHO- and BHA-level grievances, and review of client surveys.</p> <p>KCBHO ensures that grievances that are submitted through the BHO and promptly resolved the same day are recorded and tracked.</p>		<p>The BHO expressed concern regarding how the BHAs will effectively submit data to more than one MCO given many of the SUD treatment BHAs continue to need technical assistance in order to submit truthful, accurate, and timely data. After KCBHO closes operations, the BHAs will continue to need monitoring and technical assistance to ensure that all submitted encounter data are truthful, accurate, and timely. MCO- and EQRO-conducted encounter data validation record reviews would help to identify continued needs and educational opportunities as well as any cases of fraud, waste, or abuse.</p>	
Performance Improvement Projects			
Clinical PIP	Score	Strengths	Recommendations
Improved Coordination with Primary Care for Children and Youth	●	KCBHO selected this PIP through a comprehensive process, which involved discussions with numerous stakeholders as well as review of acute care utilization for children and youth continuously enrolled in outpatient, crisis, or hospital BHO services.	N/A
SUD PIP			
SUD Treatment Patient Engagement	●	This PIP is consistent with the demographics and epidemiology of the enrollees in the BHO's service region.	N/A
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	4		3
Coordination and Continuity of Care	5		2
Provider Selection	2		2
Subcontractual Relationships and Delegation	2		2
Practice Guidelines	1		1
Health Information Systems	2		2
Quality Assessment and Performance Improvement Program	1		1
PIP Validation	1		1
Encounter Data Validation	5		1
Information Systems Capabilities Assessment	2		1
Scoring Key: Fully Met ● Partially Met ◎ Not Met ○			

*This section was not scored

North Sound Behavioral Health Organization (NSBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score*		
Enrollee Rights and Protections	NS		
Grievance System	NS		
Certifications and Program Integrity	NS		
Strengths		Recommendations to the State	
<p>NSBHO’s advisory committee reviews all written enrollee materials, including policies and procedures, for format and ease of understanding.</p> <p>To determine whether the BHAs treat their clients with respect, dignity, and consideration of privacy, NSBHO conducts on-site reviews and reviews enrollee surveys and grievances.</p> <p>NSBHO’s Internal Quality Management Committee includes a chemical dependency professional to assist in reviewing concerns related to substance use disorders.</p>		<p>Currently, the BHO provides the BHAs with information regarding how to provide enrollees with interpreter services. After NSBHO closes operations, the MCOs will need to provide information to the BHAs on how to provide interpreter services to their clients.</p> <p>The BHO expressed concerns that after it closes operations, the MCOs will not support the BHAs by providing technical assistance on compliance or fraud, waste, and abuse. After the transition, the MCOs need to develop and implement a mechanism for reviewing and monitoring the BHAs’ compliance and program integrity programs.</p>	
Performance Improvement Projects			
Clinical PIP	Score	Strengths	Recommendations
EPSDT and the Effects of Care Coordination on Level of Care	●	NSBHO recognizes that EPSDT is relevant for a significant portion of the BHO’s child population. Thus, this PIP impacts a growing portion of NSBHO’s population and targets enrollees who are in need of coordinated care.	N/A
SUD PIP			
SUD Golden Thread	●	The BHO has made great strides to ensure baseline data support the fact that an issue truly exists. The BHO should continue to focus on ensuring a correlation is made between the data obtained from these reviews and how they relate to overall enrollee care.	N/A
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	5		2
Coordination and Continuity of Care	3		1
Provider Selection	3		3
Quality Assessment and Performance Improvement Program	2		2
Information Systems Capabilities Assessment	1		1
Encounter Data Validation	1		0
Scoring Key: Fully Met ● Partially Met ◎ Not Met ○			

*This section was not scored

Optum Pierce Behavioral Health Organization (OPBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score*		
Enrollee Rights and Protections	NS		
Grievance System	NS		
Certifications and Program Integrity	NS		
Strengths		Recommendations	
<p>OPBHO’s standard timeline for outpatient authorizations is 24 hours and for inpatient authorizations 2 hours, regardless of whether the authorization is standard or expedited.</p> <p>After a grievance is resolved, OPBHO requests that the involved enrollee complete a survey, in order to gain feedback on the enrollee’s satisfaction with the grievance process.</p> <p>OPBHO requires its employees to complete a Relias training on enrollee rights, privacy practices, compliance and program integrity, cultural competency, and the grievance system upon hire and annually thereafter.</p>		<p>OPBHO requires contracted BHAs to submit a compliance plan annually; however, all of the BHAs do not have a compliance plan in place, and the BHO has not issued formal corrective action to those BHAs. Once the BHAs begin contracting with the MCOs, the MCOs will need to ensure that all providers have a compliance plan that includes the seven essential elements of a compliance program and plan.</p> <p>OPBHO conducts risk assessments for the BHAs at the time of contract initiation or renewal, rather than requiring the BHAs to conduct their own risk assessments. Once the BHAs begin contracting with the MCOs, the MCOs will need to ensure the BHAs are performing annual risk assessments.</p>	
Performance Improvement Projects			
Clinical PIP	Score	Strengths	Recommendations
Increasing the Use of Natural Supports in WISE	●	OPBHO has demonstrated a substantial amount of work and effort regarding WISE and the full implementation of this program. The PIP’s focus on improving CANS assessment scores over time, specifically the 2s and 3s in one key domain, will result in improved overall service delivery.	N/A
SUD PIP			
The Use of the GAIN-SS in a Clinical Referral for Mental Health Services	●	OPBHO’s study topic could potentially yield system improvement as well as improvement in overall enrollee care, as traditionally the mental health and substance use disorder treatment systems have tended to operate independently without much coordination, leading to gaps in care and service delivery.	N/A
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	2		2
Coordination and Continuity of Care	2		1
Provider Selection	4		4
Practice Guidelines	4		4
Quality Assessment and Performance Improvement Program	1		1
Encounter Data Validation	1		1
Information Systems Capabilities Assessment	1		1
Scoring Key: Fully Met ● Partially Met ◎ Not Met ○			

*This section was not scored

Spokane County Regional Behavioral Health Organization (SCRBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	Score*		
Enrollee Rights and Protections	NS		
Grievance System	NS		
Certifications and Program Integrity	NS		
Strengths		Recommendations to the State	
<p>SCRBHO created a PowerPoint training on enrollee rights and nondiscrimination for all SCRBHO staff. The training includes a quiz, which all staff must complete and print, and which is stored with employee files to document participation in the training.</p> <p>SCRBHO's policy and contracts cite the provider requirement to collaborate with enrollees on developing an individual service plan based on each enrollee's needs and strengths.</p> <p>The BHO also completes an annual facility and personnel monitoring review and a random selection of BHA personnel files to verify that background checks have occurred.</p>		<p>SCRBHO is concerned that its interpreter services vendor will not be providing telephone interpreter services for crisis services after behavioral health service administration is transferred to the MCOs. After the transition, the State needs to ensure that all enrollees, especially people in crisis, have access to telephone interpreter services at no cost to the enrollee.</p> <p>SCRBHO currently monitors BHAs to ensure conflict of interest attestations are reviewed and completed annually. After behavioral health service administration is transferred to the MCOs, MCOs will need to develop a mechanism to monitor the BHAs for this requirement.</p>	
Performance Improvement Projects			
Clinical PIP	Score	Strengths	Recommendations
Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs	●	The BHO has conducted a thorough and comprehensive analysis that assessed the needs of enrollees who are receiving WISE services. The BHO has articulated how this PIP will address significant aspects of enrollee care by changing how providers employ intervention strategies from reactionary to a more responsive approach.	N/A
SUD PIP			
Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Treatment Services	●	The BHO's revised approach still features a strong emphasis on increasing service intensity and care coordination while an enrollee waits for a residential placement to help an enrollee achieve or maintain treatment gains to support overall recovery.	N/A
Previous-Year Corrective Action Plans			
Section	Number of CAPs		Number Resolved
Availability of Services	1		1
Coordination and Continuity of Care	2		2
Provider Selection	2		2
Subcontractual Relationships and Delegation	1		1
Quality Assessment and Performance Improvement Program	1		1
Encounter Data Validation	1		1
Scoring Key: Fully Met ● Partially Met ◎ Not Met ○			

*This section was not scored

Appendix C: Acronyms

AHAC	Apple Health Adult Coverage
AHFC	Apple Health Foster Care
AHRQ	Agency for Healthcare Research and Quality
AMG	Amerigroup Washington, Inc.
ASAM	American Society of Addiction Medicine
ASO	Administrative Services Organization
BHA	Behavioral Health Agency
BHDS	Behavioral Health Data System
BHO	Behavioral Health Organization
BHSO	Behavioral Health Services Only
CANS	Child and Adolescent Needs and Strengths
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCW	Coordinated Care of Washington
CHIP	Children's Health Insurance Program
CHPW	Community Health Plan of Washington
CFR	Code of Federal Regulations
CLIP	Children's Long-term Inpatient Program
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DBHR	Division of Behavioral Health and Recovery
DSHS	Department of Social and Health Services
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
GCBHO	Greater Columbia Behavioral Health Organization
GRBHO	Great Rivers Behavioral Health Organization
HCA	Health Care Authority
HEDIS	Healthcare Effectiveness Data and Information Set
IMC	Integrated Managed Care
ISCA	Information Systems Capabilities Assessment
KCBHO	King County Behavioral Health Organization
MCO	Managed Care Organization
MHW	Molina Healthcare of Washington
NCQA	National Committee for Quality Assurance
NSBHO	North Sound Behavioral Health Organization
OPBHO	Optum Pierce Behavioral Health Organization
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QRT	Quality Review Team
RY	Reporting Year
SBHO	Salish Behavioral Health Organization
SCRBHO	Spokane Regional Behavioral Health Organization

SERI	Service Encounter Reporting Instructions
SUD	Substance Use Disorder
TMBHO	Thurston-Mason Behavioral Health Organization
UHC	United Healthcare Community Plan
WAC	Washington Administrative Code
WISe	Wraparound with Intensive Services

Appendix D: PIP Review Procedures

HCA PIP Review Procedure

As part of its overall compliance review of Apple Health MCOs, HCA conducts a review of performance improvement projects (PIPs). (Qualis Health conducts its own review of PIPs for the Behavioral Health Organizations [BHOs], which follows.) HCA's review process and scoring methods for evaluating PIPs are outlined below.

Part A: Assessing the Study Methodology

1: Review the Selected Study Topic(s)

- a) Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?
- b) Is the PIP consistent with the demographics and epidemiology of the enrollees?
- c) Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?
- d) Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc)?
- e) Did the PIP, over time, include all enrolled populations (i.e., special healthcare needs)?

2: Review the Study Question(s)

- a) Was/were the study question(s) stated clearly in writing?

3: Review Selected Study Indicator(s)

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

4: Review the Identified Study Population

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

5: Review Sampling Methods

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

6: Review Data Collection Procedures

- a) Did the study design clearly specify the data to be collected?
- b) Did the study design clearly specify the sources of the data?

- c) Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?
- d) Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?
- e) Did the study design prospectively specify a data analysis plan?
- f) Were qualified staff and personnel used to collect the data?

7: Assess Improvement Strategies

- a) Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes?
- b) Are the interventions sufficient to be expected to improve processes or outcomes?
- c) Are the interventions culturally and linguistically appropriate?

8: Review Data Analysis and Interpretation of Study Results

- a) Was an analysis of the findings performed according to the data analysis plan?
- b) Were numerical PIP results and findings accurately and clearly presented?
- c) Did the analysis identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?
- d) Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?

9: Assess Whether Improvement is “Real” Improvement

- a) Was the same methodology as the baseline measurement used when measurement was repeated?
- b) Was there any documented, quantitative improvement in processes or outcomes of care?
- c) Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?
- d) Is there any statistical evidence that any observed performance improvement is true improvement?

10: Assess Sustained Improvement

- a) Was sustained improvement demonstrated through repeated measurements over comparable time periods?

Part B: Verifying Study Findings (optional)

Were the initial study findings verified upon repeat measurement?

Part C: Evaluate Overall Validity and Reliability of Study Results

Indicate one of the following regarding the results of the MCO's PIP.

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

PIP Scoring

TEAMonitor scored the MCOs' PIPs as Met, Partially Met or Not Met according to how well they performed against a checklist of elements designed to measure success in meeting the standards specified by CMS. The elements associated with the respective scores follow.

To achieve a score of Met, the PIP must demonstrate all of the following 12 elements:

- A problem or need for Medicaid enrollees reflected in the topic of the PIP.
- The study question(s) stated in writing.
- Relevant quantitative or qualitative measurable indicators documented.
- Descriptions of the eligible population to whom the study questions and identified indicators apply
- A sampling method documented and determined prior to data collection
- The study design and data analysis plan proactively defined
- Specific interventions undertaken to address causes/barriers identified through data analysis and QI processes (e.g., barrier analysis, focus groups, etc.)
- Numerical results reported (e.g., numerator and denominator data)
- Interpretation and analysis of the reported results
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change
- Sustained improvement demonstrated through repeat measurements over time (baseline and at least two follow-up measurements required)
- Linkage or alignment between the following: data analysis documenting need for improvement, study questions, selected clinical or nonclinical measures or indicators, results

To achieve a score of Partially Met, the PIP must demonstrate all of the following 7 elements:

- A problem or need for Medicaid enrollees reflected in the topic of the PIP.
- The study question(s) stated in writing.
- Relevant quantitative or qualitative measurable indicators documented.
- A sampling method documented and determined prior to data collection
- The study design and data analysis plan proactively defined
- Numerical results reported (e.g., numerator and denominator data)
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change

To receive a score of Not Met, the PIP must fail to demonstrate any 1 of the following elements:

- A problem or need for enrollees not reflected in the topic of the PIP
- Study questions not stated in writing
- Relevant quantitative or qualitative measurable indicators not documented
- A sampling method not documented or determined prior to data collection
- Study design and data analysis plan not proactively defined
- Numerical results, e.g., numerator and denominator data, not reported
- Consistent measurement methods not used over time without rationale provided in the case of change in measurement methods

Qualis Health PIP Review Procedure

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

Qualis Health evaluates PIP design and implementation based on documents provided by the BHO and information received through BHO staff interviews using the ten-step process outlined in "EQR Protocol 3: Validating Performance Improvement Projects, Version 2.0" developed by the Centers for Medicare & Medicaid Services (CMS). The ten steps are outlined below.

Step 1: Review the Selected Study Topic(s)

- 1.1) Was the study topic chosen through a comprehensive process that involved data collection and analysis of enrollee needs, care and services?
- 1.2) Is the PIP consistent with enrollee demographics and health risks?
- 1.3) Was input from enrollees, family members, peers and/or advocates considered during the selection of the PIP?
- 1.4) Does the PIP address a broad spectrum of key aspects of enrollee care and services (e.g., access, timeliness, preventative, chronic, acute, coordination of care, inpatient, high need, high risk, etc.)?

Step 2: Review the Study Question(s)

- 2.1) Is the study question clear, concise and answerable?
- 2.2) Does the study question set the framework for goals, data collection, analysis and interpretation?
- 2.3) Does the study question include the intervention, the study population (denominator), what is being measured (numerator), a metric (percentage or average) and a desired outcome?

Step 3: Review the Identified Study Populations

- 3.1) Is the specific enrollee population clearly defined?
- 3.2) If there is an inclusion or exclusion criterion, is it clearly defined?
- 3.3) Is the study population reflective of the entire Medicaid enrollee population to which the study indicator applies? Or is a sample used?
- 3.4) Did data collection approaches ensure that all required information was captured for all enrollees to whom the study question applied?

Step 4: Review Selected Study Indicator(s)

- 4.1) Is there a clear description of the study indicator(s)? Are the numerator and denominator clearly defined?
- 4.2) Is there an explanation of how the indicators are appropriate and adequate to answer the study question? Does it describe how the indicator objectively measures change to impact the enrollee?
- 4.3) Is there a clear and realistic plan that includes where and how the data on the indicator is collected? Are all the elements of the data collection plan in place and viable? Are there mitigation strategies in case sufficient data is not able to be collected?

4.4) Are the baseline and first and second re-measurement periods unambiguously stated and appropriate in length?

Step 5: Review Sampling Methods

5.1) Is the method for defining and calculating the sample size clearly stated? Is the true and estimated frequency of the event considered and specified? Is the confidence level plainly stated? Is the acceptable margin of error given?

5.2) Is the sampling technique specified? Is it specified whether the sample is a probability or non-probability sample?

5.3) Are valid sampling techniques employed to protect against bias?

5.4) Does the sample contain a sufficient number of enrollees?

Step 6: Review Data Collection Procedures

6.1) Does the study design clearly specify the data to be collected?

6.2) Does the study design clearly specify the sources of data?

6.3) Is there a description of the data collection methods used that includes the types of data collected, an explanation of how the methods elicit valid and reliable data, the intervals at which the data will be collected and, if HEDIS or other formal methodology is used, a description of the process?

6.4) Is there a description of the instruments used for data collection? Did the description include a narrative regarding how the instrument provided consistent and accurate data collection over the time periods studied? Was any additional documentation that was requested provided and appropriate?

6.5) Does the study say who will be collecting the data? Are the individuals collecting the data qualified to collect the data, and, if so, are their qualifications included?

6.6) Is there a description of how inter-rater reliability is ensured?

Step 7: Review Data Analysis and Interpretation of Study Results

7.1) Is there a clear description of the data analysis plan that includes the type of statistical analysis used and the confidence level (e.g., chi-square test with significance level set at $p < .05$)? Was analysis performed according to plan? (This includes having a sufficient amount data to analyze for the analysis to be meaningful.)

7.2) Are numerical PIP results and findings accurately and clearly presented?

7.3) Is the data analysis methodology appropriate to the study question and data types?

7.4) Did the analysis identify statistical significance of any differences between the initial and repeat measurements? Was the analysis performed correctly?

7.5) Did the analysis identify threats to internal or external validity?

7.6) Does the analysis include an interpretation of the PIP's success, statistically significant or otherwise? Is there a description of any follow-up activities as a result?

Step 8: Assess Improvement Strategies

8.1) Were steps taken to identify improvement opportunities during the PIP process (e.g., root cause analysis, data analysis and other quality improvement [QI] activities)?

8.2) Were interventions taken to address causes/barriers identified through analysis and QI activities?

8.3) Are the interventions sufficient that an improvement in the processes or outcomes could be expected?

8.4) Are the interventions culturally and linguistically appropriate?

Step 9: Assess Whether Improvement is “Real” Improvement

9.1) Was the same methodology used for data collection at baseline and repeat measurements?

9.2) Is there a description of the data analysis regarding improvements in process or outcomes of care?

9.3) Is there an evaluation demonstrating that improvement appears to be the result of the intervention? Or an analysis related to why there was not improvement?

9.4) Is there any statistical evidence that any observed improvement is true improvement? Was statistical analysis performed thoroughly and accurately?

Step 10: Assess Sustained Improvement

10.1) Was sustained improvement demonstrated through repeated measurements over comparable periods of time? If improvement was not sustained, was there an explanation? Is there a plan for next steps?

PIP Scoring

Qualis Health assigns a score of “Fully Met,” “Partially Met” or “Not Met” to each of the 10 evaluation components applicable to the performance improvement project being evaluated. Components may be “Not Applicable” if the performance improvement project is at an early stage of implementation. Components determined to be “Not Applicable” are not reviewed and are not included in the final scoring. Scoring is based on the answers to the questions listed under each evaluation component as determined by Qualis Health reviewers, following a review of written documentation and in-person interviews.

Fully Met means 100 percent of the required documentation under a protocol step, or component thereof, is present.

Partially Met means at least 50 percent, but not all, of the required documentation under a protocol step, or component thereof, is present.

Not Met means less than 50 percent of the required documentation under a protocol step, or component thereof, is present.

Once Qualis Health assigns a final score to the performance improvement project, an assessment is made to determine the validity and reliability of the reported results for projects that have progressed to at least a first re-measurement of the study indicator. For performance improvement projects that have not progressed to at least a first re-measurement period, the assessment will conclude that “Not enough time has elapsed to assess meaningful change.” Because determining potential issues with the validity and reliability of the study design is sometimes a judgment call, Qualis Health reports one of the following levels of confidence in the study findings based on a global assessment of study design, development and implementation:

- High confidence in reported results
- Moderate confidence in reported results
- Low confidence in reported results
- Not enough time has elapsed to assess meaningful change

“High confidence in reported results” means the study results are based on high-quality study design and data collection and analysis procedures. The study results are clearly valid and reliable.

“Moderate confidence in reported results” means the study design and data collection and analysis procedures are not of sufficient quality to warrant a higher level of confidence. Study weaknesses (e.g., threats to internal or external validity, barriers to implementation, questionable study methodology) are identified that may impact the validity and reliability of reported results.

“Low confidence in reported results” means the study design and/or data collection and analysis procedures are unlikely to result in valid and reliable study results.

“Not enough time has elapsed to assess meaningful change” means a performance improvement project has not progressed to at least the first re-measurement of the study indicator.

Appendix E: Regulatory and Contractual Requirements

The following is a list of the access, quality and timeliness elements cited in the Code of Federal Regulations (CFR) that MCOs and BHOs are required to meet. These standards, along with State contractual requirements specific to physical or mental health care, serve as the basis for the MCO and BHO compliance reviews.

438.206 Availability of Services

438.206 Availability of Services (b)(1)(i-v) Delivery network and 438.207(b)(1)(2) Assurances of adequate capacity and services

438.206 Availability of Services (b)(2) Direct access to a women's health specialist

438.206 Availability of Services (b)(3) Provides for a second opinion

438.206 Availability of Services (b)(4) Services out of network

438.206 Availability of Services (b)(5) Out of network payment

438.206(c) Furnishing of Services

438.206(c) Furnishing of Services (1)(i) through (vi) Timely access

438.206(c) Furnishing of Services (2) Cultural considerations

438.608/455 Program Integrity Requirements (Fraud and Abuse)

438.608(a)(b) Program integrity requirements

455.104 Disclosure of ownership and control

455.23 Provider Payment Suspension

Apple Health Contract

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

447.46 Timely Claims Payment by MCOs

447.46 Timely claims payment

Apple Health Contract

- Coordination of benefits – Apple Health contract
- Coordination of benefits – provider agreements
- Coordination of benefits – data
- Coordination of benefits – reports

438.208 Coordination & Continuity of Care

438.208 Continuity of care

438.208(b) Primary care and coordination of healthcare services

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

438.208(c)(1) Identification

438.208(c)(2) Assessment

438.208(c)(3) Treatment plans

438.208(c)(4) Direct access to specialists

438.240(b)(4) Care coordination oversight

Apple Health Contract

- Care coordination for individuals with special health care needs
- Transitional care
- Coordination between the contractor and external entities
- Skilled nursing facility coordination
- Care coordination with Behavioral Health Organizations (BHOs)

438.210 Coverage and Authorization of Services

- 438.210(b)(1)(2)(3) Authorization of services
 438.210(c) Notice of adverse benefit determination
 438.210(d) Timeframe for decisions (1) (2)
 438.210(e) Compensation for utilization management decisions

438.114 Emergency and Post-stabilization Services

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

Apple Health Contract

- Outpatient mental health
- Second opinion for children prescribed mental health medications
- Smoking cessation
- Emergency contraceptives
- Long Acting Reversible Contraceptives (LARC)

438.56 Enrollment and Disenrollment

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

438.100 Enrollee Rights

- 438.100(a) General rule
 438.100(b)(2)(i) Specific rights - 438.10(b) Applicability (1) and (c) Basic rules
 438.100(b)(2)(i) Specific rights - 438.10 (d) Language and format (3)
 438.100(b)(2)(i) Specific rights - 438.10(d) Language and format (4) and (5) Language – oral interpretation/ written information
 438.100(b)(2)(i) Specific rights - 438.10(d)(6) Format, easily understood (i)
 438.100(b)(2)(i) Specific rights - 438.10(d)(6)
 438.100(b)(1)(i) Specific rights - 438.10(f) (2) General requirements
 438.100(b)(2)(i) Specific rights - 438.10(g) (1 - 4) Information for enrollees – Enrollee handbook
 438.100(b)(2)(i) Specific rights - 438.10(i) Information for enrollees – formulary
 438.100(b)(2) and (3) Specific rights
 438.100 Enrollee rights (b)(2)(iv) and (v) Specific rights
 438.100 Enrollee rights (b)(3) Specific rights
 438.100(d) Compliance with other federal and State laws
 438.106 Liability for payment

Apple Health Contract

- Customer service, subsection 6.6

438.228 Grievance Systems

- 438.228 Grievance systems
 438.402(a) The grievance and appeal system
 438.402(c)(1) Filing requirements – Authority to file

- 438.402(c)(2) Filing requirements – Timing
- 438.402(c)(3) Filing requirements – Procedures
- 438.404(a) Notice of action – Language and format
- 438.404(b) Notice of action – Content of notice
- 438.404(c) Notice of action – Timing of notice
- 438.406(a) Handling of grievances and appeals – General requirements
- 438.406(b) Handling of grievances and appeals – Special requirements for appeals
- 438.408(a) Resolution and notification: Grievances and appeals – Basic rule
- 438.408(b) and (c) Resolution and notification: Grievances and appeals – specific timeframes and extension of timeframes
- 438.408(d) and (e) Resolution and notification: Grievances and appeals – Format of notice and content of notice of appeal resolution
- 438.410 Expedited resolution of appeals
- 438.414 Information about the grievance system to providers and subcontractors
- 438.416 Recordkeeping and reporting requirements
- 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending
- 438.424 Effectuation of reversed appeal resolutions

438.330 Performance Improvement Projects (PIP)

- 438.330 Quality assessment and performance improvement program (a) General rules. (b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs, and 438.330 (d) Performance improvement projects
- 438.330(e) PIP program review by State

438.236 Practice Guidelines

- 438.236(a)(b) Adoption of practice guidelines
- 438.236(c) Dissemination of practice guidelines
- 438.236(d) Application of practice guidelines

438.214 Provider Selection (Credentialing)

- 438.214(a) General rules and 438.214(b) Credentialing and re-credentialing requirements
- 438.214(c) Nondiscrimination & provider discrimination prohibited
- 438.214(d) Excluded providers
- 438.214(e) Provider selection-State requirements

438.330 Quality Assessment and Performance Improvement Program

- 438.330 Quality assessment and performance improvement program (a) General rules (1)
- 438.330 Quality assessment and performance improvement program. (b) Basic elements of quality assessment and performance improvement programs. (1)(2) and (c) Performance measurement
- 438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and under utilization of services
- 438.330 Quality assessment and performance improvement program. (b) Basic elements of quality assessment and performance improvement programs. (4) Basic elements of MCO and PIHP quality assessment and performance improvement
- 438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement – evaluating the program

438.230 Sub-contractual Relationships and Delegation

- 438.230(a) General rule (b) Specific conditions (1) evaluation of subcontractor prior to delegation

- 438.230 (b)(2) Written agreement with subcontractors
- 438.230 (b)(3) Monitoring of performance of subcontractors
- 438.230 (b)(4) Corrective action of subcontractors

438.242 Health Information Systems

- 438.242 Health information systems – General rule
- 438.242 (b)(1)(2) Basic elements
- 438.242 (b)(3) Basic elements

Health Homes – Apple Health Contract

- Health Care Authority Encounter Data Reporting Guide (Administrative), Apple Health Contract Exhibit C 2.1.3
- Administrative, Apple Health Contract Exhibit C Section 3
- Administrative, Apple Health Contract Exhibit C, Section 2.3
- Administrative, Apple Health Contract 9.4.2 as related to Exhibit C
- Administrative, Apple Health Contract 9.7
- Health Action Plan (HAP), Apple Health Contract Exhibit C, 5.3, 5.5 and 5.5.7
- Comprehensive Care Management, Apple Health Contract Exhibit C, 5.6
- Care Coordination and Health Promotion, Apple Health Contract Exhibit C 5.7
- Transitional Care, Apple Health Contract Exhibit C 5.8
- Individual and Family Support, Apple Health Contract Exhibit C 5.9
- Referral to Community and Social Support Services, Apple Health Contract Exhibit C C5.10

Appendix F: 2018 Enrollee Quality Report

As a component of its external quality review work for HCA, Qualis Health produced the *2018 Enrollee Quality Report*, designed to provide Apple Health applicants and enrollees with simple, straightforward comparative health plan performance information that may assist them in selecting a plan that best meets their needs.

The data source for this report was the Healthcare Effectiveness Data and Information Set (HEDIS®). The rating method is in alignment with the star rating systems used by other states and reflects the data sources available for the Apple Health population in Washington. For more information on the methodology used to derive this report's star rating system, see the complete *2018 Enrollee Quality Report Methodology*.

2018 Washington Apple Health Plan Report Card


























This report card shows how Washington Apple Health plans compare to each other in key performance areas. You can use this report card to help guide your selection of a plan that works best for you.

KEY: Performance compared to all Apple Health plans

ABOVE AVERAGE 

AVERAGE 

BELOW AVERAGE 

Performance Areas	Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Getting Care					
Keeping Kids Healthy					
Keeping Women and Mothers Healthy					
Preventing and Managing Illness					
Ensuring Appropriate Care					

These ratings were based on information collected from health plans in 2017. The information was reviewed for accuracy by independent auditors. Health plan performance scores were not adjusted for differences in their member populations or service regions.

Performance Area Definitions

Getting Care

- Members have access to a doctor
- Members report they get the care they need, when they need it

Keeping Kids Healthy

- Children in the plan get regular checkups
- Children get important immunizations
- Children get the appropriate level of care when they are sick

Keeping Women and Mothers Healthy

- Women get important health screenings
- New and expecting mothers get the care they need

Preventing and Managing Illness

- The plan helps its members keep long-lasting illness under control, such as asthma, high blood pressure or diabetes
- The plan helps prevent illnesses with screenings and appropriate care

Ensuring Appropriate Care

- Members receive the most appropriate care and treatment for their condition