2014 External Quality Review Annual Report

Washington Apple Health
Division of Behavioral Health and Recovery
Washington Medicaid Integration Partnership

December 2014

Presented by

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Presented to the Washington Health Care Authority and the Division of Behavioral Health and Recovery

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Acronyms Used in This Report

ALOS	average length of stay
BBA	Balanced Budget Act of 1997
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CIS	Consumer Information System
CMHA	community mental health agency
CMS	Centers for Medicare & Medicaid Services
CFT	Child and Family Team
DBHR	Division of Behavioral Health and Recovery
DSHS	Department of Social & Health Services
EDV	encounter data validation
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	emergency room
FFS	fee for service
HCA	Health Care Authority
HEDIS®	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act of 1996
ISCA	Information Systems Capabilities Assessment
MCO	managed care organization
MCS	Medical Care Services program
NCQA	National Committee for Quality Assurance
PCP	primary care provider
PIP	performance improvement project
PRISM	Predictive Risk Intelligence System
QA/PI	quality assurance and performance improvement
QI	quality improvement
QM	quality management
RSN	regional support network
SERI	Service Encounter Reporting Instructions
SHCN	special health care needs
UM	utilization management
WCC	well-child care
WISe	Wraparound with Intensive Services
WMIP	Washington Medicaid Integration Partnership

Acronyms for individual RSNs and MCOs are listed on pages 17 and 67, respectively.

EXECUTIVE SUMMARY

Federal law requires each state with a Medicaid managed care program to provide for an annual, independent external quality review (EQR) of enrollees' access to care and of the quality and timeliness of care. Acumentra Health produced this annual report on behalf of the Washington Department of Social & Health Services (DSHS) and the Health Care Authority (HCA).

This report presents performance results for the 5 managed care organizations (MCOs) and 11 regional support networks (RSNs) that were contracted to provide Medicaid managed care services during 2014. HCA oversees and monitors the MCO contracts, while the Division of Behavioral Health and Recovery (DBHR), within the Behavioral Health and Service Integration Administration, oversees and monitors the RSNs.

In comparison with the 2013 annual report, the 2014 report analyzes a much more robust set of performance data for the MCOs. Also, the 2014 measures apply to a greatly expanded Medicaid population, including many thousands of enrollees who formerly received fee-for-service (FFS) care (e.g., disabled and blind SSI recipients and other adult clients). In essence, this report presents baseline data for monitoring changes in the quality of medical services delivered for the broad range of enrollees under Apple Health.

To evaluate the services delivered to Medicaid enrollees, Acumentra Health analyzed data related to a variety of performance indicators and compliance criteria.

State-level strengths

- In providing access to primary care for children and adolescents, the Apple Health MCOs significantly outperformed the U.S. average for all but one age range (25 months to 6 years). More than 97% of enrollees ages 12–24 months had a visit with a primary care practitioner during the measurement year.
- Adult Medicaid enrollees gave the Washington MCOs high marks in 2014 on the consumer satisfaction measure of How Well Doctors Communicate.
- TEAMonitor's 2014 compliance review found that the MCOs, as a group, improved their performance on nearly every regulatory and contractual standard, compared with 2013.
- Most RSNs have a strong infrastructure for serving children with behavioral health challenges through intensive outpatient treatment, providers that treat co-occurring conditions, jail diversion programs, school-based therapy, and relationships with the Developmental Disabilities Administration and substance abuse treatment providers.
- The RSNs are meeting nearly all regulatory and contractual requirements in the areas of enrollee rights and grievance systems.
- All RSNs conduct clinical record reviews to ensure the presence of consumer voice, including treatment plans, crisis plans, clinician notes, and assessments.

Recommendations

The following recommendations are intended to help HCA, DBHR, and the MCOs and RSNs continue to strengthen the foundation for excellence in Medicaid managed care, comply with federal standards, and use resources as efficiently as possible. Some of these recommendations have appeared in previous annual reports. Additional targeted recommendations appear in sections of this report devoted to specific EQR activities.

Mental health care delivered by RSNs

Quality strategy. DBHR collaborated with HCA in drafting an updated joint Quality Strategy in 2012. To date, the agencies have not yet approved the joint strategy, although DBHR has been able to implement some processes to address the goals of the 2012 draft.

- ***DBHR needs to develop, adopt, and implement a Quality Strategy that the RSNs understand and support.***

Access to care. Faced with a large increase in enrollment due to the state's Medicaid expansion, the RSNs have found it difficult to maintain and recruit adequate numbers of qualified staff to meet the contractual timelines for both intakes and follow-up appointments.

- ***DBHR needs to explore ways to facilitate training and recruitment of mental health clinicians to to meet Medicaid enrollees' access needs.***

Children's mental health. DBHR has directed all RSNs to implement the state Children's Mental Health System Principles in serving children, adolescents, and young adults with behavioral health challenges. Key components include the Wraparound with Intensive Services (WISe) program, providing comprehensive behavioral health services and supports; the Child and Adolescent Needs and Strengths assessment; and Child and Family Team meetings, an intensive outpatient service aimed at diverting children from out-of-home placements.

RSN staff interviewed by Acumentra Health said they found it difficult to retool their mental health delivery systems in an environment of constant change with regard to the state's WISe Manual, WISe program expectations, and turnover of state staff in the children's program.

- ***DBHR needs to provide clear direction and technical assistance for the RSNs as they implement the Children's Mental Health System Principles.***
- ***DBHR needs to continue to update the WISe Manual and program expectations.***

All RSNs expressed concern that the direct service staff of community partners (e.g., DSHS, juvenile justice, schools) knew little about the children's mental health principles and WISe. Most RSNs said it will take time to change the local culture of using out-of-home placement for youth with serious emotional disturbances.

- ***DBHR needs to work with the RSNs to***
  - ***develop strategies to strengthen participation by allied partners in implementing the WISe program***
  - ***continue community education and training for allied partners and their direct staff regarding the WISe program and in-home community placement with service options***
  - ***ensure that the RSNs have developed the necessary infrastructure to implement WISe successfully***

Compliance issues. The following issues were singled out in previous years' compliance reviews but still have not been addressed.

Many RSNs failed to demonstrate that their outpatient service providers observed policies and procedures regarding the use of seclusion and restraints. In general, the RSNs did not have specific procedures in place for behavior de-escalation to ensure that providers can handle volatile situations appropriately.

- ***DBHR needs to ensure that all RSNs and their contracted providers maintain and observe policies and procedures on the use of seclusion and restraint, as well as de-escalation practices.***

Many RSNs do not track requests at the provider agencies for translation or interpreter services and for written information in alternative formats, outside of claims data. Monitoring such requests can help RSNs identify potential needs associated with changes in their service populations.

- ***DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.***

Information Systems Capabilities Assessment (ISCA) follow-up. The 2013 review of DBHR's information system identified many issues related to data quality, processing, system documentation, and staffing. Since then, DBHR has made some progress in cleaning the data entered into its Consumer Information System (CIS). However, data do not pass through validity or accuracy checks in ProviderOne, the state's Medicaid management information system, to reject invalid or incomplete data upon receipt. As a result, ProviderOne continues to receive and house invalid and inaccurate data.

- ***DBHR needs to address previous state-level ISCA recommendations related to CIS and ProviderOne data quality, accuracy, and completeness.***
- ***DBHR needs to ensure that appropriate staffing resources are allocated to ensure accurate, complete, and timely processing of Medicaid data.***

The RSN ISCA follow-up reviews, which included provider agency interviews, revealed that data security practices remain inconsistent across RSNs and provider agencies. Most agencies had not implemented data security practices required by the DBHR contract.

- ***DBHR needs to monitor the RSNs to ensure that all requirements for data security are implemented at the RSN and provider agency levels.***

Eligibility verification practices are inconsistent across RSNs. Some RSNs verify enrollee eligibility before they submit encounters to DBHR; others rely solely on their provider agencies to check eligibility on ProviderOne. Some providers do not check eligibility at each visit.

- ***DBHR needs to define and communicate clear expectations for RSNs and provider agencies regarding uniform procedures and frequency for verifying enrollment and eligibility.***

Performance measure validation. Acumentra Health could not verify that DBHR calculated and reviewed the statewide performance measure of routine service within seven days of discharge from a psychiatric inpatient setting. No frozen data set was available for validation by the RSNs or by Acumentra Health.

Finding: 42 CFR §438.358 requires annual validation of performance measures for managed care entities that serve Medicaid enrollees. DBHR did not calculate and freeze the data for the performance measure of routine service within seven days of discharge from a psychiatric inpatient setting, and therefore failed to meet CMS validation requirements.

Encounter data validation (EDV). A separate performance measure requires each RSN to ensure the accuracy of encounters submitted to DBHR by conducting an annual EDV per DBHR guidelines. Acumentra Health audits and verifies each RSN's EDV process, and conducts an independent check of the RSNs' EDV results.

Overall, the RSNs have developed appropriate systems to validate encounter data. Because of the wide variety of EDV procedures and results, this performance measure partially complies with CMS requirements.

Acumentra Health's EDV found that overall agreement between the enrollee chart data and the state's encounter data set was lower than required by the DBHR contract. The matching rate for service duration was only 52.5%, attributable to conversions performed during data processing in ProviderOne. If the data sent to CMS from ProviderOne contain the errors that Acumentra Health detected, DBHR could be at risk of recoupment of program dollars by CMS.

- ***DBHR needs to require the RSNs to report only units of service, or DSHS needs to modify ProviderOne to accept minutes of service.***

Physical health care delivered by MCOs

Clinical performance measures. The Apple Health MCOs continue to underperform on many HEDIS measures of clinical services for both child and adult enrollees, relative to national Medicaid benchmarks.

- ***HCA should designate incentive measures for which MCOs can receive quality incentive payments for top performance.***
- ***HCA should continue to provide supplemental data on Early and Periodic Screening, Diagnosis, and Treatment to assist the MCOs in calculating HEDIS well-child measures.***
- ***HCA should seek to align performance measures with other state and federal reporting requirements to reduce burden on providers and promote efficient use of health care resources.***
- ***HCA should consider adding a contract requirement for the MCOs to provide HEDIS-specific performance feedback to clinics and providers on a frequent and regular schedule.***

Consumer satisfaction. CAHPS scores for 2014 revealed that the MCOs, as a group, performed poorly in meeting adult enrollees' expectations for high-quality care. Ratings of the MCOs' customer service and several other measures of consumer satisfaction were below the 50th percentile of satisfaction scores nationally.

- ***MCOs need to assist providers in examining and improving their abilities to manage patient demand. As an example, MCOs can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments to increase physician availability.***
- ***MCOs need to identify and eliminate access barriers that prevent patients from obtaining necessary and timely care, locating a personal doctor, and receiving adequate assistance when calling a physician office.***
- ***MCOs should explore additional methods for obtaining direct patient feedback on services, such as by developing comment cards for enrollees to fill out after a physician office visit.***

Technical assistance.

- ***During 2015, HCA should sponsor formal training for all MCOs on care transitions and coordination, program integrity, and access issues, to assist the MCOs in meeting related contractual and regulatory requirements.***
- ***HCA should encourage MCOs with emerging best practices to share those practices at the regularly scheduled joint MCO/RSN quality meetings, in order to reduce performance gaps among MCOs for specific measures.***

Data quality and completeness. In 2015, the MCOs will be required to submit member-level HEDIS data to HCA or to the EQRO for analysis. Prior review of MCOs' data files revealed missing or incomplete data fields that limited analysis.

- ***HCA should help MCOs overcome barriers to collecting complete member-level encounter data, including race/ethnicity data, so that the MCOs can use these data to assess resources for improving the quality of care and establish appropriate interventions to address health care disparities.***

INTRODUCTION

Washington's Medicaid program provides medical benefits for more than 1.1 million low-income residents, about 800,000 of whom are enrolled in managed care. About 1.1 million Washingtonians are enrolled in managed mental health care services.

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

EQR requirements

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

Information in this report was collected from MCOs and RSNs through review activities based on protocols of the Centers for Medicare & Medicaid Services (CMS):

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

For the MCOs, HCA monitors compliance and validates PIPs through TEAMonitor, a state interagency review team. For the RSNs, Acumentra Health monitors compliance, validates PIPs and mental health performance measures, and conducts the ISCA.

In 2014, Acumentra Health also conducted an encounter data validation activity and a focused review of clinical records for the RSNs, as directed by DBHR.

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

Washington's Medicaid managed care programs

The Washington Medicaid program traditionally provided managed medical care for children, mothers, and pregnant women. Since July 1, 2012, HCA has expanded managed care enrollment substantially by adding disabled and blind SSI recipients and other new client populations. The net effect has been a major shift toward new adult enrollment.

As of January 1, 2014, all populations served by Washington Medicaid, including many thousands

of newly eligible enrollees authorized by the federal Affordable Care Act, were rolled up under Apple Health. This program serves people ages 19–65 with annual incomes up to 138% of the Federal Poverty Level ($16,105 for an individual, $27,310 for a family of three).

Washington Medicaid Integration Partnership (WMIP)

This project, serving adult residents of Snohomish County with complex health care needs, began in January 2005 and ended June 30, 2014, with the inclusion of the blind and disabled population into managed care and mental health parity. Contracted to Molina Healthcare of Washington (MHW), the WMIP sought to demonstrate coordination of Medicaid-funded medical, mental health, substance abuse, and long-term care within a patient-centered model.

State quality improvement activities

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

Managed care quality strategy

42 CFR §438.202 requires each state contracting with managed care entities to have a written strategy for assessing and improving the quality of managed care services. The state must conduct periodic reviews to evaluate the effectiveness of the strategy, and must update the strategy periodically, as needed.

HCA and DBHR collaborated in drafting an updated joint quality strategy in 2012. At the time of this review, the agencies had not yet approved the joint strategy.

Performance improvement projects

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

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

The current HCA contract requires each MCO to conduct at least one clinical and one nonclinical PIP. The MCO may choose the topic of its clinical PIP. An additional clinical PIP is required if the MCO's well-child visit rates fall below contractual benchmarks. The MCOs also must collaborate in conducting a nonclinical statewide PIP on Transitional Healthcare Services, focused on serving enrollees who have special health care needs or are at risk for reinstitutionalization, rehospitalization, or substance use disorder recidivism. Reviews by TEAMonitor validate the PIPs' compliance with CMS standards.

For the WMIP program, MHW conducted two clinical PIPs from 2012 through 2014, aimed at reducing avoidable hospital readmissions and emergency room visits by WMIP enrollees. For 2014, MHW also submitted a new nonclinical PIP seeking to improve screening contacts with new high-risk WMIP enrollees.

Each RSN must conduct one clinical and one nonclinical PIP annually. One PIP must be a children's PIP, targeting high-cost, high-need, high-utilizing children and youth. Acumentra Health validates the PIPs using a review protocol adapted from the CMS protocol.

Performance measurement

Each managed care plan that serves Medicaid enrollees must submit performance measurement data to the state annually. The health plan may measure and report its own performance using standard measures specified by the state, or may

submit data that enable the state to measure the health plan's performance. The EQRO validates the measures annually through methods specified by CMS or the National Committee for Quality Assurance (NCQA).

Physical health performance measures

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

HEDIS results for a given measurement year (the year in which care is given) are reported the next year, called the reporting year. For reporting year 2014, HCA required each MCO to report HEDIS measures of:

- childhood and adolescent immunization status
- comprehensive diabetes care
- well-child care (WCC) visits for infants, children, and adolescents
- utilization of inpatient and ambulatory medical care and of mental health care
- access to primary care practitioners for children through age 19
- weight assessment and counseling
- other measures of service quality

MHW reported nine HEDIS measures for the WMIP population, covering comprehensive diabetes care, inpatient and ambulatory care utilization, mental health care utilization, follow-up care after hospitalization for mental illness, medication management, and alcohol and drug dependence treatment.

For the Managed Care Services (MCS) population (formerly called Disability Lifeline/GA-U), Community Health Plan of Washington reported HEDIS measures of ambulatory care utilization, antidepression medication management, and race/ethnicity diversity of membership.

To ensure data integrity, NCQA requires certification of each health plan's data collection process by a certified HEDIS auditor. HCA funded the 2014 HEDIS audit for the MCOs to fulfill the federal requirement for validation of performance measures. For the WMIP program, MHW underwent a certified HEDIS audit that incorporated the CMS ISCA tool.

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

During 2014, the Washington MCOs collected CAHPS survey data from adult enrollees to gauge their satisfaction with managed care services. Acumentra Health's subcontractor reported the results to HCA in November 2014. The results included four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and five composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making).

Mental health performance measures

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

In 2014, Acumentra Health reviewed each RSN's response to findings and recommendations of the full ISCA performed in 2013. The goal was to determine the extent to which the RSN's information technology systems supported the production of valid and reliable state performance

measures and the capacity to manage the health care of RSN enrollees.

Compliance monitoring

HCA participates in TEAMonitor with DBHR and the Department of Health. TEAMonitor annually reviews each MCO's compliance with regulatory and contractual provisions related to access, timeliness, and quality of care. Activities in 2014 included a desktop file review of grievances and appeals followed by a two-day site visit to each MCO by TEAMonitor reviewers. The final review phase included a follow-up process and corrective action plan.

Acumentra Health monitors the RSNs' compliance with regulations and contract provisions during annual site visits, using review methods adapted from the CMS protocol. In 2014, Acumentra Health reviewed each RSN's compliance with provisions related to Enrollee Rights and Grievance Systems, and the RSNs' response to the specific 2013 EQR findings for which DBHR required the RSN to perform corrective action.

Quality oversight

DBHR's subject matter experts review the EQR results for RSNs, recommend corrective actions, and follow up on mental health program issues. Since 2008, MCOs and RSNs from across the state have convened regularly to share and discuss EQR results related to quality management.

EQR activities

Table 1 summarizes the mandatory and optional EQR activities conducted in 2014.

Table 1. Required and optional Medicaid managed care EQR activities, 2014.

Activity	How addressed for MCOs	How addressed for RSNs
Required		
Validation of PIPs	TEAMonitor reviews	EQRO onsite reviews
Validation of performance measures	HEDIS audit	Performance measure validation and ISCA by EQRO
Health plan compliance with regulatory and contractual standards	TEAMonitor onsite reviews	EQRO onsite reviews
Optional		
Administration or validation of consumer or provider surveys of quality of care	CAHPS survey by EQRO	Mental Health Statistics Improvement Program survey
Validation of encounter data reported by managed care plans		EQRO encounter data validation
Focused quality study of a particular aspect of clinical or nonclinical services		EQRO study of implementation of Children's Mental Health System Principles

METHODS

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

- 2014 HEDIS report of MCO performance in key clinical areas[1]
- 2014 CAHPS report of adult Medicaid enrollees' consumer satisfaction[2]
- 2014 TEAMonitor reports on MCOs' compliance with BBA regulations and state contractual requirements
- Acumentra Health reports on individual RSNs' regulatory and contractual compliance, PIP validation, and ISCA follow-up, submitted throughout 2014

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

BBA regulations require the EQRO to describe how conclusions were drawn about access to care and about the timeliness and quality of care furnished by managed care plans. Acumentra Health used contract language, definitions of reliable and valid quality measures, and research literature to guide the analytical approach.

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

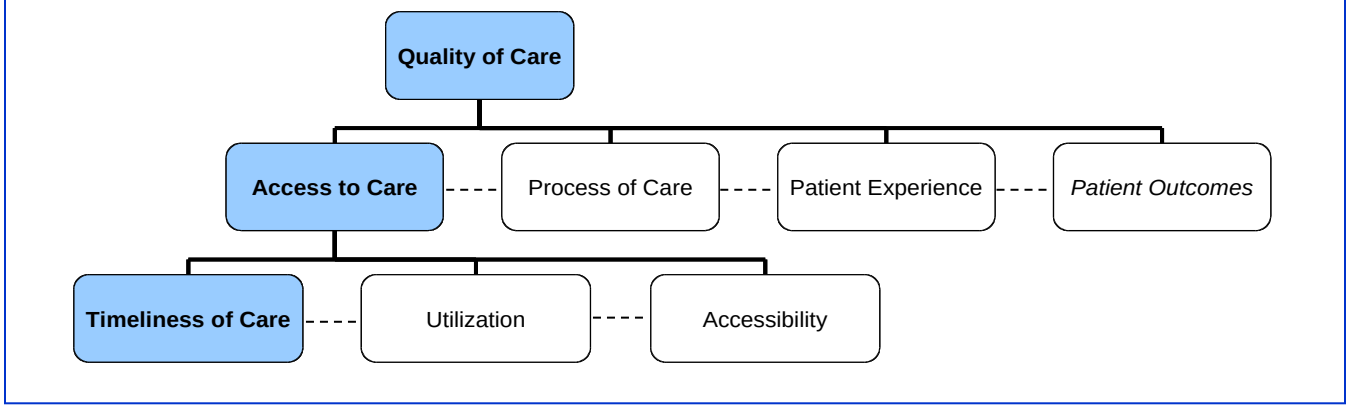
Quality of care encompasses access and timeliness as well as the *process* of care delivery (e.g., using evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall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

Access to care is the process of obtaining needed health care; thus, measures of access address the patient's experience *before* care is delivered. Access depends on many factors, including availability of appointments, the patient's ability to see a specialist, adequacy of the health care network, and availability of transportation and translation services.[3,4,5] Access to care affects a patient's experience as well as outcomes.

Timeliness, a subset of access, refers to the time frame in which a person obtains needed care. Timeliness of care can affect utilization, including both appropriate care and over- or underutilization of services. The cost of care is lower for enrollees and health plans when diseases are prevented or identified early. The earlier an enrollee sees a medical professional, the sooner he or she can receive necessary health care services. Postponing needed care may result in increased hospitalization and emergency room utilization.[6]

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

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



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

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

Mental Health Care Delivered by RSNs

During 2014, DBHR contracted with 11 RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs, in turn, contracted with provider groups, including community mental health agencies and private nonprofit agencies and hospitals, to deliver treatment services. RSNs are responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory standards for effective care.

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

Table 2 shows the approximate number of enrollees assigned to each RSN and the RSN's percentage of statewide enrollment during 2013.

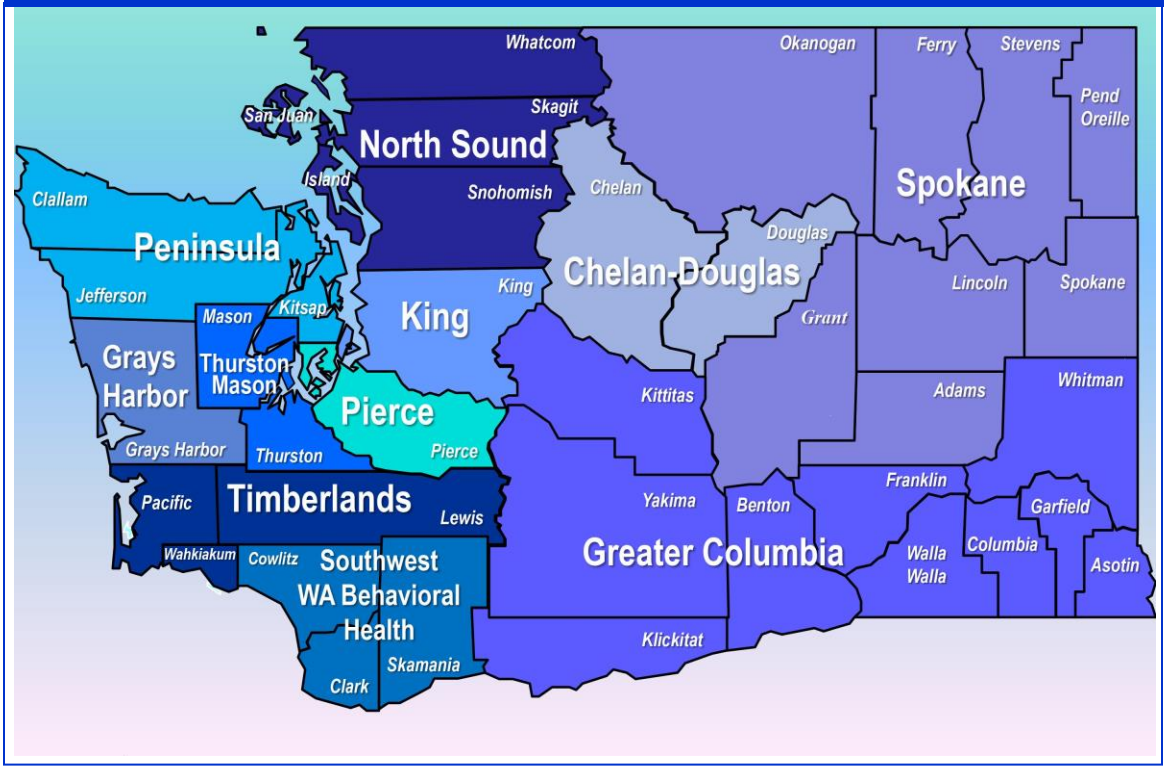
Table 2. Mental health regional support networks and enrollees, 2013.

Health plan	Acronym	Number of enrollees	% of all enrollees
Chelan-Douglas RSN	CDRSN	23,653	2.2
Grays Harbor RSN	GHRSN	16,157	1.5
Greater Columbia Behavioral Health	GCBH	163,224	14.9
King County RSN	KCRSN	237,253	21.7
North Sound Mental Health Administration	NSMHA	157,408	14.4
Peninsula RSN	PRSN	47,028	4.3
OptumHealth Pierce RSN	OPRSN	136,199	12.4
Southwest Washington Behavioral Health	SWBH	95,642	8.7
Spokane County RSN	SCRSN	148,953	13.6
Thurston-Mason RSN	TMRSN	47,690	4.4
Timberlands RSN	TRSN	21,433	2.0
Total		**1,094,641**	**100.0**

Source: Washington Mental Health Performance Indicator System.

Figure 2 shows the counties served by each RSN during 2014.

Figure 2. RSN service areas, 2014.



In 2014, Acumentra Health conducted the compliance review, PIP validation, and ISCA follow-up review for each RSN. These mandatory EQR activities addressed the following questions:

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

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

- *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations.* Version 2.0, September 2012
- *EQR Protocol 3: Validating Performance Improvement Projects (PIPs).* Version 2.0, September 2012
- *Appendix V: Information Systems Capabilities Assessment*. September 2012

General procedures consisted of these steps:

1. The RSN received a written copy of all interview questions and documentation requirements prior to onsite interviews.
2. The RSN submitted the requested documentation to Acumentra Health for review.

3. Acumentra Health staff visited the RSN to conduct onsite interviews and provided each RSN with an exit interview summarizing the results of the review.
4. Acumentra Health staff conducted interviews and reviewed documentation of up to four provider agencies and other contracted vendors for each RSN.
5. Acumentra Health scored the oral and written responses to each question and compiled results.

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

In addition to the mandatory EQR activities, Acumentra Health conducted an encounter data validation (EDV) and a review of children's clinical records for each RSN. The EDV procedure was based on the CMS protocol, *Validation of Encounter Data*, Version 2.0, September 2012. Methodology for the clinical record review was approved by DBHR.

The following sections summarize the results of individual EQR reports for 11 RSNs completed during 2014. These results represent established measurements against which DBHR will compare the results of future reviews to assess the RSNs' improvement. Individual RSN reports delivered to DBHR during the year present the specific review results in greater detail.

Access to mental health care

These observations and recommendations arose from the RSN site reviews during 2014.

Strengths

- OPRSN has worked with hospitals throughout the state to develop contacts and relationships with admission and discharge staff to facilitate immediate peer services through OPRSN's Peer Bridger program. This has improved enrollees' access to post-hospital stabilization services upon discharge, leading to lower readmission rates.
- With the implementation of its school-based provider program, SCRSN has experienced both increases in referrals for mental health treatment for children and positive feedback from parents and teachers.
- NSMHA has redesigned its crisis system by adding nursing staff, expanding voluntary crisis services, and lowering severity criteria thresholds to enable the crisis team to intervene sooner. This has resulted in increasing stabilization within 72 hours while connecting the enrollee with appropriate care and reducing ER and hospital admissions.
- To improve enrollees' access to care that meets their individual needs, both TRSN and GCBH require their contracted providers to update their practitioners' specialties, languages spoken, and credentials monthly on the RSNs' websites.
- Five of the six PIPs related to access demonstrated sound design of study questions, indicators, and data collection and analysis procedures, providing a solid framework for further PIP development.
- Among PIPs focusing on children's issues:
  - PRSN and TRSN sought to improve identification of high-risk/high-needs children and youth.
  - CDRSN aimed to improve the service penetration rate of child/family teams.
  - SCRSN focused on increasing access to mental health services for children in rural areas.
- TMRSN's PIP aimed to increase outpatient services for adult enrollees during the first 90 days following an intake.
- CDRSN's nonclinical PIP focused on increasing the percentage of clinically indicated follow-up services for enrollees who experienced mental health crises.

Opportunities for improvement

Faced with a large increase in enrollment due to the state's Medicaid expansion, the RSNs have found it difficult to maintain and recruit adequate numbers of qualified staff to meet access timelines for both intakes and follow-up appointments.

- ***DBHR needs to explore ways to facilitate training and recruitment of mental health clinicians to to meet Medicaid enrollees' access needs.***

Several RSNs' PIPs lacked a clear rationale for selecting the study indicator for one or more of their PIPs. DBHR began approving the children's PIPs in 2014.

- ***DBHR needs to ensure that all RSNs' PIPs are justified on the basis of clearly identified needs.***

Timeliness of mental health care

These observations and recommendations arose from the RSN site reviews during 2014.

Strengths

- TMRSN, OPRSN, GCBH, and TRSN respond to service authorization requests within 1–2 days.
- CDRSN has provided extensive training to its contracted provider agencies on how to log grievances and appeals into the RSN's practice management database to ensure timely tracking and resolution.
- SWBH earned a Fully Met score for its nonclinical PIP, aimed at improving the percentage of enrollees who receive non-crisis outpatient services within seven days after discharge from an inpatient psychiatric facility.

Opportunities for improvement

One RSN's PIP related to timeliness of care continued for more than three years without demonstrating statistically significant improvement. This has occurred with other RSNs in the past.

- ***DBHR needs to ensure that the RSNs develop PIPs with the intention of completing the second remeasurement within three to fours years and then choosing a different topic.***

Quality of mental health care

These observations and recommendations arose from the RSN site reviews in 2014.

Strengths

- All RSNs conduct clinical record reviews to ensure the presence of consumer voice throughout the clinical records, including treatment plans, crisis plans, clinician notes, and assessments.
- TRSN, GHRSN, TMRSN, and PRSN use extensive chart review tools to monitor medical necessity, adherence to the "golden thread" of mental health therapy, and other best practices.
- SCRSN has provided training for providers in all counties on recovery principles, case management, and community support, with positive responses. The RSN streamlined its "golden thread" monitoring tool from 52 to 36 critical elements, and has instituted inter-rater reliability testing.
- NSMHA remains active in the national and local Dignity and Respect Campaign and requires all provider agencies to take part in the campaign. The number of grievances related to dignity and respect has fallen significantly across NSMHA's network since this initiative began.
- TMRSN supplies language-line reference cards to the provider agencies and requires assessment of the enrollee's language capability at intake to identify difficulty with written information.
- NSMHA provides classes for clinical practitioners to earn continuing education credits through online training. The RSN reported that these classes have drawn as many as 1,200 users.
- A majority of the 2014 PIPs were related to quality of care. Five PIPs earned Fully Met scores, including:
    - GCBH (reducing children's inpatient readmission rate)
    - OPRSN (consumer voice in treatment planning)
    - PRSN (weight monitoring)
    - SCRSN (reducing readmissions to Eastern State Hospital)
    - TMRSN (wraparound services for high-risk youth)
- Seven PIPs related to quality demonstrated sound design of study questions, indicators, and data collection and analysis procedures, providing a solid framework for further PIP development.

Opportunities for improvement

Many of the RSNs failed to demonstrate that all providers, including outpatient providers, observed policies and procedures regarding the use of seclusion and restraints. The RSNs generally did not have specific procedures in place for behavior de-escalation to ensure that providers can handle volatile situations appropriately.

- ***DBHR needs to ensure that all RSNs and their contracted providers maintain and observe policies and procedures on the use of seclusion and restraint, as well as de-escalation practices.***

Several RSNs lack mechanisms to monitor customer service among their providers and/or vendors to ensure that enrollees are treated with respect and dignity, and that the RSNs can handle requests for interpreter services expeditiously.

- ***DBHR needs to continue to work with the RSNs to establish mechanisms to monitor customer service within the RSN network.***

Several RSNs need to provide leadership for their providers regarding the benefits to the enrollee of having advance directives for physical and mental health. More frequent community training could facilitate the development of advance directives.

- ***DBHR needs to encourage the RSNs to provide leadership for their providers regarding enrollees' use of advance directives for physical and mental health.***

One RSN focused on the same PIP topic and study population for seven years without demonstrating improvement. Several RSNs did not use local data and stakeholder input to justify selection of their PIP topics, and several RSNs failed to support the validity of their chosen study indicators.

- ***DBHR needs to establish a process to approve all PIP topics prior to RSN implementation.***
- ***DBHR should establish a process for providing mid-year technical assistance to help the RSNs address PIP design flaws in a timely manner.***
- ***DBHR should continue to conduct regular PIP training seminars to assist the RSNs' QI staff in understanding key concepts in study design.***

Mental health regulatory and contractual standards

Acumentra Health's 2014 review of RSN compliance focused on federal and state standards related to Enrollee Rights and Grievance Systems. The Enrollee Rights section of the review protocol assesses the degree to which the RSN has written policies in place on enrollee rights; communicates those rights to enrollees annually; makes that information available in accessible formats and in language that enrollees can understand; and monitors its provider agencies to ensure full implementation of enrollee rights. The Grievance Systems section evaluates the RSN's policies and procedures regarding grievance and appeal processes and the RSN's process for monitoring adherence to mandated timelines.

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

The provisions of Washington's Medicaid waiver and the RSN contract are such that some parts of the federal protocol do not apply directly to RSN practices. For a more detailed description of these standards, including a list of relevant contract provisions and a list of elements within each BBA regulation, see Appendix C.

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

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

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

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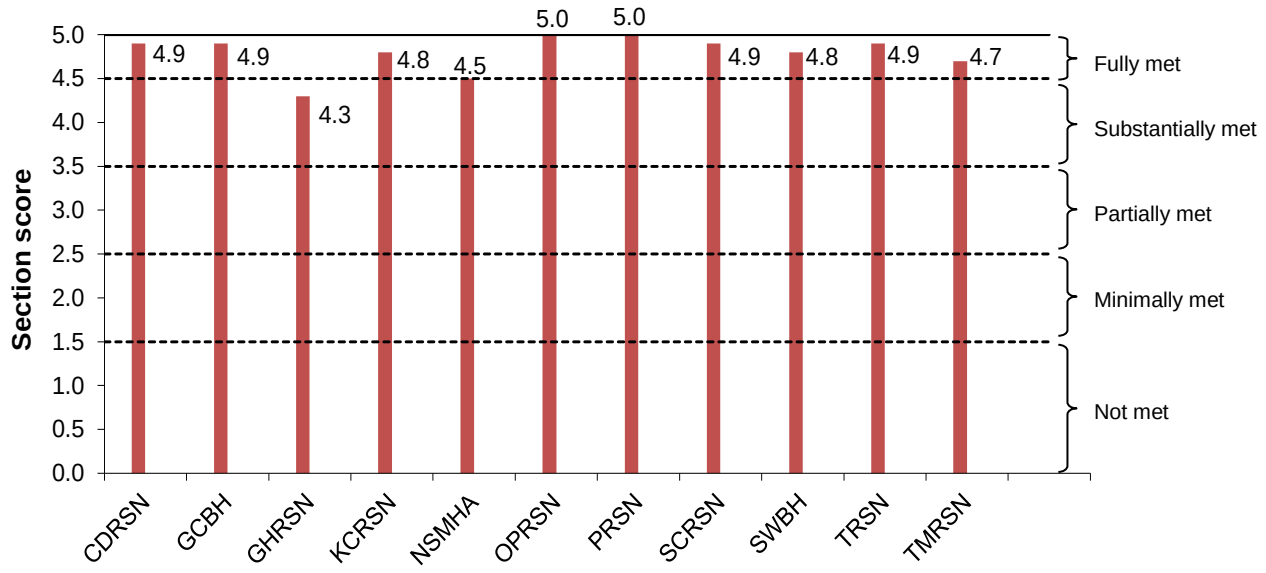
Enrollee rights

As shown in Figure 3, all but one RSN (GHRSN) fully met this standard in 2014, though most RSNs were deficient in at least one program element. Some of the deficiencies require corrective action.

Figure 3. RSN compliance scores: Enrollee Rights.



Strengths

- The RSNs have sustained compliance with nearly all elements of enrollee rights since the previous review in 2011.
- The RSNs ensure that enrollees receive the state's *Benefits Booklet for People Enrolled in Medicaid* at intake. However, the RSNs that produce a local enrollee handbook address more information requirements than do the RSNs that rely solely on the state benefits booklet.
- To ensure that enrollees receive timely notice of their rights, DBHR developed a streamlined notice to be sent annually to all Medicaid-eligible people.
- Most RSNs maintain websites that inform the public about mental health services, enrollee rights, RSN structure and operation, and policies and procedures.
- The RSNs monitor clinical records to ensure that enrollees are notified of their rights at the time of the initial assessment. The majority of RSNs monitor compliance with other enrollee rights issues, including advance directives, referral for cultural assessments, and use of second opinions. Some RSNs have developed specific quality assurance activities related to enrollee rights.

Opportunities for improvement

Many RSNs reviewed in 2014 did not understand the importance of requiring all contracted providers to have in place policies and procedures on the use of seclusion and restraint. Enrollees have the right to be free from seclusion and restraint at all provider facilities. This issue was singled out in previous years' reviews but has not been addressed.

- ***DBHR needs to clarify its expectation for monitoring the use of seclusion and restraint and behavioral de-escalation processes across the RSN network.***

Federal regulations specify that enrollees have the right to request and obtain names, specialties, credentials, locations, telephone numbers of, and all non-English languages spoken by mental health professionals in the RSN's service area. Several RSNs do not collect this information from their provider agencies to distribute to enrollees upon request.

- ***DBHR needs to ensure that all RSNs obtain and make readily available current information on the names, specialties, credentials, locations, telephone numbers of , and all non-English languages spoken by mental health professionals in the RSN's service area. The RSNs need to inform enrollees that this information is available upon request.***

Many RSNs do not track requests at the provider agencies for translation or interpreter services and for written information in alternative formats, outside of claims data. Monitoring such requests can help RSNs identify potential needs associated with changes in their service populations. This issue was singled out in previous years' reviews but has not been addressed.

- ***DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.***

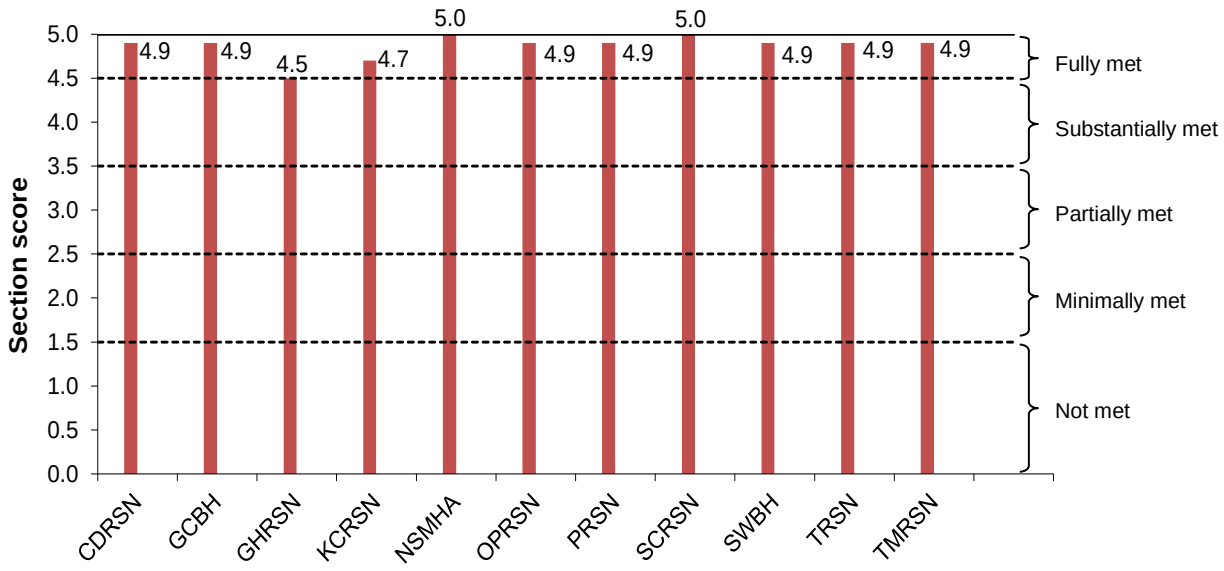
Several RSNs lack policies and procedures to ensure that enrollees are informed about both medical and mental health advance directives.

- ***DBHR needs to ensure that all RSNs have policies and procedures related to both medical and mental health advance directives.***
- ***DBHR needs to ensure that RSNs' responsibilities related to advance directives include medical as well as mental health directives.***

Grievance systems

As shown in Figure 4, all 11 RSNs fully met this standard, some with minor deficiencies that required corrective action.

Figure 4. RSN compliance scores: Grievance Systems.



DBHR's contract defines a grievance as "any expression of dissatisfaction about any matter other than [a notice of] action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights." RSNs are required to report enrollee grievances, appeals, and fair hearings to DBHR quarterly on Exhibit N forms.

DBHR has made an intensive effort to clarify expectations regarding grievances, including by adding a contract requirement for the RSNs to report provider-level grievances in their quarterly reports to the state.

RSNs across the state continue to report few grievances, though not all concerns at the provider agency level are monitored and reported. Some RSNs have not implemented the required change in reporting. As a result, the compliance scores for some RSNs were lower than in the previous review of their grievance systems in 2011.

Similarly, very few appeals occur across the system because the RSNs seldom deny service authorization.

Strengths

- Most RSNs review grievance and appeal reports during meetings of their internal quality committees. A few RSNs present grievance and appeal reports to their governing boards.
- A few RSNs incorporate grievance analysis into their quality management and performance improvement programs.

Opportunities for improvement

Most RSNs do not consistently analyze their grievances and appeals. Analysis of grievances could provide important data from which to identify system improvement needs.

- ***DBHR needs to ensure that all RSNs analyze their consumer grievances and appeals to help identify system improvement needs.***

All RSNs record grievances initiated with the Ombuds in their grievance logs. However, many Exhibit N forms submitted by the RSNs do not report grievances filed at the provider agency level.

- ***DBHR needs to require each RSN to collect and review all grievances from providers, Ombuds, and the RSN's own grievance system.***

Tracking and monitoring of grievances vary among RSNs. Some RSNs require the agencies to record all verbal and written expressions of dissatisfaction from enrollees, while other RSNs require agencies only to track grievances that have escalated to the RSN level. Also, confusion exists as to how to record multiple issues within a single grievance.

- ***DBHR needs to continue its efforts to guide the RSNs in tracking and monitoring all enrollees' verbal and written expressions of dissatisfaction with quality, access, or timeliness of care and services.***

Issues identified in RSN compliance reviews

Table 3 summarizes the primary issues identified in the 2014 RSN compliance reviews.

Table 3. Issues identified in RSN compliance reviews, 2014.

Compliance area	42 CFR citation (see Appendix C)	Number of RSNs with issues identified
Enrollee Rights		
General rule: Policies and procedures addressing any state and federal laws regarding enrollee rights	*438.100(a)*	4
Information requirements: Track enrollee requests for translation/interpreter services and for written information in alternative formats	*438.100(b); 438.10(b–d)*	5
General information for all enrollees: Timing—Notify enrollees at least annually of their right to obtain detailed information about network practitioners	*438.100(b); 438.10(f)(2–6)*	1
General information for all enrollees: Content	*438.100(b); 438.10(f)(2–6)*	2
Information on grievance process and timeframes	*438.100(b); 438.10(g)(1)(3)*	3
Respect and dignity	*438.100(b)(2)(ii)*	2
Advance directive policies and procedures	*438.100(b)(2)(iv)*	2
Seclusion and restraint	*438.100(b)(2)(v)*	4
Compliance with civil rights and ADA	*438.100(b)(d)*	4
Grievance Systems		
General rule	*438.228*	1
General requirements and filing requirements	*438.402(a)–(b)*	3
Language and format requirements for notice of action	*438.404(a)*	2
Content of notice of action	*438.404(b)*	3
Timing of notice of action	*438.404(c)(1)–(6)*	1
Handling of grievances and appeals	*438.406(a)–(b)*	2
Expedited resolution of appeals	*438.408(a)–(c)*	1
Information to providers and subcontractors	*438.414*	1
Record keeping and reporting requirements	*438.416*	2
Continuation of benefits while appeal and state fair hearing are pending	*438.420(a)–(d)*	1
Effectuation of reversed appeal resolutions	*438.424(a)–(b)*	2

Mental health PIP validation

Acumentra Health has evaluated the RSNs' PIPs each year since 2008, using data collection tools and procedures adapted from the CMS protocol. In September 2012, CMS published a new version of the PIP validation protocol. Acumentra Health, in consultation with DBHR, revised the 2014 PIP validation protocol to comply with the new CMS protocol and to incorporate feedback and address challenges from past PIP reviews.

Through document review and onsite interviews, Acumentra Health evaluates these required elements of each PIP:

- a written project plan with a study design, an analysis plan, and a summary of results
- a clear, concise statement of the topic, the specific questions the study is designed to address, and the quantifiable indicators that will answer those questions
- a clear description of the improvement strategies, the analysis used to select the improvement strategies, and the plan to measure implementation effectiveness
- evidence that the intervention services and materials are culturally and linguistically appropriate
- an analysis plan that discusses the methods for analyzing the data and performing statistical tests
- if applicable, a sampling methodology that yields a representative sample
- a data collection and validation plan that ensures that both manual and administrative study data are accurate and reliable
- a summary of the results of all data collection and analysis, explaining limitations inherent in the data and methodologies and discussing whether the strategies resulted in improvements

Children's PIPs

In 2013, in accordance with the Children's Mental Health System Redesign, DBHR outlined the requirement for each RSN to submit a children's PIP targeting high-cost, high-need, high-utilizing children and youth.

All 11 RSNs submitted children's PIPs for the 2014 review, addressing topics approved by DBHR. Six RSNs submitted new children's PIPs in 2014.

PIP scoring

Acumentra Health assigns a score to each standard and to the PIP overall to measure compliance with federal standards. In 2014, Acumentra Health, in consultation with DBHR, revised the scoring system to reflect the 2012 CMS protocol changes and to guide RSNs further in sound PIP study design and implementation.

Each standard has a potential score of 100 points. The scores for each standard are weighted and combined to determine an overall score. The maximum overall score is 85 points for Standards 1–8, and 100 points for Standards 1–10. The overall score corresponds to a compliance rating that ranges from Fully Met to Not Met. (See Appendix D.)

Because RSNs begin their PIPs at different times, and because PIPs are typically multi-year projects, these projects may be in different stages at the time of the EQR evaluation. Per the protocol approved by DBHR, Acumentra Health scores all PIPs on the first eight standards, regardless of the stage of completion. As ongoing QI projects, the PIPs are expected to achieve better scores as project activities progress.

Table 4 identifies the 10 standards adapted from the CMS protocol for validating PIPs.

Table 4. Standards for RSN PIP validation.	
Demonstrable improvement	
1	Study Topic
2	Study Question
3	Study Population
4	Study Indicator
5	Data Collection and Data Analysis Plan
6	Study Results
7	Interpretation of Results
8	Improvement Strategies
Sustained improvement	
9	Repeated Measurement of the Study Indicator
10	Sustained Improvement

Table 5 shows the compliance ratings and associated scoring ranges for PIPs graded on the 85-point and 100-point scales. Appendix D presents a sample scoring worksheet.

Table 5. PIP scoring ranges.

Compliance rating	Description	100-point scale	85-point scale
Fully Met	Meets or exceeds all requirements	80–100	68–85
Substantially Met	Meets essential requirements, has minor deficiencies	60–79	51–67
Partially Met	Meets essential requirements in most, but not all, areas	40–59	34–50
Minimally Met	Marginally meets requirements	20–39	17–33
Not Met	Does not meet essential requirements	0–19	0–16

Table 6 shows the topics of the PIPs submitted by each RSN for 2014.

Table 6. PIP topics by RSN, 2014.

RSN	PIP topic
CDRSN	Nonclinical: Crisis Intervention Follow-up
	Children's: Improving the Penetration Rate of Child and Family Team Participation
GCBH	Clinical: Increasing Inclusion of Health Care Information and PCP Involvement into Outpatient Mental Health Treatment Through Provider Training and Shared PRISM Health Information
	Children's: Lowered Inpatient Readmission Rates in a High-Risk Population Through the Development of Enhanced Communication with Inpatient Providers
GHRSN	Clinical: Reducing Self-Reported Symptoms of Depression Through Group Psychotherapy
	Children's: Providing Youth Discharging from Juvenile Detention with Non-crisis Mental Health Services within 7 Days of Release
KCRSN	Clinical: Lifestyle Intervention to Reduce Weight for Adults with Serious Mental Illnesses
	Children's: Improved Coordination with Primary Care for Children and Youth
NSMHA	Clinical: Wrap + MAP: Integrating Care Coordination and Clinical Practice Models for Medicaid Children and Youth Enrolled in WISe
	Children's: Improving the Quality of Care Coordination for High-Risk Transition Age Youth
OPRSN	Nonclinical: Residential Satisfaction in Integrated Community Settings
	Children's: Effects of the WISe Model on Caregiver Strain
PRSN	Nonclinical: Weight Monitoring
	Children's: Improved Identification of Intensive Needs Children and Youth
SCRSN	Clinical: Reducing Readmissions to Eastern State Hospital
	Children's: Increase in Access to Treatment for Children Residing in Rural Underserved Areas as a Result of School-Based Outpatient Services
SWBH	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
	Children's: Reduction in Out-of-Home Placements for Medicaid-Enrolled Youth Participating in Wraparound Intensive Services
TMRSN	Nonclinical: Implementing LOCUS to Increase Service Episodes for Adult Medicaid Clients
	Children's: High-Fidelity Wraparound
TRSN	Nonclinical: Improving Coordination of Care Outcomes for Individuals with Major or Severe Physical Health Co-occurring Disorders
	Children's: Improving Identification and Clinical Outcomes for Children in Need of Intensive Home- and Community-based Mental Health Services

Summary of 2014 PIP validation results

Acumentra Health reviewed 22 PIPs for the 11 RSNs in 2014. Eleven PIPs were submitted to meet the DBHR requirement for a children's PIP targeting high-risk/high-need children and youth. Six of the 11 children's PIPs were new and five were continued from the previous year.

Of the 11 clinical and nonclinical PIPs, 10 were geared toward the adult Medicaid population and one toward the child/youth Medicaid population. Four of the 11 clinical/nonclinical PIPs were new and seven were continued from previous years.

New PIP topics:

- nonclinical—4 PIPs
- children's—6 PIPs

Continuing PIP topics:

- clinical—3 PIPs
- nonclinical—4 PIPs
- children's—5 PIPs

Clinical and nonclinical PIP topics. In 2014, themes included

- care coordination (4 PIPs)
- weight reduction or monitoring (2 PIPs)
- improving access to outpatient services (2 PIPs)
- reducing hospital readmission rates (1 PIP)
- depression (1 PIP)
- community resources (1 PIP)

Children's PIP topics. Themes included

- effects of WISe or Wraparound on children/youth and caregivers (3 PIPs)
- care coordination (2 PIPs)
- improving identification of high-risk/ high-need children and youth (2 PIPs)
- improving access to outpatient services (2 PIPs)
- reducing hospital readmission rates (1 PIP)
- increasing penetration rate of Child and Family Teams (1 PIP)

The following analysis summarizes the RSNs' performance on new and continuing PIPs according to their designation as clinical/ nonclinical or children's projects.

Results for new clinical and nonclinical PIPs. As shown in Figure 5, three of the four clinical and nonclinical PIPs initiated in 2014 were rated as Substantially Met, and one PIP was rated as Fully Met.

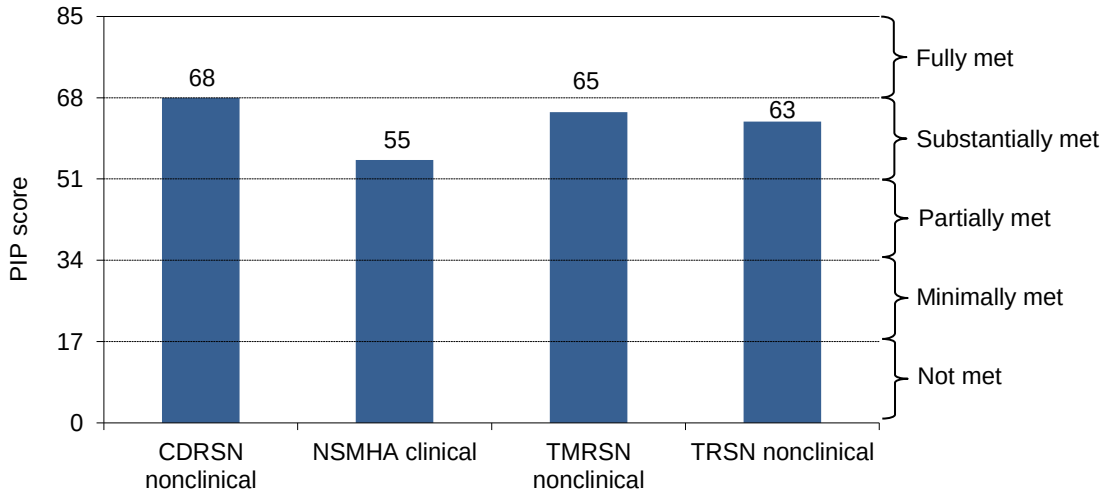
New PIPs focused mainly on creating a sound project design that provides a strong framework for further PIP development. The new 2014 clinical/nonclinical PIPs showed improvement in these planning stages over the previous year (the the majority of new PIPs in 2013 were rated as Partially Met). This improvement is likely a result of growing experience among the RSNs' QI staff and increased understanding of PIP principles (Acumentra Health conducted PIP training in February 2014). In addition, Acumentra Health's new PIP review tool was designed to be more user-friendly and to promote the development of key QI concepts.

CDRSN achieved the highest rating for its nonclinical PIP because it demonstrated that the study topic was relevant to the local Medicaid population; listed all of the relevant numerator and denominator inclusion criteria; presented a rationale for the validity of the study indicator; described procedures to collect and ensure the validity and reliability of the data; described the intervention and how it addressed cultural and linguistic factors; and reported baseline measurement results.

NSMHA submitted two PIPs focusing on children and youth, including a new clinical PIP. The nonclinical PIP, discussed in the continuing PIPs section, was submitted to meet the contract requirement for a children's PIP.

In their next iteration, all of these PIPs need to describe the barriers encountered during intervention implementation, discuss results of tracking and monitoring efforts, and finish collecting measurement period data.

Figure 5. Overall scores for new clinical and nonclinical PIPs, 2014.



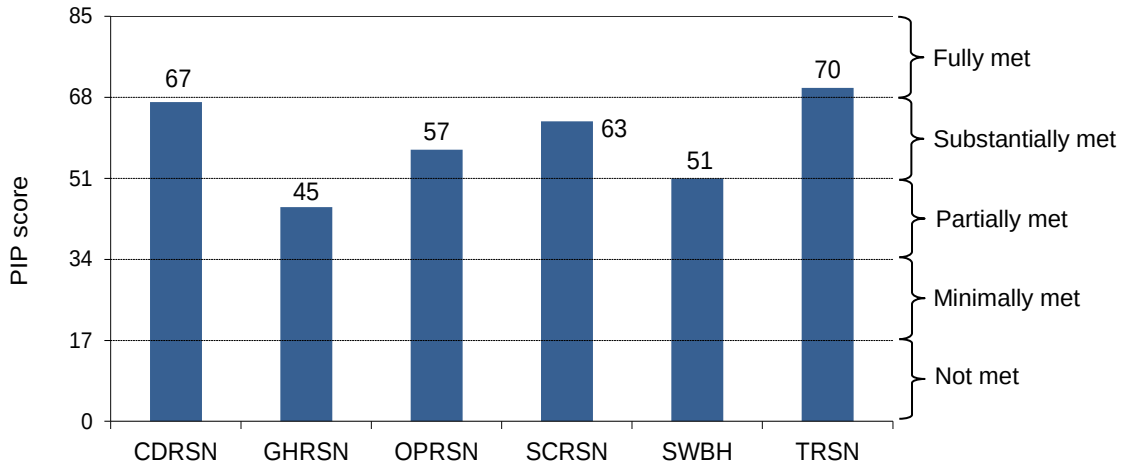
Results for new children's PIPs. As shown in Figure 6, of the six children's PIPs initiated in 2014, one was rated as Partially Met, four were rated as Substantially Met, and one PIP was rated as Fully Met.

In general, the new 2014 children's PIPs earned higher overall scores than those initiated in 2013. By 2014, QI staff who were new in 2013 had the benefit of additional experience and attendance at a PIP training. Also, 2013 was the first year in which DBHR required children's PIPs.

TRSN, CDRSN, and OPRSN fully or substantially met the first five of eight standards, demonstrating sound study design. TRSN's PIP achieved a Fully Met rating because the RSN also described how the intervention was selected through a root cause analysis, how it addressed cultural and linguistic factors, the barriers encountered and how they were addressed, and how the implementation was tracked and monitored. CDRSN had implemented its intervention, and needed to report on barriers and the results of its tracking and monitoring plan. OPRSN had not yet implemented its intervention and could not report results.

GHRSN, SCRSN and SWBH selected study topics that met the DBHR contractual requirement, but needed to provide additional local data to support their topic selection and demonstrate a gap in care. For these PIPs, different aspects of the study design (study population definition, numerator inclusion criteria, study indicator rationale) also needed further clarification.

Figure 6. Overall scores for new children's PIPs, 2014.



Results for continuing PIPs. Due to changes in the PIP standards and scoring, overall scores and individual standard scores for PIPs reviewed in 2014 cannot be compared with PIP scores from previous years.

Figure 7 shows the 2014 scores for four continuing clinical/nonclinical PIPs on the 85-point scale (Standards 1–8). SCRSN's clinical PIP earned a rating of Fully Met, and the other three PIPs were rated as Substantially Met. In 2013, five of the six continuing PIPs were rated as Fully Met and the other was Substantially Met.

One PIP (GCBH) presented no measurement data. Two PIPs (SCRSN and GHRSN) demonstrated improvement, though not statistically significant, in the study indicator between baseline and first remeasurement. For both of these PIPs, the lack of statistical significance was attributed, in part, to small study populations.

KCRSN submitted its clinical PIP as a new study topic and presented partial baseline data, but the project has addressed the same topic (morbidity and mortality among enrollees with serious mental illness) over the past seven years through different interventions focused on various aspects of metabolic syndrome. The RSN presented no analyses from its 2013 activities.

The primary factor affecting scores for continuing PIPs involved data collection and reporting. In some cases, the PIP review occurred before the RSN could complete its data collection and present results. One RSN had to make significant revisions to its 2013 PIP that delayed data collection. In other cases, significant changes were needed in the study design for the PIP to fully meet the standards at the time of review.

Figure 7. Overall scores for continuing clinical and nonclinical PIPs, 85-point scale, 2014.

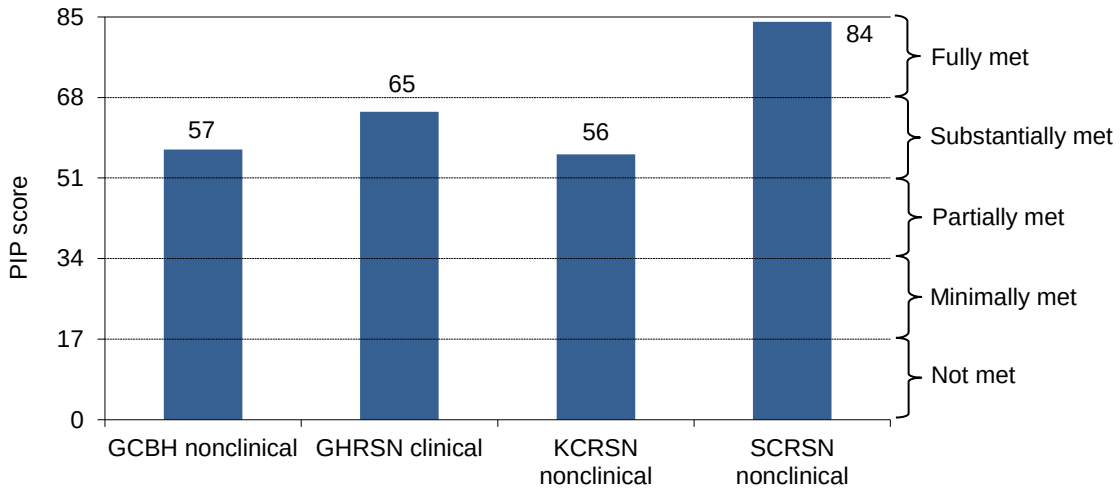
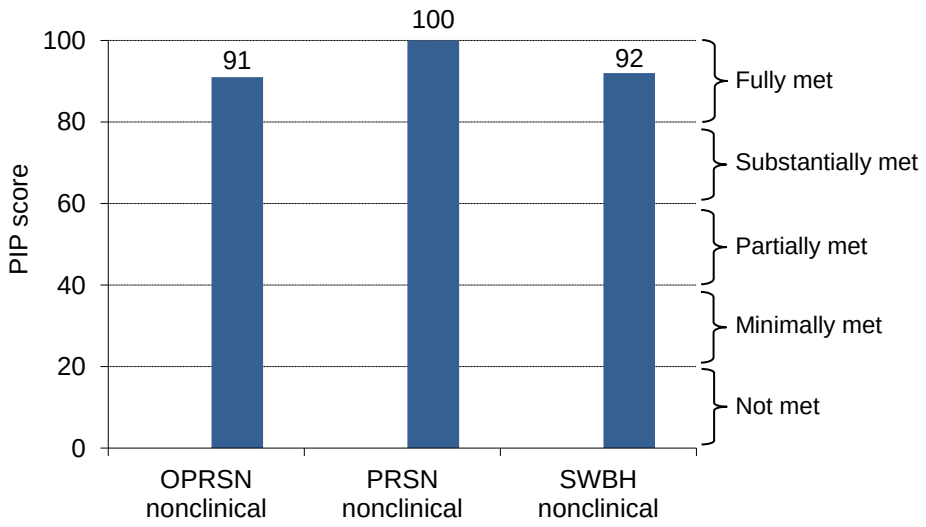


Figure 8 shows the 2014 scores for continuing clinical/nonclinical PIPs on the 100-point scale (Standards 1–10). All three PIPs in this category earned overall ratings of Fully Met, progressing to Standards 9 and 10 in which the RSN discusses study modifications and summarizes final results following a second remeasurement. This is consistent with the results in 2013, when all five PIPs scored on the 100-point scale achieved ratings of Fully Met.

The CMS definition of sustained improvement for PIPs includes achieving statistically significant improvement during at least one remeasurement period over baseline, and/or if there is a decline during the second remeasurement, it is not statistically significant. OPRSN's and PRSN's nonclinical PIPs showed significant improvement in their study indicators at first remeasurement, but the indicators declined between the first and second remeasurements. PRSN's decline was not statistically significant; OPRSN presented no statistical analyses for its second remeasurement. SWBH's nonclinical PIP achieved no significant improvement during any of its remeasurement periods, a result that the RSN attributed to significant organizational and structural changes during the course of the PIP.

In the revised 2014 PIP review tool and scoring procedure, the scoring weights for Standards 9 and 10 were increased to reflect CMS's emphasis on sustained improvement. Previously, PIPs had been scored only on their documentation and calculation of remeasurement data and their interpretation of the results. Scoring in 2014 took into account whether the PIPs had achieved significant improvement as well. These changes resulted in lower scores on Standards 9 and 10 for two RSNs, and thus lower overall scores, compared with previous years.

Figure 8. Overall scores for continuing clinical and nonclinical PIPs, 100-point scale, 2014.



Results for continuing children's PIPs. Five RSNs submitted continuing children's PIPs for review in 2014. Four were scored on the 85-point scale and TMRSN's PIP score was based on the 100-point scale. Figure 9 shows the scores for all children's PIPs except TMRSN, which scored 89 out of 100 (Fully Met).

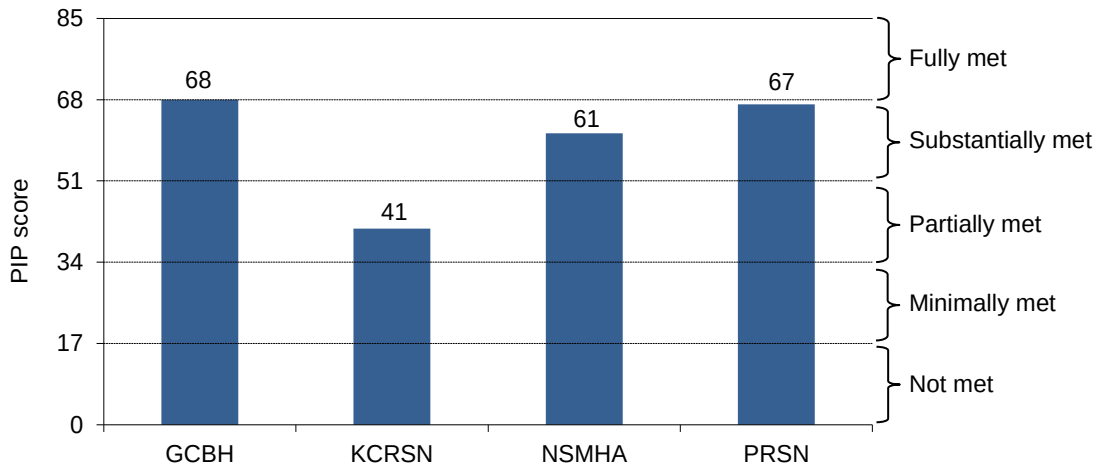
The majority of these PIPs made progress during the past year. GCBH received a rating of Fully Met, and NSMHA and PRSN were rated as Substantially Met. KCRSN received a rating of Partially Met, as the RSN did not adequately justify the selection of its study topic and presented no data.

Two PIPs (NSMHA and TMRSN) progressed to at least a first remeasurement and presented the results of statistical analyses. NSMHA's PIP showed statistically significant improvement between baseline and first remeasurement for one of its two indicators; data and analyses were not complete for the second indicator. TMRSN's PIP showed significant improvement between baseline and first remeasurement, but not between baseline and second remeasurement. TMRSN anticipates achieving statistical significance as the size of its study population increases.

Two PIPs (GCBH and PRSN) presented baseline data, but did not progress to a first remeasurement. KCRSN presented neither baseline nor first remeasurement data.

For 2014, the majority of RSNs have examined their local data related to the high-cost, high-need, high-utilizing child and youth population to identify the areas of greatest need, and have worked to include consumer and provider input in the prioritization process.

Figure 9. Overall scores for continuing children's PIPs, 2014.



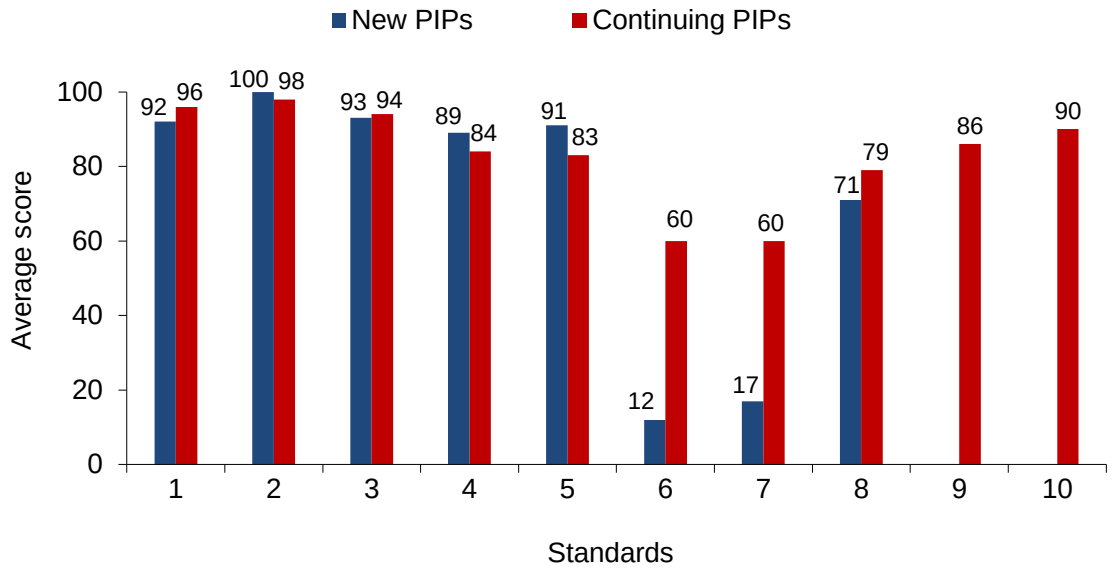
Scores by PIP validation standard. Average scores on the individual PIP validation standards illustrate the strong development of the new PIPs through the planning stage, represented by Standards 1–5 (see Figure 10). On average, the continuing PIPs demonstrated stronger planning, following the first-year review, than did the newly initiated PIPs. However, on average, new PIPs scored higher than the continuing PIPs on Standards 2, 4, and 5 (Study Question, Study Indicator, and Data Collection and Validation), while the continuing PIPs scored higher on Standards 1, 6, 7, and 8 (Study Topic, Study Results, Interpretation of Results, and Improvement Strategies).

Several reasons are apparent for differences in scoring between the new and continuing PIPs. In 2013, a number of new QI staff at the RSNs were less familiar with the PIP process. These staff members have since gained experience and attended a PIP training. Also, Acumentra Health modified the PIP submission template to make the documentation of PIP activity more user-friendly for the RSNs. For continuing PIPs, changes in the review protocol regarding required documentation may have presented a challenge.

The average scores for Standards 6 and 7, in which the RSN presents and interprets the study results, were understandably lower for new PIPs than for continuing PIPs. On average, continuing PIPs also scored slightly higher on Standard 8, in which the RSN describes its improvement strategy and intervention(s). PIPs that have not progressed to a first remeasurement cannot fully address Standards 6, 7, and 8, and therefore cannot be scored in their entirety. With respect to Standard 8, RSNs with continuing PIPs also have had more time to refine and modify their improvement strategies and interventions.

For both continuing and new PIPs, the RSNs continued to struggle with providing adequate documentation of local data analysis, or failed to complete such analysis, to justify their selection of study topics. RSNs also continued to have difficulty planning and reporting on their processes for tracking and monitoring the implementation of their interventions.

Figure 10. Average scores by PIP validation standard, 2014.



Recommendations

The following recommendations address issues that appeared in PIPs submitted by more than one RSN. The recommendations are similar to those presented in the 2013 annual report.

RSNs need to:

- analyze local Medicaid data to justify selection of study topics (Standard 1)
- provide evidence to support the validity of the study indicator (Standard 4)
- demonstrate that the selected intervention addresses barriers identified through a root cause analysis or other recognized QI process (Standard 8)
- plan and report on tracking measures to evaluate how effectively the intervention was implemented (Standard 8)
- design PIPs so as to complete the second remeasurement within three to four years (Standard 10)
- select a new PIP topic once a PIP reaches a second remeasurement, or if the study design is determined to be flawed such that achieving improvement is no longer feasible (Standard 10)

DBHR needs to:

- clearly communicate expectations for PIPs
- require the RSN to select a new topic after completion of the second remeasurement period or if four years have elapsed
- ensure that the RSN selects a study topic that demonstrates
  - relevance to the local Medicaid population
  - inclusion of enrollee input in the prioritization and selection process
  - focus on a high-volume or high-risk study population
- require the RSNs to demonstrate that their PIP interventions address barriers identified by means of a thorough root cause analysis or other recognized QI process

PIP descriptions and discussion

Chelan-Douglas RSN

Children's: Improving the Penetration Rate of Child and Family Team Participation for Medicaid Children. This PIP, in its first year, focuses on adoption and implementation of the state Children's Mental Health System Principles and the Core Practice Model as a practice guideline for CDRSN's provider network. Local data indicated that 78% of the Medicaid-enrolled child population was classified as meeting criteria for Early and Periodic Screening, Diagnosis, and Treatment Level 2 status, but only 3% of the unduplicated child population received team-based Child and Family Team (CFT) services in 2013. To address the underutilization of team-based services for children and their families, CDRSN plans to train provider agencies on the new practice guideline and on appropriate use of the CFT code, and monitor the intervention to help inform additional trainings as needed. At the time of the PIP review, CDRSN had completed the baseline measurement and conducted three trainings, and planned to provide additional training in October 2014.

Nonclinical: Crisis Intervention Follow Up. This first-year PIP seeks to increase the percentage of clinically indicated follow-up services for Medicaid enrollees who experience mental health crises. CDRSN's chart review found that 54% of crisis episodes did not include follow-up care that had been clinically indicated. A survey of individuals who had received crisis services in 2013 identified lack of follow-up as a particular point of dissatisfaction. In response, CDRSN developed a new discharge protocol for the local agency that provides crisis care. CDRSN intends for enrollees to participate in discharge planning, and the provider plans to implement a daily staff meeting to facilitate communication within the crisis response team. At the time of the PIP review, CDRSN had completed the baseline measurement and begun implementing the intervention.

Grays Harbor RSN

Children's: Providing Youth Discharging from Juvenile Detention with Non-crisis Mental Health Services within 7 Days of Release. This first-year PIP focuses on connecting young enrollees with outpatient mental health services within seven days of being discharged from a juvenile detention facility. GHRSN's local community accounts for 20% of the youth in Washington who are incarcerated on status offenses. The RSN also reported a widely held perception that youth involved in the juvenile justice system have poor mental health and difficulty obtaining mental health services. GHRSN intends to establish a referral system between the RSN, the detention center, and the Grays Harbor Community Hospital liaison, who will assist with establishing timely outpatient appointments. As of the PIP review, GHRSN had not yet implemented this intervention.

Clinical: Reducing Self-Reported Symptoms of Depression through Participation in Group Psychotherapy. This PIP, in its second year, was designed to build on GHRSN's previous clinical PIP related to major depressive disorder. The PIP focuses on examining the effect of group treatment sessions on the experience of symptoms associated with major depression. GHRSN measured results by comparing scores from PHQ-9 surveys administered at intake and at the sixth group session attended within a 180-day time frame. Results at first remeasurement were found to be not statistically significant. The study population was very small, as had been the case in previous versions of this PIP. Given the continued lack of significant improvement and the limited impact on the target population, Acumentra Health recommended that GHRSN retire this PIP and select a new topic for next year. During the onsite review, GHRSN indicated that it plans to discontinue this PIP.

Greater Columbia Behavioral Health

Children's: Lowered Inpatient Readmission Rates in a High-Risk Population Through the Development of Enhanced Communication with Inpatient Providers. This PIP, initiated in 2013, focuses on reducing the rate of children's readmissions to community inpatient facilities. Research studies and experiences of several local mental health projects indicated that effective discharge planning and the establishment of better collaborative relationships between managed care and inpatient providers are critical in reducing readmissions. For its intervention, GCBH will use its internally developed Child Inpatient Admission Review Questionnaire for each child authorized for an inpatient stay in a community setting. The goal is to enhance communication with inpatient providers and facilitate discharge planning that leads to better outpatient outcomes for enrollees. Baseline data showed a child readmission rate of 28%. The PIP seeks to reduce the readmission rate to 15% or lower by the end of the second remeasurement period.

Nonclinical: Increasing Inclusion of Health Care Information and PCP Involvement into Through Provider Training and Shared PRISM Health Information. This PIP, in its second year, addresses the integration of physical and mental health care. Following the 2013 PIP review, GCBH revised its study design and developed study indicators for 2014 that have more validity than the original indicators. Instead of measuring the effect of provider training on PRISM scores over time, GCBH will track the documentation of physical health information and communication with the primary care practitioner within mental health records. At the time of the PIP review, GCBH had not yet collected its first measurement data.

King County RSN

Children's: Improved Coordination with Primary Care for Children and Youth. This PIP, initiated in 2013, focuses on reducing psychiatrically-related hospital admissions and ER visits for children and youth through care coordination with primary care, and specifically through the use of data-sharing protocols. KCRSN discussed the importance of care coordination, data sharing, identification of mental health concerns in the primary care setting, and reducing psychiatrically-related hospital admissions and ER visits, but failed to demonstrate a link between these topics at the local level. Other than developing data-sharing agreements with five Medicaid managed care plans, this PIP has shown no progress since last year. The revised plan for data analysis indicates that baseline data collection and analysis may not be completed by the time the PIP enters its third year.

Clinical: Lifestyle Intervention to Reduce Weight for Adults with Serious Mental Illness. Over the past seven years, KCRSN has implemented multiple interventions targeting different aspects of metabolic syndrome among enrollees with serious mental illness. In 2013, KCRSN initiated a PIP that targeted obesity by piloting a Diabetes Prevention Program at six provider agencies. After receiving feedback from enrollees and staff, the RSN standardized program changes initiated by some providers in 2013, and added other modifications. The modified program was implemented at eight provider agencies beginning in January 2014. KCRSN submitted the 2014 PIP as a new project, citing significant changes to the study population and intervention, but did not fully support its rationale. Also, the RSN did not adequately justify selecting a new study indicator for 2014 in preference to the evidence-based indicator from 2013. As of the PIP review, KCRSN had not finished collecting its baseline data, and so reported partial results. Evaluation of the effect of the 2014 intervention modifications on the study indicator (weight loss) will be challenging because of possible threats to validity, incomplete 2013 study results, low 2014 study numbers, and variable implementation of the 2014 intervention by provider agencies.

North Sound MHA

Children's: Improving the Quality of Care Coordination for High-Risk Transition Age Youth. This second-year PIP focuses on improving care coordination for high-risk transition age youth (HRTAY) by increasing provider skills and knowledge. Due to a lack of resources, NSMHA eliminated two of its previously reported study indicators (youth and caregiver perception/satisfaction) and retained only a process measure of provider confidence in providing appropriate care. NSMHA's high-level root cause analysis of the HRTAY care gap determined that lack of care coordination was due to insufficient service provider skills and knowledge. However, providers surveyed after receiving the training identified factors other than lack of skills or knowledge as the main barriers to their effective care coordination for HRTAY, undermining the RSN's assumptions. This PIP faces multiple confounders and challenges. Acumentra Health recommends that NSMHA either continue with this study topic, but conduct a new root cause analysis (resulting in new interventions), or choose a new study topic.

Clinical: WRAP + MAP: Integrating Care Coordination and Clinical Practice Models for Medicaid Children and Youth Enrolled in WISe. This PIP, new for 2014, involves augmenting the Wraparound with Intensive Services (WISe) program with Managing and Adapting Practices (MAP), a clinical decision and support system. The project is being conducted in conjunction with and evaluated by University of Washington researchers. For this PIP, NSMHA will use the standardized Strengths and Difficulties Questionnaire to measure improvement in emotional and behavioral outcomes for high-risk/high-need children and youth. At the time of the PIP review, NSMHA had conducted MAP trainings for WISe staff and partners and had developed an evaluation plan, but had not yet implemented the intervention or reported baseline data.

OptumHealth Pierce RSN

Children's: Effects of the WISe Model on Caregiver Strain. This first-year PIP focuses on measuring strain for caregivers of children and youth who are enrolled in OPRSN's local WISe program. Relevant literature described the impact of children's emotional and behavioral disorders on caregivers, and the correlation between reduction of caregiver strain and improved outcomes for children and youth. OPRSN prioritized the selected topic with feedback from RSN committees, subcommittees, and its contracted provider. OPRSN will use a validated survey instrument to assess caregiver strain at WISe enrollment and 180 days post-enrollment, and will analyze the results to determine whether enrollment in WISe leads to a significant reduction of caregiver strain. The first measurement period and the intervention were scheduled to begin December 1, 2014.

Nonclinical: Residential Satisfaction in Integrated Community Settings. This PIP, in its fourth and final year, has focused on engaging people who live in residential treatment facilities (RTFs) to make them aware of community-based supported housing alternatives, and to assess satisfaction levels for those who move out of an RTF and into supported housing through the Community Building program. The RSN used a validated survey instrument, designed specifically for people diagnosed with psychiatric disabilities, to measure housing satisfaction. The first survey was completed prior to the intervention, and later surveys were fielded in August 2013 and August 2014. Analysis of the results showed significant improvement in residential satisfaction between baseline and the first remeasurement. Average satisfaction levels fell at the second remeasurement but remained higher than those found at baseline. OPRSN encountered barriers in recruiting people into the Community Building program, including resistance from RTF staff and reluctance on the part of some of RTF residents. OPRSN is retiring this PIP, but plans to address these barriers and continue the Community Building program.

Peninsula RSN

Children's: Improved Identification of Intensive Needs Children and Youth. This PIP, initiated in 2013, targets children and youth who need or who are at risk for needing intensive home- and community-based mental health services. In selecting and prioritizing PIP topics, PRSN discovered that each of its provider agencies used a different method to identity the target population. The current PIP focuses on accurately identifying high-risk/high-need children and youth, which PRSN called "the first step in ensuring they are provided the increased support and services needed." In cooperation with stakeholders and provider clinicians, PRSN created standardized criteria for identifying high-risk/high-need children and youth, and developed appropriate documentation for the electronic health record (EHR). PRSN began training provider clinicians on the new criteria and data entry into the EHR in December 2013, and implemented the intervention January 1, 2014. As of the PIP review, the study had not progressed to the first remeasurement.

Nonclinical: Weight Monitoring. This project, first reported in 2012, grew out of PRSN's previous PIP on metabolic syndrome. Local data showed that 76% of PRSN's Medicaid enrollees who were prescribed atypical antipsychotic medications were overweight or obese, putting them at risk of early death from diabetes and cardiovascular conditions. PRSN identified regular weight monitoring as an established practice guideline and first step in clinical intervention to improve weight outcomes. As of October 1, 2011, all enrollees receiving medical appointments with Jefferson Mental Health Services (JMHS) must have their body mass index (BMI) or weight and height documented in the EHR. Medical staff at JMHS received documentation training before this policy took effect. PRSN reported that the study indicator (percentage of eligible enrollees with recorded BMI or weight/height) improved significantly from 11.3% at baseline to 87.0% at first remeasurement and to 80.1% at second remeasurement. PRSN will continue monitoring BMI documentation in the EHR as part of its routine QI efforts. As this PIP has demonstrated sustained improvement, Acumentra Health supports PRSN's decision to choose a new PIP topic for 2015.

Southwest Washington Behavioral Health

Children: Reduction in Out-of-Home Placements for Medicaid-Enrolled Youth Participating in Wraparound Intensive Services. This PIP, in its first year, focuses on implementing the WISe model, as required by DBHR, in an effort to improve mental health outcomes and reduce out-of-home placements for children and youth. SWBH has committed to being an early adopter of the WISe model. At the time of the PIP review, SWBH had not yet implemented its intervention for this PIP, as many elements of the WISe program were still under development at the state level.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after a Psychiatric Hospitalization. This PIP, in its fourth year, seeks to improve follow-up care for Medicaid-enrolled adults discharged from an inpatient psychiatric hospitalization by implementing a protocol focused on collaborative discharge planning. Washington's statewide target is that 75% of enrollees discharged from inpatient care will receive outpatient appointments within seven days. SWBH's performance on this indicator declined during the PIP's first remeasurement (57.4%) and second remeasurement (38.8%) periods, compared to baseline (61.1%). As a primary confounding factor, this PIP began before the formation of SWBH as an RSN, and continued during the period when two RSNs were merging to form SWBH.

Spokane County RSN

Children's: Increase in Access to Treatment for Children Residing in Rural Underserved Areas as a Result of School-Based Outpatient Services. This PIP, initiated in 2014, focuses on increasing access to mental health services for children in rural areas. School administrators approached the RSN about providing mental health services in schools for high-risk children and youth. YFA, a competitively selected vendor, began delivering school-based mental health services through its Directions program in September 2013. In the baseline measurement period, 6.7% of the study population received at least two mental health services. SCRSN planned to finish collecting first remeasurement data in August 2014.

Clinical: Reducing Hospital Readmissions to Eastern State Hospital. This PIP, initiated in 2013, focuses on reducing readmissions within 30 days of discharge from Eastern State Hospital (ESH) for adults discharged to Spokane County. SCRSN chose Enhanced Case Management (ECM) as an intervention to improve enrollee outcomes. To target factors contributing to recidivism, SCRSN expanded ECM to focus on facilitation of prescriber-to-prescriber and hospital-to-outpatient provider communication and coordination; promotion of relationships between enrollees and outpatient mental health providers prior to hospital discharge; increasing community supports; and ensuring that provider agencies support enrollees in necessary ways. SCRSN reported a reduction in the ESH readmission rate from 12.0% at baseline to 6.2% at first remeasurement, but the improvement was not statistically significant, possibly because of small population numbers. The RSN plans to continue to refine this intervention and expects to achieve significant improvement in the next measurement period.

Thurston-Mason RSN

Children's: High-Fidelity Wraparound. This PIP, now in its third year, focuses on improving mental health and family functioning for Medicaid-enrolled children and youth by implementing the High-Fidelity Wraparound model. TMRSN and local stakeholders identified this model, developed by the University of Washington, as an important component of the effort to improve children's mental health. The RSN began implementing the Wraparound intervention for eligible high-risk/high-need children and their families in July 2011. To measure improvement, this PIP analyzes data from Strengths and Difficulties Questionnaires completed by study participants at baseline, 6 months, 12 months, and end of treatment. TMRSN reported statistically significant improvement from baseline to 6-month follow-up and non-significant improvement from baseline to 12-month follow-up. The RSN theorized that significant improvement will occur as the size of the study population grows over time.

Nonclinical: Implementing LOCUS to Increase Service Episodes for Adult Medicaid Clients. This first-year PIP focuses on implementing the Level of Care Utilization System (LOCUS) at TMRSN's largest provider for adult Medicaid enrollees in an effort to improve utilization of core outpatient services during the first 90 days following an intake. The RSN plans to use LOCUS scores, in conjunction with Access to Care standards and a navigator tool, to help determine the best treatment modalities and the frequency and intensity of outpatient services needed for adult enrollees who seek authorization for services. As of the PIP review, this project had not progressed to the first remeasurement. Baseline data showed that 341 enrollees who had an intake during 2012 received an average of 6.069 core outpatient hours during the first 90 days (about 2 hours per month).

Timberlands RSN

Children's: Improving Identification and Clinical Outcomes for Children in Need of Intensive Home- and-Community-Based Mental Health Services. TRSN discovered that the two-level system of care its provider agencies had been using was not sensitive enough to identify children and youth who need intensive services, and that provider agencies were using different criteria to identify these young enrollees. TRSN has implemented standardized assessment tools to provide guidance as to the frequency and intensity of services for children and youth based on their assessed level of care (LOC). For this PIP, children and youth assessed at LOC 4 are identified as needing intensive home- and community-based mental health services. Baseline data indicated that fewer children and youth than expected were identified at LOC 4. TRSN plans to provide additional training for provider agencies to help ensure that clinicians understand how to use the new assessment tools appropriately. The first remeasurement period ended July 31, 2014.

Nonclinical: Improving Coordination of Care and Outcomes for Individuals with Major or Severe Physical Health Co-Occurring Disorders. This project builds on a previous PIP that focused on improving care coordination with primary care providers for TRSN's general Medicaid population. Although the use of Coordination of Care (COC) service codes increased during the previous PIP, TRSN found little difference in the amount of COC services provided for enrollees based on the degree of physical health issues. Although the inclusion of physical health COC goals in mental health treatment plans increased substantially for enrollees with serious physical health problems, the average number of COC service hours provided for those enrollees remained low. TRSN has revised its COC protocol such that the level of care identified through its new assessment tool corresponds with the intensity and frequency of COC services provided. TRSN will track the use of COC service codes, as well as requests for physical health data, as indicated in the revised protocol. The intervention occurred during July 2014, and the first remeasurement began August 1.

Mental health performance measure validation

Two core performance measures were reviewed in 2014: one that is calculated and reviewed by the state, and a second that is calculated by the RSNs and verified by Acumentra Health. An RSN that fails to meet performance targets must submit a corrective action plan.

The two core performance measures are discussed separately below. Table 7 shows the compliance ratings for both measures.

Table 7. Performance measure validation ratings, 2014.

Performance measure	Status	Compliance rating
Consumers receiving first routine service within 7 days of discharge from a psychiatric inpatient setting	Not calculated by state for RSNs; data not frozen for validation	Not Met
Mental health encounter data validation	Procedures and results vary widely among RSNs	Partially Met

Routine service within 7 days of discharge

Each RSN must meet the performance target specified in its contract with DBHR. In prior years, RSNs were required to show year-to-year improvement. Beginning in 2013, each RSN had a different target according to its baseline performance.

The state contracts with Olympia-based Looking Glass Analytics (LGAN) to calculate this measure according to state-supplied methodology, using encounter data submitted from the RSNs and stored in DBHR's Consumer Information System (CIS). LGAN maintains a web-based portal enabling DBHR and RSN staff to calculate the performance measure with user-determined specifications. Since LGAN updates the source data weekly, a procedure is in place for LGAN to archive a frozen copy of the data set when the state calculates the required performance measure for each RSN. The frozen data are available to the RSNs for performance measure validation and corrective action planning.

2014 performance measure results

LGAN continued to maintain the portal of results, but DBHR did not initiate the annual process of performance measure freezing, publishing, and working with RSN results. In previous years, a process was in place for sharing results with the RSNs and enabling the RSNs to verify their member-level results. The 2014 results did not appear to be published and shared with the RSNs, and it was unclear whether any corrective actions resulted or follow-up occurred for the target measure. DBHR expressed concern that some follow-up visit encounters may have been filtered out because of the known issue with respect to using minutes or units to measure service duration. DBHR was unsure what impact this issue may have had on the data, as the results had not been shared with the RSNs.

Acumentra Health was unable to verify that the state calculated and reviewed this performance measure. No frozen data set was available for validation by the RSNs or Acumentra Health.

Finding

42 CFR §438.358 requires the annual validation of performance measures for managed care entities that serve Medicaid enrollees. DBHR did not calculate and freeze the data for one of two required performance measures, and therefore failed to meet CMS standards for validation of this measure.

Recommendations for 2014

DBHR needs to implement a process to calculate the performance measures by RSN annually and to notify LGAN to freeze the data. This process should include distributing or publishing the data set for the RSNs and should include corrective follow-up where needed.

Follow-up on 2013 recommendations

The 2013 EQR report presented the following recommendations.

1. DBHR should improve its documentation of all data steps, data flow, and processes from the time the data are received to the time the data are exported from CIS. Modifications should be documented and tracked over time.

   2014 status: Recommendation in progress. DBHR reported some progress in documenting its process and procedures. In anticipation of changing its IT systems in the near future, DBHR has decided not to allocate resources to documenting all systems. DBHR agrees that as new IT systems are established, appropriate documentation must be developed to support those processes.

2. LGAN should improve its documentation of all data steps, data flow, and processes from the time the data are received from CIS to the time the results are posted on the secure web server. DBHR should validate this documentation.

   2014 status: Recommendation stands. LGAN maintains a data flow diagram identifying files used in calculating the performance measures. However, neither DBHR nor LGAN had any supporting documentation to support the process taken to calculate the performance measures, including checks for missing or incomplete data.

3. SAS code used to process the data and calculate the measure should include notes explaining what each portion of code does.

   2014 status: Recommendation stands. DBHR and LGAN disagree with the recommendation to include notes in the SAS code or determine other methods for documentation.

4. DBHR should implement a system to check for encounters that were erroneously left out of the performance measure calculation, either by omission or by active exclusion.

   DBHR should modify its data flow processes to receive hospitalization data directly from the hospital, rather than waiting for the data to be processed and submitted by the RSN first.

   DBHR should have a system in place to replicate the performance measure analyses performed by LGAN. DBHR's validation of the LGAN calculations would create greater confidence in the reported results.

   2014 status: Recommendation in progress. DBHR stated that other changes to CIS may have improved the data quality. DBHR should continue to monitor for complete data in the numerator and the denominator.

5. DBHR should work with LGAN to extend the functionality of its performance measure reporting.

   - Statistical tests should be used to identify significant changes in performance measures from one period to the next.
   - Trend tests should be used to detect shifts in rates over more than two time periods.

   2014 status: Recommendation in progress. DBHR agrees that extended functionality of performance measure reporting, as well as additional statistical analysis, would be of significant benefit to internal analytic staff. DBHR will explore options to expand its reporting and to use statistical and trend testing when new performance measures are implemented.

6. DBHR should ensure that performance measure results are calculated and displayed

correctly for all RSNs, including those with recent regional shifts.

2014 status: Recommendation in progress. DBHR acknowledged the need to monitor this issue at the time of the next RSN change or merger.

7. DBHR should examine the measurement calculation when multiple RSNs are involved in hospitalization and follow-up care for an enrollee.

   2014 status: Recommendation in progress. DBHR has implemented a process to use eligibility data to determine the RSN of record. DBHR reported that it has made improvements seeking greater consistency for performance measure reporting, but continues to monitor this issue.

8. DBHR should develop processes to track dual-eligible enrollees, and work with the RSNs to ensure that they receive notice when those enrollees are hospitalized.

   2014 status: Recommendation in progress. DBHR continues to examine this issue and work toward a resolution for this complex topic.

Encounter data validation

DBHR requires each RSN to conduct an annual encounter data validation (EDV) to determine the accuracy and completeness of encounter data submitted by the RSN's providers. Acumentra Health audits and verifies the EDV process used by each RSN, as discussed further in a later section of this report.

At least 95% of all required data elements in a random sample of encounters in the RSN's data system must exactly match the same elements in providers' clinical records. No more than 2% of the RSN's encounters may be unsubstantiated (not verifiable in the clinical record or duplicated).

The RSNs must conduct EDV checks using the guidelines established by the DBHR contract, relating to minimum sample sizes and random selection of enrollee charts that represent the proportion of enrollees served (children vs. adults) within the RSN's service area during the review year. DBHR specifies the minimum data elements to be reviewed by the RSNs.

2014 performance measure results

This discussion focuses on the general trends Acumentra Health found in reviewing the RSNs' EDV systems: whether the RSNs used sampling procedures that resulted in pulling a random sample; whether data entry tools appropriately displayed encounter and demographic data; and whether the analytical tools accurately calculated the EDV results.

Basic EDV procedures. All 11 RSNs submitted documentation describing the dates when they performed the EDV and the time period covered by the encounters they reviewed. Each RSN also described its sampling procedure and the analytical methods used to calculate EDV results, and submitted the EDV report deliverable.

All RSNs used their internal data, rather than data downloaded from ProviderOne, to compare with provider agency data, although most RSNs stated that the data they used had been accepted by ProviderOne. Most RSNs reviewed the minimum data elements: procedure code, service date and location, service duration, provider type, and an assessment of whether the service code matched the service described in the chart.

RSN sampling procedures. Acumentra Health evaluated each RSN's sampling procedure on the basis of two criteria. First, was the sample large enough to meet contract requirements? Second, was it a random sample?

The minimum sample size varied by the number of community mental health agencies (CMHAs) in the RSN. All but one RSN pulled samples of adequate size; a few RSNs' sample sizes exceeded DBHR contract requirements. Of the 11 RSNs, 7 used procedures that should have resulted in a random sample, while 4 provided insufficient documentation to establish whether the sample would be random.

- ***RSNs should thoroughly describe their EDV sampling procedures so that the process can be validated.***

The sampling procedures used by most of the seven RSNs with sufficient documentation were similar. First, the RSN assigned a randomly generated number to each encounter that occurred in a specific time period, or to each enrollee who had encounters in that period. The list of encounters was sorted by random number, and a target number of encounters (at least 411, 822, or 1,233, depending on the number of contracted CMHAs) was selected from the top of the list. The RSNs used a variety of software packages to generate random numbers, including MS Access, MS Excel, and websites that provide lists of randomly generated numbers.

Data entry tools. Six of the 11 RSNs used data entry tools (usually MS Access) to capture EDV results. Two RSNs entered data directly into MS Excel for calculation. Three RSNs manually entered the results of their data checks onto paper forms before entering the results into Excel or Access. Acumentra Health recommends that these RSNs develop database systems to reduce the potential for error involved in using unsecured data sets (MS Excel) or entering results twice.

- ***RSNs that use manual data entry should develop and use a database to capture and analyze encounter data.***

Analytical procedures. RSNs used Access, Excel, or Crystal Reports to analyze their EDV results. Most RSNs used the same programs to analyze results as they used in previous years.

Per contract, RSNs were required to score the EDV as follows:

- Match
- No Match
  - Erroneous (incorrect data or missing minimum elements)
  - Missing (not in encounter record)
  - Unsubstantiated (not in state data)

One RSN did not assess "missing" encounters as part of its EDV activity, and one RSN did not break out any "No Match" subcategories.

- ***RSNs' EDV activities should include an assessment of "missing" encounters.***

Three RSNs used an inter-rater reliability system to ensure consistency in scoring between reviewers. Two RSNs used only one reviewer, and six submitted no documentation indicating whether they used an inter-rater system.

- ***RSNs should use an inter-rater reliability system to ensure consistency in EDV scoring over time.***

Summary and recommendations

Overall, the RSNs have developed appropriate systems to validate providers' encounter data. Acumentra Health's review found that, when documentation was provided, the sampling procedure almost always resulted in random samples of more than adequate size.

In reviewing individual RSNs' EDV procedures, Acumentra Health often recommended that the RSN enter results directly into the data entry tool rather than recording results on paper and manually entering results into a computer-based tool. Acumentra Health also recommended that the nine RSNs without an integrated database develop a system to display the encounter data elements to be checked, and to record the EDV results. Such systems can also support automatic calculation of EDV results at the CMHA and RSN levels. This would reduce the potential for error in recording results twice, once on paper and again in Excel or Access. It would also cut down on the manual manipulation of Excel tools used to calculate EDV results.

Eight RSNs required corrective action plans from CMHAs that did not meet defined improvement targets (5% no match; 2% unsubstantiated). For one RSN, the threshold set for requiring corrective action was unclear. Several RSNs provided technical assistance or training, thereby building a relationship with their contracted providers and

improving data validity. One RSN applied a financial withhold.

If the RSN does not meet defined improvement targets for these measures, the RSN must submit a corrective action plan to DBHR. However, submission of, and follow-up on, RSN corrective action plans were inconsistent.

- ***DBHR should ensure that the RSNs submit corrective action plans, and should monitor improvement if an RSN does not meet the defined targets.***

All RSNs validated enrollee chart data against encounters they planned to send to ProviderOne. Using these data, rather than encounters processed by the state, hinders the RSNs' ability to identify discrepancies between the data they submit and the data after processing. Acumentra Health used the state-processed data for its EDV reviews and identified issues with service duration, ethnicity, and duplicate claim IDs that were not identified by the RSNs.

- ***DBHR should ensure that all RSNs are aware that they can download encounter data from the state.***
- ***DBHR should require that RSNs use the state extracts to validate their encounter data.***

The EDV processes used by the RSNs vary greatly, preventing DBHR from aggregating results for a statewide report on the validity of encounter data submitted by the RSNs.

- ***DBHR should work with the RSNs to standardize EDV data collection and analytical procedures.***

Because of the wide variety of performance and EDV procedures implemented, this performance measure is *partially compliant* (see Table 7).

Information Systems Capabilities Assessment follow-up

In 2014, Acumentra Health reviewed responses to the recommendations for the RSNs and for DBHR arising from the full ISCA review conducted in 2013. Table 8 summarizes results of the follow-up review for DBHR.

Responding to some ISCA recommendations may require significant planning and resources. As a result, organizations may not fully address all recommendations in the follow-up year. In 2014, Acumentra Health found that DBHR and the RSNs were still in the process of addressing most recommendations from 2011 and 2013.

The 2013 ISCA review revealed the following strengths at the RSN level.

- All RSNs continue to perform well in meeting the Administrative Data standard. As a group, the RSNs are following most recommended practices aimed at ensuring the validity and timeliness of encounter and claims data.
- Most RSNs are fully meeting requirements related to staffing, enrollment systems, and provider data. RSNs have enhanced their provider profile directories to enable enrollees to make informed choices among network providers.
- RSNs' data center facilities and hardware systems are typically well designed and maintained. RSNs need to continue updating hardware at regular intervals to avoid disruption of services caused by hardware failures.

The 2014 follow-up review addressed the areas for improvement noted in 2013 and updated the RSNs' progress as noted below.

- Eligibility verification practices remain inconsistent across RSNs. Some RSNs verify enrollee eligibility before they submit encounters to DBHR; others rely solely on their provider agencies to check eligibility on the ProviderOne web portal at the time of service. Some providers check eligibility at each visit, while others check much less frequently.

  Update: RSNs have begun working to educate provider agencies and monitor to ensure that providers verify eligibility at each service encounter.

- All but two RSNs failed to demonstrate compliance with DBHR's more stringent criteria for data security. RSNs need to ensure that all contractual requirements are implemented at the RSN and provider agency levels, with particular attention to the following.
  - Update and test Business Continuity/ Disaster Recovery (BC/DR) plans for the RSN and provider agencies at least annually (including BC/DR plans for outsourced IT services).

    Update: Most RSNs have made progress in updating their BC/DR plans and have scheduled testing. Many RSNs still struggle to ensure that all partner organizations' and provider agencies' plans contain the level of detail needed for recovery, and that plans are kept up to date and tested per DBHR contract requirements.
  - Encrypt all data that will be in transit outside the RSN's internal network. Encrypt all data storage on portable devices or media with a key length of at least 128 bits.

    Update: Most RSNs remain in the planning stages in determining how they will address encryption issues at both the RSN and the provider agency levels. Many RSNs plan to add IS security questions to their current compliance and/or administrative monitoring tools.

- Remove access to data immediately when a previously authorized person no longer requires access.

  Update: Most RSNs have revised their practices to remove access immediately when an authorized person no longer requires access. Many RSNs are still updating their policies to reflect this change.

- Require password security to meet standards for complexity and forced changes at least every 90 days.

  Update: While most RSNs have made progress in updating their password policies to agree with DBHR requirements and current business standards, many partner organizations and provider agencies still appear to be addressing these issues.

- Monitor outsourced IT services and review for adherence to DBHR contract requirements.

  Update: Many RSNs have outsourced or contracted IT services. Some RSNs have implemented a formal review process to monitor for adherence to DBHR contract requirements. Many RSNs struggle to understand the need for oversight of these outsourced IT services, and have not implemented appropriate monitoring strategies.

- Some RSNs report that they submit only the primary diagnosis or do not submit diagnoses. DBHR has no method in place to ensure that the diagnosis being treated at the time of service is reported.

  ***Update*:** DBHR issued an update to the Service Encounter Reporting Instructions (SERI) in November 2014, effective 1/1/2015, that specifically addresses how RSNs should report diagnoses for mental health encounters.

Table 8. Status of ISCA recommendations identified for DBHR in 2013.		
2013 opportunities for improvement	**2013 recommendations**	**2014 response**
Information Systems		
DBHR still lacks robust documentation of IT systems, staffing, and data processing and reporting procedures. Insufficient documentation can create problems related to data recovery, staff turnover, and overall system supportability.	DBHR needs to fully document its IT systems, staffing responsibilities, and data processing and reporting procedures.	DBHR reported that it has made some progress in documenting process and procedures. In anticipation of changing its IT systems in the near future, DBHR has decided not to allocate resources to documenting all systems. DBHR agrees that as new IT systems are established, appropriate documentation must be developed to support those processes. ***Status of recommendation: In progress***
DBHR has no budget for training to keep programmers abreast of rapid changes in information technology.	DBHR needs to develop a plan for programmer training during this period of budget austerity.	DBHR has subscribed to online training services for each member of its programming staff. Staff will use this resource until the budget allows more focused hands-on training to resume. ***Status of recommendation: In progress***
CNSI has not upgraded its ProviderOne software since implementation in 2010.	DBHR should develop a planned upgrade schedule to ensure continuing support for critical software.	DBHR reported that CNSI issues regular updates to ProviderOne coding to address fixes, updates, and changes. ***Status of recommendation: In progress***
Staffing		
DBHR employs limited staff to analyze mental health data and oversee the flow of encounter data throughout the process.	DBHR should consider allocating more resources for staff to analyze and oversee the flow of mental health data.	DBHR remains short-staffed for key IT positions, but is pursuing more staff to support all system changes. DBHR holds weekly and bi-weekly meetings integrating IT, decision support, and evaluation staff along with those processing and reviewing encounter data. ***Status of recommendation: In progress***

Table 8. Status of ISCA recommendations identified for DBHR in 2013.		
2013 opportunities for improvement	**2013 recommendations**	**2014 response**
Hardware Systems		
DBHR lacks a formal policy and plan for replacing hardware to avoid disruption of services caused by hardware failures.	DBHR should formalize its hardware replacement policy to ensure that current equipment does not reach end of life and fall out of warranty while in production.	DBHR reported that it has formalized its hardware replacement policy, which addresses critical hardware, but DBHR did not submit this policy for review. ***Status of recommendation: In progress***
Security		
DBHR has a policy to remove access within five days for an employee or contractor who no longer requires access to Medicaid data systems. This practice does not align with industry standards.	DBHR needs to revise its access policy to ensure immediate removal of access when a previously authorized person no longer requires access.	DBHR agrees that it needs to update this policy. DBHR has an informal practice to remove access immediately, but only on a case-by-case basis. ***Status of recommendation: In progress***
Administrative Data		
DBHR has a process for screening encounters upon receipt. However, several issues noted during the ISCA review call into question the accuracy and completeness of the state's encounter data.	DBHR needs to ensure that encounter data submitted electronically by the RSNs pass through a stringent screening process to ensure accuracy and validity.	DBHR has made some progress regarding cleaning the data entered into its CIS. However, data do not pass through validity or accuracy checks in ProviderOne to reject invalid or incomplete data upon receipt. As a result, ProviderOne continues to receive and house invalid and inaccurate data. A special request was granted in November 2014 to allow some limited encounter data cleanup that is currently not allowed in ProviderOne. DBHR is working with several RSNs to identify a time in December to submit and process these fixed or missing encounter records. ***Status of recommendation: In progress***

Table 8. Status of ISCA recommendations identified for DBHR in 2013.		
2013 opportunities for improvement	**2013 recommendations**	**2014 response**
DBHR uses the 837 electronic format, which accepts multiple diagnoses. However, some RSNs report that they submit only the primary diagnosis or do not submit diagnoses on the 837. DBHR has no method in place to ensure that the diagnosis being treated at the time of service is reported on the 837.	DBHR needs to implement a method to ensure that the diagnosis being treated at the time of service is reported on the 837.	DBHR issued a SERI update in November 2014, effective 1/1/2015, that addresses how RSNs should report diagnoses for mental health encounters. ***Status of recommendation: In progress***
Enrollment Systems		
Although DBHR developed a process that RSNs can use to update eligibility data (e.g., change of address or name), RSNs are not sufficiently aware of this new process to use it effectively.	DBHR needs to clearly communicate to RSNs the process by which they can update eligibility data.	DBHR has a formal process for RSNs to contact the MMIS help desk for correcting eligibility data. DBHR agrees that RSNs still struggle with the process of updating eligibility information. DBHR will continue to work with RSNs and direct them on an as-needed basis. ***Status of recommendation: In progress***
RSNs submit all encounters paid for with RSN funds. Many RSNs are not tracking which services are being paid for with Medicaid funds, since all encounters are included in the same file. DBHR provides no specifications for RSNs to distinguish services paid by Medicaid from those paid by other sources. Some services for a Medicaid-eligible person may not be covered by Medicaid (e.g., jail services). ProviderOne accepts all encounters regardless of funding source. DBHR uses internal processes to determine if a person was Medicaid-eligible at the time of a service, and attaches a revenue code to the encounter. This practice does not replicate RSN processing rules, such as ensuring that non-Medicaid-eligible services are excluded.	DBHR needs to work with the RSNs to develop and/or clarify reporting rules to identify services and encounters that RSNs pay for with Medicaid funds. DBHR needs to develop internal practices for tracking services paid for by Medicaid.	DBHR disagrees with Acumentra Health that it is necessary for DBHR to require RSNs to identify services paid for by Medicaid funds versus Medicare, state funds, or other sources, either within the 837 or by other reporting means. DBHR continues to use the eligibility file to assign revenue codes at the state level and does not verify the accuracy of this process with the RSNs. Acumentra Health disagrees with the practice of relying solely on the eligibility file. Although a client may be eligible for Medicaid services, the funding source may not automatically be Medicaid. ***Status: Recommendation stands***

Table 8. Status of ISCA recommendations identified for DBHR in 2013.		
2013 opportunities for improvement	**2013 recommendations**	**2014 response**
Performance Measure Reporting		
DBHR does not keep a frozen data set for the calculated performance measures. ProviderOne data are dynamic, preventing replication of the performance measure reports if they are lost.	In the absence of a frozen data set, DBHR needs to develop procedures to validate the integrity of data undergoing formatting changes in transition from ProviderOne to Looking Glass Analytics.	Looking Glass Analytics can freeze the data for performance measure calculations, but DBHR needs to initiate this process. At the time of review, DBHR had not initiated this process for the 2013 measures. ***Status: Recommendation stands***
The ProviderOne/CIS file consolidation project is complete, but documentation was not available at the time of the ISCA review.	DBHR needs to fully document the process by which source data are extracted from CIS, aggregated and uploaded to DBHR's SAS server, and made available for Looking Glass Analytics to use.	DBHR agrees that the data pass through approximately six conversions before being made available to Looking Glass Analytics, and that these processes lack documentation that clearly describes the data flow. ***Status of recommendation: In progress***

Mental health encounter data validation

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

As an independent check of the RSNs' EDV results, Acumentra Health audited and verified the EDV process for each RSN in 2014. For each RSN, the EDV involved:

- checking each field in all outpatient records for missing and out-of-range data and logic problems
- comparing specific data fields in clinical records of the RSN's providers against the state's electronic data sets to determine whether data submitted by the providers were accurate and complete

Validation results

This report presents aggregate EDV results for all RSNs in two parts: (1) results of electronic data checks, and (2) results of comparing the clinical chart documentation with the state's electronic data, as part of the onsite review.

Electronic data checks

Acumentra Health analysts checked data fields in 3,033,419 outpatient encounters for missing and out-of-range data and logic problems, representing all outpatient encounters reported by the RSNs during October 2012–September 2013. The fields examined included RSN ID, consumer ID, agency ID, primary diagnosis, service date and location, provider type, procedure code, claim number, and minutes of service. (See Table 9.)

All fields were complete and within expected limits except for minutes of service. In 14,497 records (0.5%), the minutes reported did not meet specifications in the SERI.

Analysts found 72,785 records (2.4%) with a duplicate claim number, 71.1% of which occurred at a single RSN. Only three RSNs had duplicate claim numbers.

Analysts also found 298,542 records (9.8%) in which all fields were exact duplicates except for the claim number, and 41,088 records (1.4%) in which all fields were exact duplicates except for the consumer ID field. Again, all of these records were from a few RSNs.

Next, analysts checked the demographic data set, examining 16,384 records. The fields examined included RSN ID, consumer ID, first and last names, date of birth, gender, ethnicity, Hispanic origin, language preference, Social Security number (SSN), and sexual orientation.

Considering mandatory fields, 10,915 records (9.6%) had out-of-range RSN ID information, due to the submission of invalid codes. Language preference was missing from 1,278 records (27.5%), and sexual orientation was missing from 171 records (0.1%). All other mandatory fields were complete with expected values.

In 2013, ethnicity data were out of range in 17.2% of records checked. As last year's annual report noted, the invalid codes appeared to be a string of multiple three-digit codes, possibly representing multiethnic background. Acumentra Health recommended that DBHR explore options that would facilitate accurate documentation of ethnicity in ProviderOne. Data received from DBHR in 2014 included four distinct ethnicity fields. Members with multiple ethnicities had those ethnicity codes split into different fields, as opposed to a single string in one variable. This resulted in a notable improvement in the quality of ethnicity data in 2014.

Considering optional fields, 19,509 records (17.2%) omitted SSN information.

Table 9. Results of 2014 electronic data checks for 11 RSNs.

Field	State standard	% complete[a]
Outpatient encounter data		
RSN ID	100% complete (non-missing values), with values known to DBHR	100.0
Consumer ID	100% complete (non-missing values), with values known to DBHR	100.0
Agency ID	100% complete (non-missing values)	100.0
Primary diagnosis	100% complete (non-missing values), one diagnosis must be present	100.0
Service date	100% complete (non-missing values), must be in valid date format	100.0
Service location	100% complete (non-missing values), with values specified in data dictionary	100.0
Provider type	100% complete (non-missing values), with values specified in data dictionary	100.0
Procedure code	100% complete (non-missing values), with values specified in service instructions	100.0
Claim number	100% complete (non-missing values)	100.0
Minutes of service	100% complete for records with no per diem CPT/HCPCS codes	99.5
Demographic data		
RSN ID	100% complete (values in range), with values known to DBHR	90.4
Consumer ID	100% complete (values in range)	100.0
First name	100% complete (values in range)	100.0
Last name	100% complete (values in range)	100.0
Date of birth	Optional per the state's Data Dictionary	100.0
Gender	Optional per the state's Data Dictionary	100.0
Ethnicity	100% complete (values in range), with values specified in data dictionary	100.0
Hispanic origin	100% complete (values in range)	100.0
Language preference	100% complete (values in range)	72.5
Social Security number	Optional per the state's Data Dictionary	82.8
Sexual orientation	100% complete (values in range)	99.9

[a]Due to rounding, some fields showing 100.0 percent completeness may have had a small number of missing data values.

Onsite review results

Acumentra Health staff audited 2,410 encounter records from the 11 RSNs, comparing data processed by ProviderOne with documentation found in the enrollee charts. The encounters were recorded in 479 charts. Data fields compared for each encounter included procedure code, provider name, provider type, duration of service, service date, service location, and whether the procedure code accurately described the treatment provided. Acumentra Health also compared electronic data from the state's demographic data set with the chart documentation for the 479 enrollees.

Table 10 shows the results of Acumentra Health's validation activity.

The choices available to the audit team in comparing electronic data with the source chart documentation for each field were:

1. *Match:* State data and chart data exactly match
2. *No Match–Erroneous*: Data present in both the state data set and the chart do not match
3. *No Match–Unsubstantiated*: Elements of the state data cannot be found in the chart (e.g., an encounter in the state data set is not documented in the chart)
4. *No Match–Missing*: An encounter element in the chart is missing from the state data

Within the demographic data set, the chart information matched the state data in more than 98% of records for first and last name, date of birth, and gender. Match rates were much lower for sexual orientation, race, Hispanic origin (ethnicity), and language. As shown, 12.7% of the charts omitted data on language altogether, and 7.3% omitted Hispanic origin.

Table 10. Results of Acumentra Health's encounter data validation for 11 RSNs, 2014.

Field	Match	No Match–Erroneous	No Match–Unsubstantiated	No Match–Missing
Demographic information from each clinical record reviewed (N=479)				
First name	472 (98.5%)	5 (1.0%)	2 (0.4%)	0 (0.0%)
Last name	476 (99.4%)	3 (0.6%)	0 (0.0%)	0 (0.0%)
Date of birth	472 (98.5%)	5 (1.0%)	2 (0.4%)	0 (0.0%)
Gender	475 (99.2%)	2 (0.4%)	2 (0.4%)	0 (0.0%)
Sexual orientation	389 (81.6%)	62 (13.0%)	25 (5.2%)	1 (0.2%)
Race	425 (88.7%)	46 (9.6%)	7 (1.5%)	1 (0.2%)
Hispanic origin	374 (78.1%)	48 (10.0%)	22 (4.6%)	35 (7.3%)
Language	361 (75.4%)	28 (5.8%)	29 (6.1%)	61 (12.7%)
Results from multiple encounters and a mix of services (N=2,410)				
Provider name*	2,199 (91.2%)	90(3.7%)	119 (4.9%)	2 (0.1%)
Provider type*	1980 (82.2%)	174 (7.1%)	170 (7.1%)	84 (3.5%)
Minutes of service*	1,266 (52.5%)	663 (27.5%)	126 (5.2%)	354 (14.7%)
Service location*	2,160 (89.6%)	132 (5.5%)	117 (4.9%)	1 (0.04%)
Procedure code*	2,045 (84.9%)	192 (8.0%)	171 (7.1%)	2 (0.1%)
Service date*	2,207 (91.7%)	89 (3.7%)	111 (4.6%)	1 (0.04%)
Progress notes match SERI criteria*	2116 (87.8%)	291 (12.1%)	3 (0.1%)	NA

*Minimum data elements: these are the fields required by contract to be validated.

Considering the encounter data set, the service code matched the service described in the chart note in 87.8% of records reviewed. Matching rates for other encounter data elements ranged from 91.7% for service date to only 52.5% for minutes of service. All of these matching rates were below the DBHR contract requirement of at least a 95% match.

Discussion and recommendations

The state's outpatient encounter data generally were complete with expected values, as were demographic data except for RSN ID, language, and sexual orientation. Language preference was omitted from 27.5% of records. A small number of records omitted sexual orientation or contained invalid codes.

Comparison of the state's demographic data with enrollee charts at the provider agencies found relatively low agreement rates in fields for race, ethnicity, sexual orientation, and language. Matching rates improved from the 2013 results for ethnicity and language. However, because the RSNs need accurate information about enrollees' ethnicity and language preferences in order to provide culturally and linguistically appropriate services, as required by CMS, these lower match rates remain a concern.

- ***DBHR needs to ensure that ethnicity and language data can be accurately captured and reported to CMS and the RSNs.***
- ***DBHR needs to provide guidance to the RSNs to ensure that:***
  - ***ethnicity and language data are entered in the chart correctly and match the state's electronic data***
  - ***information about race and sexual orientation is entered in the chart and reported to the state correctly***

For all encounter data elements, agreement between the chart data and state data was lower than required by the DBHR contract. The low matching rate for minutes of service (52.5%) has been attributed to conversions performed as part of data processing in ProviderOne. The SERI manual requires RSNs to submit certain procedure codes expressing the service duration in minutes. Other codes are submitted with duration expressed in units, which can vary in terms of the number or range of minutes, depending on the procedure. RSNs are instructed to round down to the lower code if the actual service duration falls between the set ranges. However, ProviderOne accepts only units of service.

The encounter data that DBHR submitted to Acumentra Health for validation contained minutes of service. DBHR staff reported that ProviderOne converted the reported units to minutes by selecting the middle of a unit's range. For example, one unit of a half-hour individual session may have been documented as 25 minutes in the encounter data Acumentra Health used for the EDV, whereas the clinical record documented 30 minutes.

The high percentage of encounters with inaccurate service duration remains a concern. As noted in the 2013 annual report, CMS occasionally has required states and providers to reimburse Medicaid for claims with incomplete or inaccurate documentation. If the percentage of inaccurate or incomplete documentation exceeds 20%, CMS could require proportionate reimbursement for all Medicaid encounters during a given period.

- ***DBHR needs to modify the SERI to allow RSNs to report only units of service, or DSHS needs to modify ProviderOne to accept minutes of service.***
- ***DBHR needs to provide guidance to the RSNs to ensure that service minutes are accurate for the encounter and comply with the SERI.***

Focus study: Implementation of children's mental health principles

DBHR has directed all RSNs to implement the state Children's Mental Health System Principles in providing services for children, adolescents, and young adults with behavioral health challenges. As part of the 2014 EQR, DBHR asked Acumentra Health to study local progress made by the RSNs in implementing the children's mental health principles.

Key components include the Wraparound with Intensive Services (WISe) program, providing comprehensive behavioral health services and supports; the Child and Adolescent Needs and Strengths (CANS) assessment; and Child and Family Team (CFT) meetings, an intensive outpatient service aimed at diverting children from out-of-home placements.

Acumentra Health interviewed RSN staff to probe barriers to implementation and steps the RSNs planned to take to address those barriers. In conjunction with the interviews, Acumentra Health reviewed children's clinical records at 27 outpatient provider agencies to determine whether the records documented a cross-system care plan and the required elements of CFT meetings.

Implementation status

Wraparound and WISe implementation

In general, the RSNs intend to integrate the WISe program into their current mental health services for children. A few RSNs have implemented WISe, while 10 RSNs are delivering some form of Wraparound or "wraparound like" services. One RSN has no Wraparound program, though its providers use cross-system care plans.

Strengths

Most RSNs have a strong infrastructure for serving children through intensive outpatient treatment, providers that treat co-occurring conditions, jail diversion programs, school-based therapy, and relationships with the Developmental Disabilities Administration (DDA) and with substance abuse treatment services. At the time of the interviews, four RSNs had attended the WISe certification training program.

Several RSNs receive county tax revenues to assist children and families in the community with mental health services. The RSNs use those tax revenues to provide flexible services not reimbursable through Medicaid. As an example, some RSNs offer targeted employment services to enhance their Wraparound and WISe programs. One RSN has employed more than 200 peer counselors. However, more than half of the RSNs lack access to local tax revenue for this purpose, leaving them with limited options for developing flexible services.

Infrastructure and contracting changes

Several RSNs are working to change the traditional practice of clinician-driven care to involve the child and family more actively in identifying needs and goals. This change involves delivering care by a multidisciplinary team (MDT) in the community rather than in the clinician's office. In addition, several RSNs are working with schools, juvenile justice, and DSHS to integrate and co-locate services.

All RSNs have incorporated the children's mental health principles into their contracts with local CMHAs, many of which have certified or are in the process of certifying peers, clinicians, and care coordinators in WISe and CANS. A few RSNs have contracted with a Family Assessment and Stabilization Team, a Children's Intensive Program, or a Home-Based team to conduct WISe. These contractual changes have reduced availability of intensive services for children and families who do not meet CANS criteria. If a child does not meet WISe enrollment criteria, most RSNs lack the resources to provide Wraparound services for youth and families in standard outpatient services.

To monitor implementation of the children's mental health principles, all RSNs are conducting chart and utilization reviews, and most are conducting contract reviews. Most RSNs have

incorporated the principles into their clinical and quality audit tools. Several RSNs have implemented WISe-specific PIPs.

Barriers

RSNs reported encountering similar barriers and obstacles in implementing the children's mental health principles and WISe program requirements. Some barriers are unique to rural or frontier areas. Barriers are listed below, followed by Acumentra Health's recommendations for DBHR.

1. All RSNs reported workforce barriers due to a shortage of qualified clinicians, coupled with the recent expansion of the Medicaid population.
    - ***DBHR needs to work with the RSNs to ensure adequate recruitment for and maintainance of appropriate staff to meet the access needs of enrollees.***
2. Most RSNs expressed concern that children in Behavioral Rehabilitative Services must receive a CANS screening by the RSN, even though those children are not eligible to receive WISe services. Most RSNs would prefer that the money used for WISe and CANS be blended with DSHS, rather than holding the RSN responsible for covering the expense of all CANS screening.
    - ***DBHR should examine who holds the financial responsibility for the WISe program, and how funds could be blended and used to best meet the needs of the targeted population in a cross-system plan of care.***
3. All RSNs expressed concern that the direct service staff of community partners (e.g., juvenile justice, DSHS, schools) knew little about the children's mental health principles and WISe. Most RSNs said it will take time to change the local culture of using out-of-home placement for youth with serious emotional disturbances.
    - ***DBHR needs to work with the RSNs to continue community education and trainings for allied partners and their direct staff regarding the WISe program and in-home community placement with service options.***
4. Many RSNs said they found it difficult to retool their mental health delivery systems in an environment of constant change with regard to the state's WISe Manual, WISe program expectations, and turnover of state staff in the children's program.
    - ***DBHR needs to continue to update the WISe Manual and program expectations.***
5. Most RSNs have not developed or updated their policies and procedures to reflect the WISe program.
    - ***DBHR needs to ensure that the RSNs have developed and implemented current policies and procedures specific to the WISe program.***

Clinical record review results

RSNs were asked to provide Acumentra Health with encounter data for children's services that included the SERI codes for CFT, Wraparound, or High Intensity Treatment (HIT) services. Acumentra Health reviewed at least 37 children's charts from each RSN.

Table 11 reports the aggregate results of the clinical record reviews for the 11 RSNs with respect to the content of cross-system care plans and the CFT members identified in the care plans. Most RSNs maintained some type of cross-system care plan that stated the treatment and service goals for the child and that included family voice, needs, and goals. Cross-system care plans were present in most Wraparound charts, but in most non-Wraparound records, the care plans were traditional mental health treatment plans lacking a cross-system approach. Crisis plans were found in most Wraparound and HIT charts, but not in most CFT records. The majority of Wraparound cross-system care plans omitted mention of clinical

interventions and/or modalities and frequencies. Often the allied agencies listed in the care plan (DSHS, school, juvenile justice, DDA, and primary care provider) did not attend the majority of MDT meetings.

The continuation of Table 11 reports the aggregate review results with regard to required documentation of team meetings. The results omit one RSN that had no meeting documentation. A majority of the CFT records reviewed showed no documentation of a sign-in sheet or that the meeting minutes had been mailed to participants within 7 days. Many of the progress notes omitted agreement and/or progress toward meeting the goals of the cross-system care plans or treatment plans. The majority of charts lacked youth-specific voice regarding needs and goals. In many cases, goals for the child were not directly voiced by the child, and in many team meetings the child was not present.

Discussion and recommendations

Many of the cross-system care plans reviewed did not specify objective and measurable treatment service goals and the supports designed to achieve these service goals.

The Wraparound service charts typically lacked clinical interventions with specific modalities and frequencies. The cross-system care plans consistently lacked an evaluation of progress and a statement of the family/youth needs and goals in the youth's and family's own voice.

Crisis plans were present in only 54% of the CFT cross-system care plans. The majority of cross-system care plans failed to document the frequency of team meetings, and failed to list natural supports identified by the family.

- ***DBHR needs to ensure that the RSNs work with their provider agencies to create and and document cross-system care plans that address all required elements.***

In the cross-system team meeting progress notes, minutes documenting agreement and progress toward goals were missing from about half of the charts. Nearly all charts failed to document the provision of minutes to the team members within a week, and most charts omitted sign-in sheets.

The following members listed in the cross-system care plan were absent from about half of the team meetings: agency staff, allied providers working with the youth or family, the youth/enrollee, and a family/youth partner.

- ***DBHR needs to ensure that the RSNs work with their provider agencies to document all required elements of MDT meetings, including all team members.***

Table 11. Aggregate results of clinical record review for all RSNs, 2014.									
Clinical record contains cross-system care plan with the required elements.									
	Encounter code used								
Number of charts reviewed = 400	**CFT services (N=268 charts)**			**Wraparound services (N=127 charts)**			**HIT services (N=5 charts)**		
Cross-system care plan is present	**% Yes**	**% No**	**% N/A or Partial**	**% Yes**	**% No**	**% N/A or Partial**	**% Yes**	**% No**	**% N/A or Partial**
1. Is there a cross-system care plan for the child and family members?	79.85	20.15		89.76	10.24		60.00	40.00	
Care plan includes:									
1. Statement of treatment and service goals	89.51	2.25	8.24	73.81	0.79	25.40	100.00		
2. Supports designed to achieve treatment goals	68.91	31.09		80.95	19.05		100.00		
3. Clinical interventions	85.02	4.87	10.11	64.29	11.11	24.60	100.00		
4. Evaluation of progress	70.41	13.11	16.48	37.30	14.29	48.41	100.00		
5. Addresses family's needs and goals	68.54	16.10	15.36	66.67	13.49	19.84	80.00		20.00
6. Addresses youth's needs and goals	71.16	12.73	16.10	60.32	12.70	26.98	40.00	40.00	20.00
7. Crisis plan	53.93	44.57	1.50	80.16	15.87	3.97	100.00		
8. Frequency of team meetings									
Monthly	1.88			33.60					
Other/None identified	96.60			64.00			100.00		
Team membership identified in cross-system care plan	**% Yes**	**% No**	**% N/A or Partial**	**% Yes**	**% No**	**% N/A or Partial**	**% Yes**	**% No**	**% N/A or Partial**
1. Natural support(s) identified by family	5.60	94.40		10.85	89.15			100.00	
2. Agency staff	78.36	21.64		93.02	6.98		80.00	20.00	
3. Allied providers working with the youth/family	89.93	10.07		82.17	17.83		60.00	40.00	
4. Youth	100.00			100.00			100.00		
5. Family/youth partner	91.79	8.21		94.57	5.43		100.00		

Table 11. Aggregate results of clinical record review for all RSNs (cont.).*

Clinical record contains the documentation required in the definition of Child and Family Team meetings.

Number of meetings reviewed=776	CFT services (N=451 meetings)				Wraparound services (N= 313 meetings)				HIT services (N=12 meetings)			
Meeting documentation	**% Yes**	**% Partial**	**% No**	**% N/A**	**% Yes**	**% Partial**	**% No**	**% N/A**	**% Yes**	**% Partial**	**% No**	**%N/A**
1. Type of meeting minutes match type of service encounter	82.26				89.46							
2. Minutes document agreement and progress toward goals	59.47	30.73	9.80		45.66	29.90	24.40		16.67	50.00	33.30	
3. Minutes provided to team within a week after meeting	2.24		97.76		5.79		94.21				100.00	
4. Sign-in sheet is present	30.61		69.39		14.10		85.90				100.00	
5. Date of documentation matches reported encounter date	97.07		2.93		97.64		2.03	0.34	100.00			
6. Encounter meets SERI code definition		100.00				100.00				100.00		
7. Team meets with frequency listed in cross-system care plan	17.83	80.81	1.35		9.51	86.56	3.93			75.00	25.00	
Team members present/absent	**% of meetings attended**				**% of meetings attended**				**% of meetings attended**			
1. Facilitator member	93.30				81.64							
2. Agency staff	76.10				59.30				83.33			
3. Allied providers working with the youth/family	52.90				26.70							
4. Youth	46.29				57.14				66.67			
5. Family/youth partner	65.40				58.50							

* One RSN had no meeting documentation.

Physical Health Care Delivered by MCOs

HCA contracts with five MCOs to deliver physical health care services to managed care enrollees. Table 12 shows the approximate number and percentage of enrollees assigned to each health plan as of December 2013. Figure 11 shows the counties served by each plan.

Traditionally, the state provided managed medical care primarily for children, mothers, and pregnant women, and for a small number of adult SSI or SSI-related clients through the WMIP program in Snohomish County.

Since July 1, 2012, however, HCA has expanded managed care enrollment significantly with the addition of disabled and blind SSI recipients and other new populations, such as those served by Medical Care Services. The net effect has been a major shift toward adult enrollment.

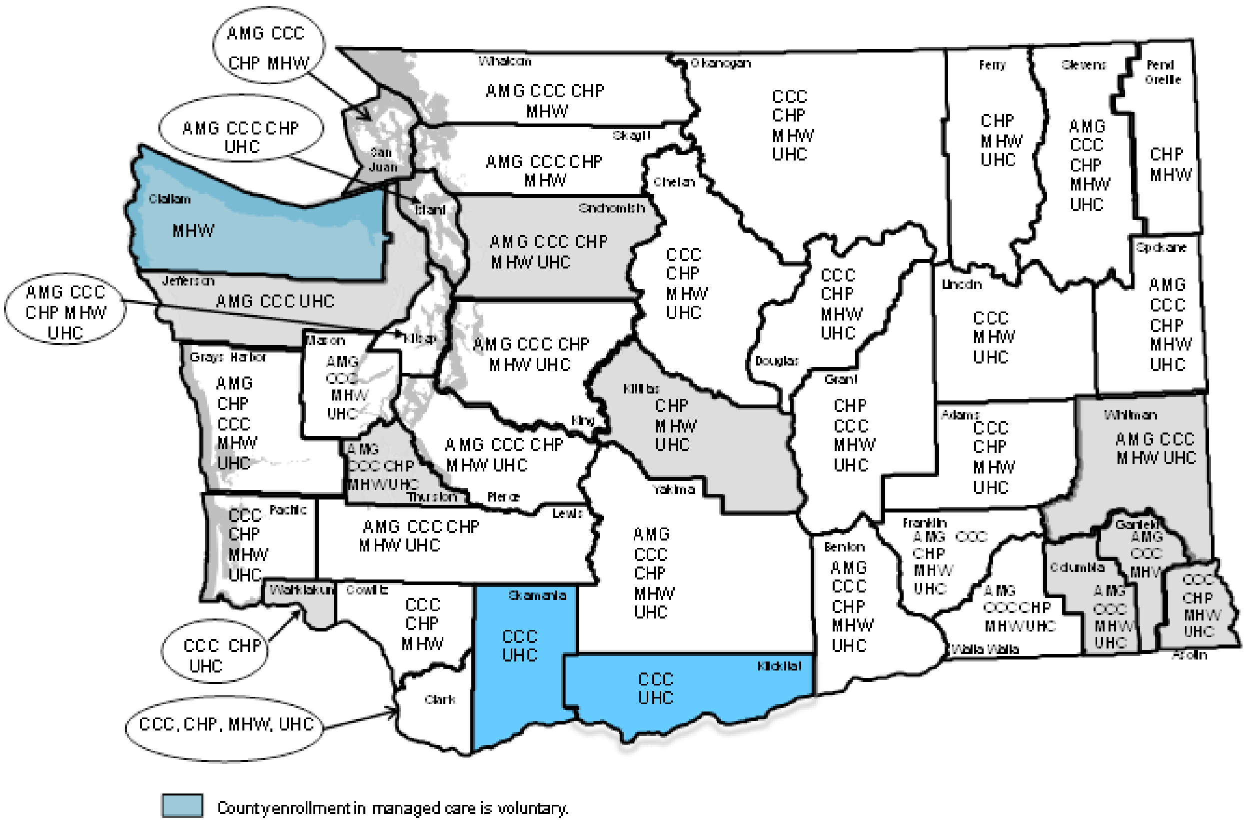
As of January 1, 2014, all populations served by Washington Medicaid, including many thousands of newly eligible enrollees authorized by the federal Affordable Care Act, were rolled up under Apple Health.

Table 12. Managed care organizations and Medicaid enrollees, December 2013.[a]

Health plan	Enrollment
Amerigroup Washington Inc. (AMG)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	34,241
SSI recipients (included in above)	*10,503*
Community Health Plan of Washington (CHP)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	236,404
SSI recipients (included in above)	*27,468*
Health Home	61
Medical Care Services (formerly GA-U)	7,180
CHP total	243,645
Coordinated Care Corp. (CCC)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	80,592
SSI recipients (included in above)	*15,759*
Molina Healthcare of Washington (MHW)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	375,231
SSI recipients (included in above)	*29,964*
WMIP	3,055
MHW total	378,286
UnitedHealthcare Community Plan (UHC)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	60,754
SSI recipients (included in above)	*14,555*
Health Home	265
UHC total	61,019
Total	**797,783**

[a] Healthy Options includes SSI recipients in the blind/disabled population.
Source: Washington Health Care Authority.

Figure 11. Healthy Options/CHIP service areas, May 2013.



Note: Healthy Options coverage includes blind/disabled populations. AMG began serving enrollees in Benton and Franklin counties during 2013.

In analyzing quality, access, and timeliness measures for physical health care, this report considers performance at both a statewide and health plan level. "Star" ratings compare the statewide scores and individual MCO scores with NCQA's national Medicaid benchmarks for each indicator. For the HEDIS measures, statewide average percentages were calculated by adding individual MCO numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and multiplying the resulting proportion by 100. National comparisons were based on the 2014 Medicaid averages from the NCQA *Quality Compass* report.[7]

For each CAHPS measure, star ratings were derived by calculating three-point mean scores for the state and each MCO, and comparing those scores with NCQA's HEDIS Benchmarks and Thresholds for Accreditation. Interpretation of the star rating system is shown below.

90th percentile or above (Excellent)	☆☆☆☆☆
75th–89th percentile (Very Good)	☆☆☆☆
50th–74th percentile (Good)	☆☆☆
25th–49th percentile (Fair)	☆☆
25th percentile or below (Poor)	☆

Access to physical health care

HCA monitors MCO performance on the standardized measures of clinical care and consumer satisfaction shown in Table 13. TEAMonitor assesses compliance with regulatory and contractual requirements related to access.

Performance on access measures

Statewide results: The HEDIS measure of well-child care tracks the percentage of children and adolescents who receive the recommended number of WCC visits for their age group. In 2014, the Washington average WCC visit rates remained significantly below the U.S. averages for all age groups.

In contrast, the Washington MCOs significantly outperformed the U.S. average for access to PCPs in all but one age group. This measure expresses the percentage of children and adolescents with at least one PCP visit during the measurement year (or, in the case of children age 7 and older, during the measurement year or the prior year).

Getting Needed Care, a CAHPS measure, gauges how often the enrollee found it easy to get needed care, tests, or treatment, and got an appointment with a specialist as soon as needed. The Apple Health MCOs, as a group, performed poorly on this measure in 2014, ranking below the 25th percentile of national Medicaid scores.

Table 13. Washington and U.S. scores for physical health access measures, 2014.

	U.S. score◖	Washington score	Washington rating
HEDIS measures			
Infant WCC visits (6 or more)	61.55%	56.25%*	☆☆
WCC visit, 3–6 years	71.49%	63.84%*	☆
Adolescent WCC visit	50.03%	39.13%*	☆
Access to PCPs:			
Ages 12–24 months	96.14%	97.25%*	☆☆☆
Ages 25 months–6 years	88.25%	87.53%*	☆☆
Ages 7–11 years	90.02%	91.22%*	☆☆☆
Ages 12–19 years	88.52%	90.75%*	☆☆☆
CAHPS measure			
Getting Needed Care	2.37	2.30	☆

Stars represent Washington's performance compared with the 2014 NCQA national percentile rankings. One star (Poor) represents scores below the 25th percentile; five stars (Excellent) represent scores at or above the 90th percentile.
*State average is significantly different from the NCQA average ($p<0.05$).
◖ U.S. score for each HEDIS measure is an average; U.S. score for each CAHPS measure is the NCQA national median.

MCO results: Considering *WCC visits*, MHW outperformed the state average for infant and adolescent visits, while CCC and CHP exceeded the state average for child visits (see Table 14). AMG's infant and child visit rates were significantly below average, and CCC's infant visit rate was significantly below average.

Rates of *access to PCPs* ranged between 93% and 98% for children age 12–24 months, and between 77% and 89% for children age 25 months–6 years. MHW significantly exceeded the state average for all four age groups. UHC outperformed other MCOs on the Getting Needed Care measure, scoring between the 50th and 74th percentile of national scores.

Table 14. MCO and state scores for physical health access measures, 2014.						
	AMG	CCC	CHP	MHW	UHC	State
HEDIS measures						
Infant WCC (6+ visits)	45.26% ▼	43.06% ▼	60.10%	67.77% ▲	58.64%	56.25%
Child WCC visit, 3–6 years	58.33% ▼	67.36%	66.18%	64.60%	62.77%	63.84%
Adolescent WCC visit	34.95%	38.19%	42.34%	44.37% ▲	35.52%	39.13%
Access to PCPs:						
Ages 12–24 months	93.45% ▼	97.19%	97.14%	97.78% ▲	93.94% ▼	97.25%
Ages 25 months–6 years	77.52% ▼	86.13% ▼	86.22% ▼	89.04% ▲	82.20% ▼	87.53%
Ages 7–11 years	NA	NA	89.39% ▼	92.24% ▲	NA	91.22%
Ages 12–19 years	NA	NA	88.49% ▼	92.12% ▲	NA	90.75%
CAHPS measure						
Getting Needed Care	☆☆	☆	☆ ▼	☆	☆☆☆ ▲	☆

Stars represent Washington's performance compared with the 2014 NCQA national percentile rankings. One star (Poor) represents scores below the 25th percentile; five stars (Excellent) represent scores at or above the 90th percentile.
▲ MCO score is significantly higher than state average (p<0.05).
▼ MCO score is significantly lower than state average (p<0.05).
NA: Sample size was less than the minimum required.

Compliance with access standards

Each MCO must monitor the capacity of its provider network in relation to utilization patterns, and demonstrate that the network can serve all eligible enrollees, considering the numbers and types of providers required, geographic location of providers and enrollees, and enrollees' cultural, ethnic, racial, and language needs. MCOs must provide adequate information to enable enrollees to understand benefit coverage and how to obtain care. Written information must discuss how to choose and change PCPs and how to obtain emergency services, hospital care, and services outside the network. The MCO must inform enrollees about available specialists, advance directives, grievance procedures, well-child care, translation and interpretation services, and how to obtain a second opinion.

The MCO must comply with regulations in 42 CFR §438 pertaining to:

- Availability of Services
- Furnishing of Services
- Coverage and Authorization of Services
- Emergency and Post-stabilization Services
- Enrollee Rights

TEAMonitor's 2014 review found that the MCOs, as a group, fully complied with at least 70% of the elements of all access standards, except for Coverage and Authorization of Services (65%). Many of the identified deficiencies related to inadequate or incomplete documentation of MCO policies and procedures, particularly regarding enrollee rights requirements and monitoring of utilization management activities. Table 18 on page 78 reports compliance by MCO.

Timeliness of physical health care

The CAHPS measure of Getting Care Quickly expresses how often the enrollee got urgent care as soon as needed, and got an appointment for a checkup or routine care at a doctor's office or clinic as soon as needed.

In 2014, the Washington MCOs, as a group, scored between the 25th and 49th percentile of national Medicaid scores on Getting Care Quickly. UHC was top performer among MCOs, scoring between the 75th and 89th percentile. (See Table 15.)

Table 15. Washington and U.S. scores for physical health timeliness measure, 2014.

Washington/U.S. comparison	U.S. score◖	Washington score	Washington rating
Getting Care Quickly	2.41	2.37	☆☆

MCO comparison	AMG	CCC	CHP	MHW	UHC
Getting Care Quickly	☆☆☆	☆	☆ ▼	☆☆	☆☆☆☆ ▲

Stars represent Washington's performance compared with the 2014 NCQA national percentile rankings. One star (Poor) represents scores below the 25th percentile; five stars (Excellent) represent scores at or above the 90th percentile.
▲ MCO score is significantly higher than state average (p<0.05).
▼ MCO score is significantly lower than state average (p<0.05).
◖ U.S. score for the CAHPS measure is the NCQA national median.

Compliance with timeliness standards

Through TEAMonitor review, HCA monitors the MCOs' compliance with contractual standards for ensuring timely care delivery. MCOs must ensure timely access to services, taking into account the urgency of the need for services. Per the HCA contract, each MCO must

- offer designated services 24 hours a day, seven days a week by telephone
- make available preventive care office visits with the enrollee's PCP or another provider within 30 calendar days; routine care visits, within 10 calendar days; urgent, symptomatic visits, within 48 hours; and emergency care, 24 hours a day, seven days a week.

Federal regulations require MCOs to provide operating hours for Medicaid enrollees that are no less than the hours for any other patient. The MCO must ensure compliance by its providers. TEAMonitor's 2014 review found:

- AMG and CHP fully met this standard, and CCC and UHC partially met the standard.
- MHW failed to meet the standard, providing limited evaluation summaries and no analysis of improvement measures and needs.

Regulations under 42 CFR Subpart F specify the time frames within which the MCO must

- notify the enrollee about a decision to deny payment; to terminate, suspend, or reduce previously authorized services; or to deny or limit services
- enable enrollees, or providers acting on their behalf, to file an appeal or request a state fair hearing following the MCO's notice of action
- resolve the enrollee's grievance in a standard or expedited proceeding

TEAMonitor found that CCC, MHW, and UHC met all of the specified time frames. CHP did not demonstrate compliance with timely handling of grievances within 45 days of receipt, and AMG did not consistently resolve appeals within the specified time frame.

42 CFR §438.10(f) requires MCOs to furnish timely information to enrollees regarding their rights, protections, and benefits, including but not limited to disenrollment rights, the termination of contracted providers, and detailed identification of providers in the enrollee's service area. According to TEAMonitor, only UHC fully met this standard during the review period. The other MCOs did not consistently give enrollees timely notice of significant changes in the provider network or of the termination of contracted providers.

Quality of physical health care

The HCA contract and 42 CFR §438.320 define quality as the degree to which a managed care plan "increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge."

HCA monitors MCO performance on the standardized measures of clinical care delivery and consumer satisfaction discussed below.

Performance on quality measures

Statewide results: Table 16 displays state and national results on a broad array of HEDIS and CAHPS measures related to service quality.

Table 16. Washington and U.S. scores for physical health quality measures, 2014.

	U.S. score◖	Washington score	Washington rating
HEDIS measures			
Childhood Immunizations (Combo 2)	74.02%	65.96%*	☆
Childhood Immunizations (Combo 3)	70.85%	62.59%*	☆
Adolescent Immunizations (Combo 1)	70.17%	65.44%*	☆☆
Diabetes Care (annual HbA1c test)	83.81%	86.27%*	☆☆☆
Diabetes Care (dilated retinal exam)	53.53%	46.06%*	☆
Diabetes Care (LDL-C screening)	75.97%	71.97%*	☆☆
Diabetes Care (nephropathy monitoring)	79.02%	79.33%	☆☆
Weight Assessment/Counseling (BMI)	56.92%	30.07%*	☆
Weight Assessment/Counseling (nutrition)	58.70%	45.70%*	☆
Weight Assessment/Counseling (physical)	50.50%	41.39%*	☆
Appropriate Testing for Pharyngitis	66.52%	63.74%*	☆☆
Appropriate Use of Asthma Medications	84.07%	83.47%	☆☆
CAHPS measures			
How Well Doctors Communicate	2.54	2.58	☆☆☆☆
Customer Service	2.54	2.46	☆
Rating of Personal Doctor	2.50	2.46	☆☆
Rating of Specialist Seen Most Often	2.51	2.51	☆☆☆
Rating of All Health Care	2.32	2.25	☆
Rating of Health Plan	2.40	2.23	☆

Stars represent Washington's performance compared with the 2014 NCQA national percentile rankings. One star (Poor) represents scores below the 25th percentile; five stars (Excellent) represent scores at or above the 90th percentile.
*State average is significantly different from the NCQA average ($p<0.05$).
◖ U.S. score for each HEDIS measure is an average; U.S. score for each CAHPS measure is the NCQA national median.

Immunizations: Average Combo 2 and Combo 3 immunization rates for the Washington MCOs in 2014 were significantly below the U.S. average rates, as has been the case in the past. The MCOs reported adolescent immunization rates to HCA for the first time in 2014; the average Combo 1 rate for this age group was also significantly lower than the U.S. average.

Diabetes care: Performance on these indicators showed mixed results in 2014. The statewide rate of HbA1c testing significantly exceeded the U.S. average rate, and the statewide rate of monitoring for diabetic nephropathy was in line with the U.S. average. However, the Washington MCOs significantly underperformed the U.S. average for dilated retinal exams and LDL-C screening.

Weight assessment/counseling for enrollees ages 3–17 years: The Washington MCOs reported these measures to HCA for the first time in 2014. As shown, the MCOs provided assessment and counseling related to body mass index (BMI), nutrition, and physical activity at rates that were significantly below the U.S. average rates.

HCA also required the MCOs to report rates of *appropriate testing for pharyngitis* and *appropriate use of asthma medications* for the first time in 2014. For pharyngitis testing, the MCOs significantly underperformed relative to the U.S. average. However, the statewide average performance on use of asthma medications was marginally better than the U.S. average.

Looking at CAHPS measures, the Washington MCOs, as a group, performed between the 75th and 89th percentile of nation scores for How Well Doctors Communicate. The MCOs achieved moderate enrollee satisfaction with Rating of Specialist Seen Most Often. Adult enrollees gave the MCOs low ratings on other CAHPS measures, particularly Customer Service, Rating of All Health Care, and Rating of Health Plan.

Customer Service is a composite measure of how often the MCO's customer service staff provided information or help the enrollee needed, and treated the enrollee with courtesy and respect. For the "global" ratings of Personal Doctor, Specialist, All Health Care, and Health Plan, adult enrollees were asked to rate the MCO on a scale of 0 to 10, with 0 being the "worst possible" and 10 being the "best possible."

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

Immunizations: CHP remained the top performing MCO in 2014, with immunization rates above 70%. AMG reported results significantly below the state average for all three indicators, while UHC underperformed on Combo 2.

Diabetes care: For HbA1c testing, CHP's rate (91.79%) significantly exceeded the statewide average and the NCQA 90th percentile, while AMG's rate (81.64%) was significantly below the state average. Both CHP and MHW significantly outperformed the state average by providing dilated retinal exams for more than half of their enrollees with diabetes.

Weight assessment/counseling: CHP significantly outperformed other MCOs on all three indicators. UHC reported rates far below the state average, as did CCC for the BMI indicator.

Considering CAHPS measures, all MCOs except AMG scored high on How Well Doctors Communicate. MHW and UHC scored high on Rating of Specialist. MCO scores on other measures were in the moderate range, or more often, below the national 50th percentile.

Table 17. MCO and state scores for physical health quality measures, 2014.						
	AMG	CCC	CHP	MHW	UHC	State
HEDIS measures						
Childhood Immunizations (Combo 2)	53.89% ▼	64.35%	76.89% ▲	67.77%	59.61% ▼	65.96%
Childhood Immunizations (Combo 3)	50.30% ▼	59.95%	73.48% ▲	64.24%	57.66%	62.59%
Adolescent Immunizations (Combo 1)	54.84% ▼	69.21%	71.29% ▲	64.58%	61.31%	65.44%
Diabetes Care (annual HbA1c test)	81.64% ▼	86.09%	91.79% ▲	87.61%	82.73%	86.27%
Diabetes Care (dilated retinal exam)	38.72% ▼	47.24%	51.82% ▲	52.70% ▲	37.96% ▼	46.06%
Diabetes Care (LDL-C screening)	70.80%	72.19%	75.91%	71.17%	68.61%	71.97%
Diabetes Care (nephropathy monitoring)	78.98%	80.57%	80.84%	79.95%	75.67%	79.33%
Weight Assessment/ Counseling (BMI)	28.07%	19.91% ▼	53.04% ▲	35.10% ▲	14.36% ▼	30.07%
Weight Assessment/ Counseling (nutrition)	44.55%	46.30%	52.80% ▲	45.03%	39.90% ▼	45.70%
Weight Assessment/ Counseling (physical)	37.82%	45.14%	51.58% ▲	38.19%	34.55% ▼	41.39%
Appropriate Testing for Pharyngitis	68.16%	54.35% ▼	59.18% ▼	67.38% ▲	66.77%	63.74%
Appropriate Use of Asthma Medications	NA	NA	84.08%	83.14%	NA	83.47%
CAHPS measures						
How Well Doctors Communicate	☆☆	☆☆☆☆	☆☆☆☆	☆☆☆☆	☆☆☆☆	☆☆☆☆
Customer Service	☆	☆☆☆	☆ ▼	☆☆	☆	☆
Rating of Personal Doctor	☆	☆☆	☆☆	☆☆☆	☆☆	☆☆
Rating of Specialist	☆☆☆	☆☆	☆ ▼	☆☆☆☆	☆☆☆☆	☆☆☆
Rating of All Health Care	☆	☆	☆ ▼	☆☆	☆☆☆ ▲	☆
Rating of Health Plan	☆	☆	☆	☆☆ ▲	☆	☆

Stars represent Washington's performance compared with the 2014 NCQA national percentile rankings. One star (Poor) represents scores below the 25th percentile; five stars (Excellent) represent scores at or above the 90th percentile.
▲ MCO score is significantly higher than state average (p<0.05).
▼ MCO score is significantly lower than state average (p<0.05).
NA: Sample size was less than the minimum required.

Compliance with quality standards

Through TEAMonitor, HCA assesses the MCOs' compliance with many regulatory and contractual requirements related to quality (see Appendix C). Quality standards are embedded in the portions of the compliance review addressing

- Coordination and Continuity of Care
- Patient Review and Coordination
- Provider Selection (Credentialing)
- Practice Guidelines
- QA/PI Program
- Enrollee Rights
- Grievance Systems
- Health Homes

Last year, the MCOs, as a group, had difficulty meeting the requirements for Coordination and Continuity of Care, which focus on

- preventing the interruption of medically necessary care
- facilitating care for enrollees in transition from one setting or level of care to another
- ensuring coordination of care between primary care and other service systems
- ensuring that enrollees at high risk of rehospitalization and/or substance use disorder treatment recidivism have a documented, individual plan for interventions to mitigate risk
- coordinating care for children in foster care

In 2014, TEAMonitor found that the MCOs met two-thirds of the elements of this standard. Most MCOs, however, did not consistently complete or attempt initial screens to identify and assess enrollees with special health care needs (SHCN).

TEAMonitor added Health Homes as a review standard in 2014. CHP, MHW, and UHC met three-quarters of the elements of this standard, while AMG and CCC failed to comply with most or all elements.

Considering other compliance areas, the MCOs met 95% of the Provider Selection elements and 86–89% of the elements for Grievance Systems, Patient Review and Coordination, and Practice Guidelines. Group scores on these standards represented a substantial improvement over the previous year's performance. Notably, MHW and UHC met 100% of these elements.

The weakest overall performance occurred in complying with the QA/PI Program standard. Each MCO's QA/PI program must include a quality improvement committee to oversee quality functions, an annual work plan, and an annual written program evaluation. MCOs must have mechanisms for identifying both under- and overutilization of services, and for assessing care furnished to enrollees with SHCN. The MCOs also must report performance measures as required by HCA. TEAMonitor found that the MCOs, as a group, met only 60% of the QA/PI Program elements, though MHW and UHC met 100% of these elements.

Physical health regulatory and contractual standards

In 2014, TEAMonitor reviewers scored MCOs on their compliance with the required elements of federal regulations and HCA contract provisions, and followed up with the MCOs on corrective action items noted in 2013. TEAMonitor rated each MCO as having met, partially met, or not met the requirements for each standard listed in Table 18, as well as for the MCO's PIPs.

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

Separately, HCA and ADSA reviewed the WMIP contractor's compliance with relevant regulations and contract provisions (see page 96).

Compliance scoring methods

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

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

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

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

Summary of compliance review results

Table 18 breaks out the 2014 compliance scores assigned by TEAMonitor for each standard by MCO. Figure 12 depicts the 2013 and 2014 compliance scores on selected standards by MCO, along with 2012 scores for CHP and MHW.

Compliance patterns for the MCOs were discussed in previous sections relating to access, timeliness, and quality. In 2014, the MCOs improved their performance on nearly every standard, compared with 2013. A notable exception was the QA/PI Program standard, for which the MCOs met only 60% of the elements.

TEAMonitor added *Health Homes* as a review standard in 2014. For eligible high-cost, high-need enrollees, the MCOs are required to provide community-based health home services that are integrated and coordinated across medical, mental health, chemical dependency, and long-term services and supports. The MCOs must develop and implement a Health Action Plan for each enrollee, based on specified patient data and input from the enrollee and his or her family and/or caregivers. The HCA contract specifies services for comprehensive care coordination, health promotion, transitional care, individual and family support, and referral to community and special support services. The MCOs must submit monthly reports to HCA to support their submission of health home encounters.

Table 18. MCO compliance scores for physical health regulatory and contractual standards, 2014.

Percentage of elements Met, Partially Met, and Not Met

Standard (# of elements)	AMG			CCC			CHP			MHW			UHC			State average		
	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM
Availability of Services (5)	**80**	20	0	**60**	20	20	**100**	0	0	**60**	40	0	**80**	20	0	**76**	20	4
Furnishing of Services (2)	**100**	0	0	**50**	50	0	**100**	0	0	**50**	0	50	**50**	50	0	**70**	20	10
Program Integrity (5)	**100**	0	0	**80**	20	0	**80**	20	0	**80**	0	20	**100**	0	0	**88**	8	4
Claims Payment (2)	**100**	0	0	**0**	100	0	**0**	100	0	**100**	0	0	**100**	0	0	**60**	40	0
Coordination and Continuity of Care (8)	**63**	37	0	**63**	25	12	**63**	37	0	**63**	25	12	**88**	12	0	**67**	27	5
Patient Review and Coordination (5)	**80**	20	0	**80**	20	0	**80**	20	0	**100**	0	0	**100**	0	0	**88**	12	0
Coverage and Authorization of Services (4)	**50**	25	25	**25**	75	0	**75**	25	0	**100**	0	0	**75**	25	0	**65**	30	5
Emergency and Post-stabilization Services (2)	**50**	0	50	**50**	50	0	**50**	0	50	**100**	0	0	**100**	0	0	**70**	10	20
Enrollee Rights (15)	**60**	7	33	**66**	27	7	**66**	27	7	**86**	7	7	**100**	0	0	**75**	13	11
Enrollment/Disenrollment (2)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Grievance Systems (18)	**66**	11	22	**94**	6	0	**83**	17	0	**100**	0	0	**100**	0	0	**89**	7	4
Practice Guidelines (3)	**33**	33	33	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**86**	7	7
Provider Selection (4)	**100**	0	0	**75**	0	25	**100**	0	0	**100**	0	0	**100**	0	0	**95**	0	5
QA/PI Program (5)	**20**	40	40	**40**	40	20	**40**	0	60	**100**	0	0	**100**	0	0	**60**	16	24
Subcontractual Relationships and Delegation (4)	**100**	0	0	**100**	0	0	**100**	0	0	**75**	25	0	**100**	0	0	**95**	5	0
Health Homes (4)	**25**	0	75	**0**	0	100	**75**	0	25	**75**	0	25	**75**	0	25	**50**	0	50

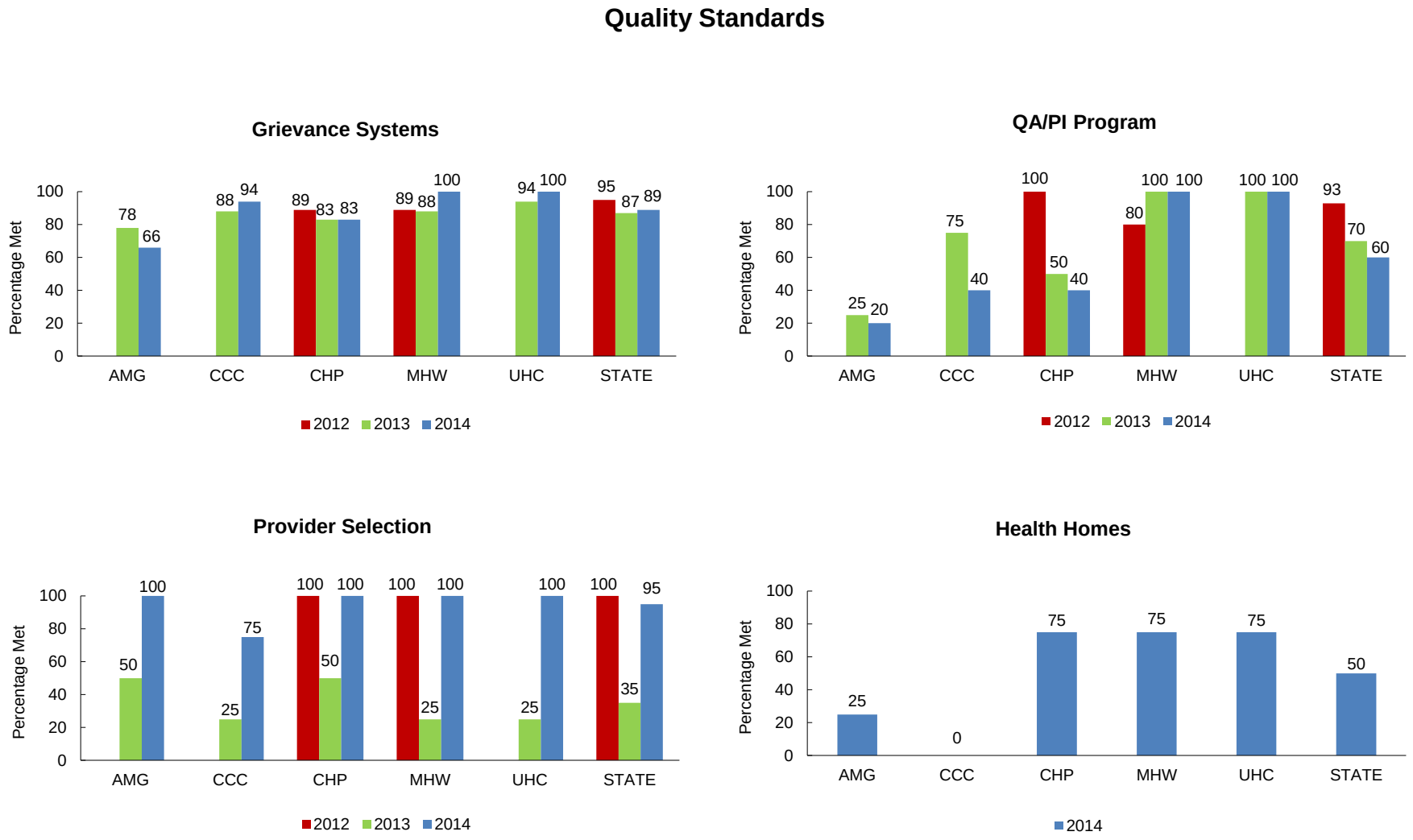
M=Met; PM=Partially Met; NM=Not Met

NOTE: These standards were scored during the first half of 2013. MCOs with a score of “Partially Met” or “Not Met” for any standard may have submitted corrective action plans to address deficiencies following review; therefore, the above scores may not reflect the status of plan performance as of December 2013.

Percentages may not add to 100 because of rounding.

Figure 12. Changes in compliance scores for selected physical health regulatory standards by MCO, 2012–2014.

Figure 12. Changes in compliance scores for selected physical health regulatory standards by MCO, 2012–2014 (cont.).



Corrective action plans

In 2014, TEAMonitor reviewed the MCOs' 2013 readiness review follow-up/corrective action plans (CAPs) and documented how the MCOs had resolved corrective actions. If the review identified old or new findings, TEAMonitor required the MCO to perform corrective action in 2014. Table 19 shows the disposition of CAPs required in 2014.

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

Table 19. Disposition of MCOs' corrective action plans.

Health plan	2014 CAPs required	2014 CAPs accepted	2014 percentage accepted	2013 CAP follow-up status not resolved
AMG	31	30	90%	11
CCC	28	26	80%	5
CHP	22	22	100%	2
MHW/WMIP	13	13	100%	4
UHC	6	2	80%	0

Physical health PIP validation

The HCA contract requires each MCO to conduct

- one clinical PIP of the MCO's choosing
- a nonclinical statewide PIP on Transitional Healthcare Services, focused on enrollees with special health care needs or at risk for reinstitutionalization, rehospitalization, or substance use disorder recidivism

PIP validation by TEAMonitor follows the CMS protocol. MCOs must conduct their PIPs as formal studies, describing the study question, numerator and denominator, confidence interval, and tests for statistical significance. All Medicaid enrollees must have access to the interventions described in the PIP. (See Appendix D.)

Table 20 shows the topics of each MCO's PIPs and the scores assigned by TEAMonitor.

Transitional Healthcare Services PIP. All MCOs took part in this PIP, which began in 2013 and focused on reducing unnecessary hospital readmissions within 30 days of hospital discharge. Interventions during a 90-day pilot project with St. Joseph Medical Center Tacoma focused on enrollees receiving follow-up care with a provider within 7 days of discharge. The MCOs observed no overall decrease in readmission rates, but the number of enrollees who saw a provider increased, and readmission rates for high-risk patients who saw a provider within 7 days of discharge fell slightly. The MCOs were to plan for expansion and sustainability during 2015.

TEAMonitor scored this PIP as Partially Met. The reviewers found the interventions appropriate for the topic and the population served, but noted that not enough time had elapsed for the MCOs to assess meaningful change. Gaps in the PIP documentation included the absence of a data analysis plan, interpretation of the initial results, and discussion of the next steps.

The following pages report TEAMonitor scores and findings for each MCO's individual PIPs.

Table 20. PIP topics and scores by MCO, 2014.

MCO	PIP topic	Score
AMG	Clinical: Well-Child Visits During the First 15 Months of Life (5 or More Visits)	Not Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met
CCC	Clinical: Increasing Compliance of Female Members Over Age 40 in Getting an Annual Screening Mammogram	Partially Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met
CHP	Clinical: Improving Use of Appropriate Medications for People with Asthma	Partially Met
	Clinical: MCS Accountable and Collaborative Care	Partially Met
	Nonclinical: Reducing the Volume of MCS Member Grievance Calls Taken by Customer Service Representatives	Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met
MHW	Clinical: Improving Breast Cancer Screening	Partially Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met
UHC	Clinical: Increasing Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Partially Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met

Source: TEAMonitor.

Amerigroup Washington

Table 21 displays the topics and scores of AMG's PIPs in 2014.

In addition to taking part in the collaborative statewide PIP, AMG continued its clinical PIP aimed at increasing the percentage of infants who receive at least five WCC visits, a HEDIS measure. As in 2013, TEAMonitor scored this PIP as Not Met, citing insufficient or incomplete documentation. AMG submitted a list of barriers to improving WCC visit rates and a list of education-based interventions to address them, but it was unclear whether the interventions were actually implemented or simply planned. AMG reported no results to the state. AMG is required by contract to conduct this PIP again in 2015.

Table 21. Amerigroup Washington PIP topics and scores, 2014.

Topic	Score
Clinical: Well-Child Visits During the First 15 Months of Life (5 or More Visits)	Not Met
Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met

Coordinated Care Corp.

Table 22 displays the topics and scores of CCC's PIPs in 2014.

CCC continued a clinical PIP aimed at increasing the compliance of female members age 40 and older with recommended annual mammograms. Interventions consisted of mailings and outreach calls to women who had not had mammograms within the past two years, to help them make appointments with their PCPs or to help with transportation if needed.

TEAMonitor scored this PIP as Partially Met, stating that the study appeared to be solid, using the HEDIS breast cancer screening measure. However, CCC submitted its PIP documentation on the wrong validation worksheet, omitting some required elements and making interpretation of the project difficult.

Table 22. Coordinated Care Corp. PIP topics and scores, 2014.

Topic	Score
Clinical: Increasing Compliance of Female Members Over Age 40 in Getting an Annual Screening Mammogram	Partially Met
Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met

Community Health Plan

Table 23 displays the topics and scores of CHP's PIPs in 2014.

CHP continued its clinical PIP aimed at improving the use of appropriate asthma medications (a HEDIS measure) for blind and disabled enrollees. The MCO also began a new clinical PIP, seeking to improve antidepressant medication adherence and diabetes screening and tracking for the MCS population. The intervention for this project involved implementing care coordination services through the MCO's mental health integration program.

In addition to taking part in the collaborative statewide PIP, CHP submitted a new nonclinical PIP, aimed at reducing the volume of grievance calls from MCS members taken by the MCO's customer service representatives.

Strengths

- CHP's nonclinical PIP had the useful objective of reducing the number of MCS enrollee grievances from 2012 to 2013. This PIP was well designed and implemented, and succeeded in reducing grievances even more than originally targeted.
- The clinical PIP on asthma medications was generally well written and documented.

Opportunities for improvement

- CHP's two clinical PIPs did not have significantly favorable effects on enrollees' health outcomes or satisfaction, and neither project appeared to have been retooled to improve outcomes.
- For the asthma medications PIP, CHP needs to reevaluate the interventions and study design to ensure that the interventions are appropriate and are linked to barriers.
- For the accountable and collaborative care PIP, CHP needs to improve the data analysis documenting the improvement need, the description of the population receiving the intervention, and linkage between the data analysis and interventions.

Table 23. Community Health Plan PIP topics and scores, 2014.

Topic	Score
Clinical: Improving Use of Appropriate Medications for People with Asthma	Partially Met
Clinical: MCS Accountable and Collaborative Care	Partially Met
Nonclinical: Reducing the Volume of MCS Member Grievance Calls Taken by Customer Service Representatives	Met
Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met

Molina Healthcare of Washington

Table 24 displays the topics and scores of MHW's PIPs in 2014.

MHW continued its clinical PIP aimed at increasing breast cancer screening rates for women age 40 through 69 in the blind and disabled population. TEAMonitor scored this PIP as Met in 2013, but only Partially Met in 2014. The reviewers found this PIP well planned and documented, with interventions tailored to address the needs of special populations with cultural and/or linguistic barriers to services. the interventions empowered targeted provider groups to support MHW's outreach efforts by providing tailored rates and lists of enrollees overdue for screening. However, MHW did not revise its study question for clarity as requested by TEAMonitor last year.

MHW also submitted three PIPs targeting improvements for the WMIP population, discussed on page 97.

Table 24. Molina Healthcare of Washington PIP topics and scores, 2014.

Topic	Score
Clinical: Improving Breast Cancer Screening	Partially Met
Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met

UnitedHealthcare Community Plan

Table 25 displays the topics and scores of UHC's PIPs in 2014.

UHC discontinued its previous clinical PIP and began a project aimed at improving WCC visit rates for children in their third through sixth years. In 2013, the MCO mailed an incentive letter to parents of children in this age group, urging them to obtain a WCC visit. UHC listed other planned interventions, including outreach and member incentives and a clinical practice consultant program.

TEAMonitor scored the clinical PIP as Partially Met. The project was generally well presented, but the interventions were minimal, poorly described, and not linked to causes or barriers identified through data analysis and root cause analysis.

Table 25. UnitedHealthcare Community Plan PIP topics and scores, 2014.

Topic	Score
Clinical: Increasing Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Partially Met
Nonclinical: Statewide Transitional Healthcare Services PIP	Partially Met

Washington Medicaid Integration Partnership Evaluation

The WMIP, initiated in 2005, sought to integrate medical, mental health, chemical dependency, and long-term care services for categorically needy aged, blind, and disabled people who are eligible for both Medicaid and Medicare. These enrollees, who tend to have complex health profiles, are among the most expensive enrollees to serve. The pilot project focused on reducing overall health care costs, particularly by reducing ER visits and improving the use of mental health and substance abuse services, in addition to improving enrollees' quality of life and independence.

MHW conducted the WMIP in Snohomish County under contract with HCA. Key elements of the service approach included:

- intensive care coordination to help clients navigate the healthcare system
- involving clients in care planning
- use of the Chronic Care Model to link medical, pharmacy, and community services
- use of standards for preventive health and evidence-based treatment to guide care and improve health outcomes

The WMIP target population excluded children under 21, Apple Health enrollees, and recipients of Temporary Assistance for Needy Families.

With the inclusion of the blind and disabled population into managed care and mental health parity, HCA ended the WMIP program June 30, 2014, at which time the program had about 3,000 enrollees.

Because the WMIP population differs categorically from the traditional Medicaid population, it has not been feasible to compare WMIP performance data meaningfully with the data reported for Apple Health enrollees or with national data for health plans serving traditional Medicaid recipients. However, it is possible to evaluate changes in the WMIP measures for diabetes care and other services, to assess the long-term record of this groundbreaking pilot project.

WMIP performance measures

For 2014, MHW reported nine HEDIS measures for the WMIP population:

- comprehensive diabetes care
- inpatient care utilization—general hospital/acute care
- ambulatory care utilization
- mental health utilization
- follow-up after hospitalization for mental illness
- antidepression medication management
- use of high-risk medications for the elderly
- identification of alcohol and other drug services
- initiation and engagement of alcohol and other drug dependence treatment

Data were validated through the NCQA HEDIS compliance audit.

This final analysis of WMIP performance measures looks at long-term trends in diabetes care, antidepression medication management, follow-up after hospitalization for mental illness, and ambulatory care utilization (outpatient and ER visits) spanning the program's existence. Additional tables display data for the past two or three years for remaining measures.

Long-term performance trends

Figure 13 presents the trends in HbA1c testing and control for the WMIP population since 2006. As shown, the percentage of enrollees with diabetes who received HbA1c testing remained flat during this period, fluctuating between 82% and 88%, while the trends in enrollees' HbA1c control moved in a negative direction (good control declining, poor control increasing). By the end of the program, only about 42% of enrollees had good control of HbA1c.

Figure 13. HbA1c testing and control for WMIP enrollees, 2006–2014.

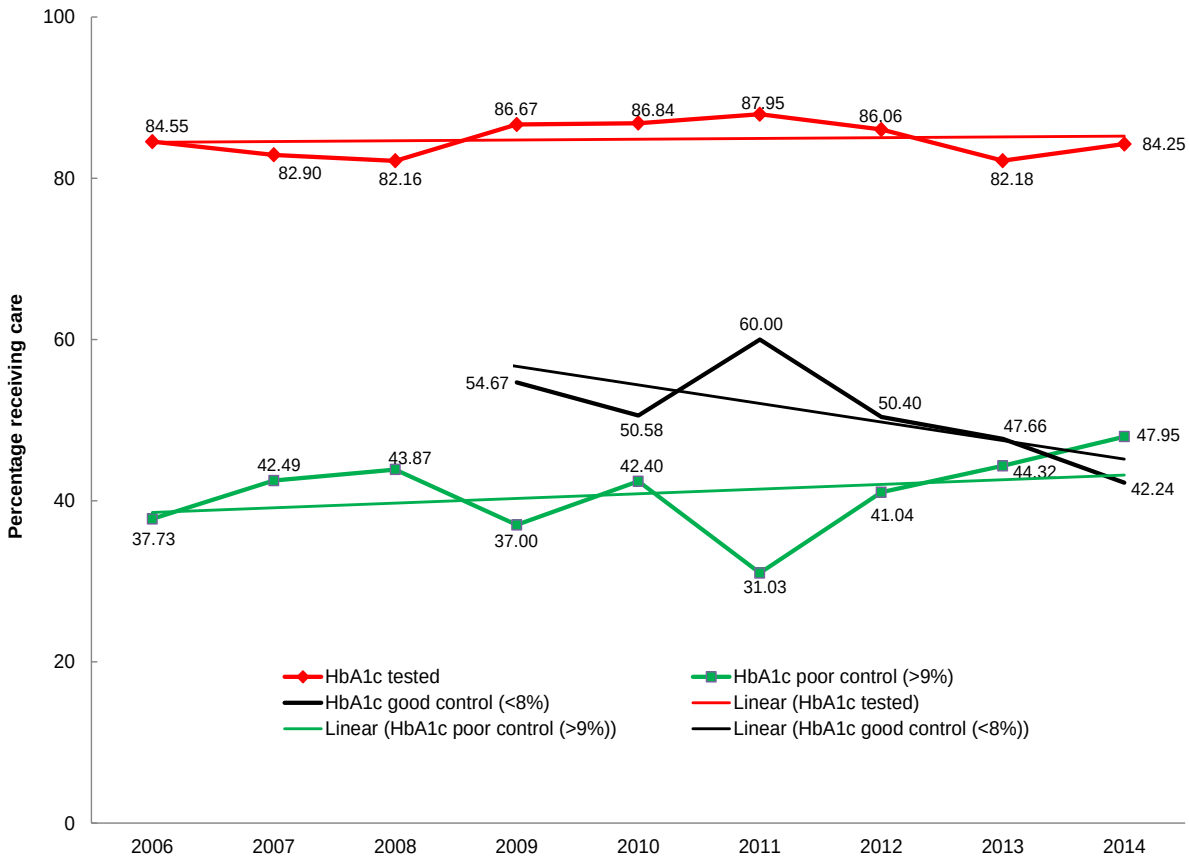


Figure 14 shows the trends in screening measures (dilated retinal exams and monitoring for diabetic nephropathy) for WMIP enrollees with diabetes since 2006. Nephropathy monitoring improved significantly following the onset of the program, despite some fluctuation in recent years, while the percentage of enrollees receiving eye exams trended downward.

Figure 14. Diabetes screening measures for WMIP enrollees, 2006–2014.

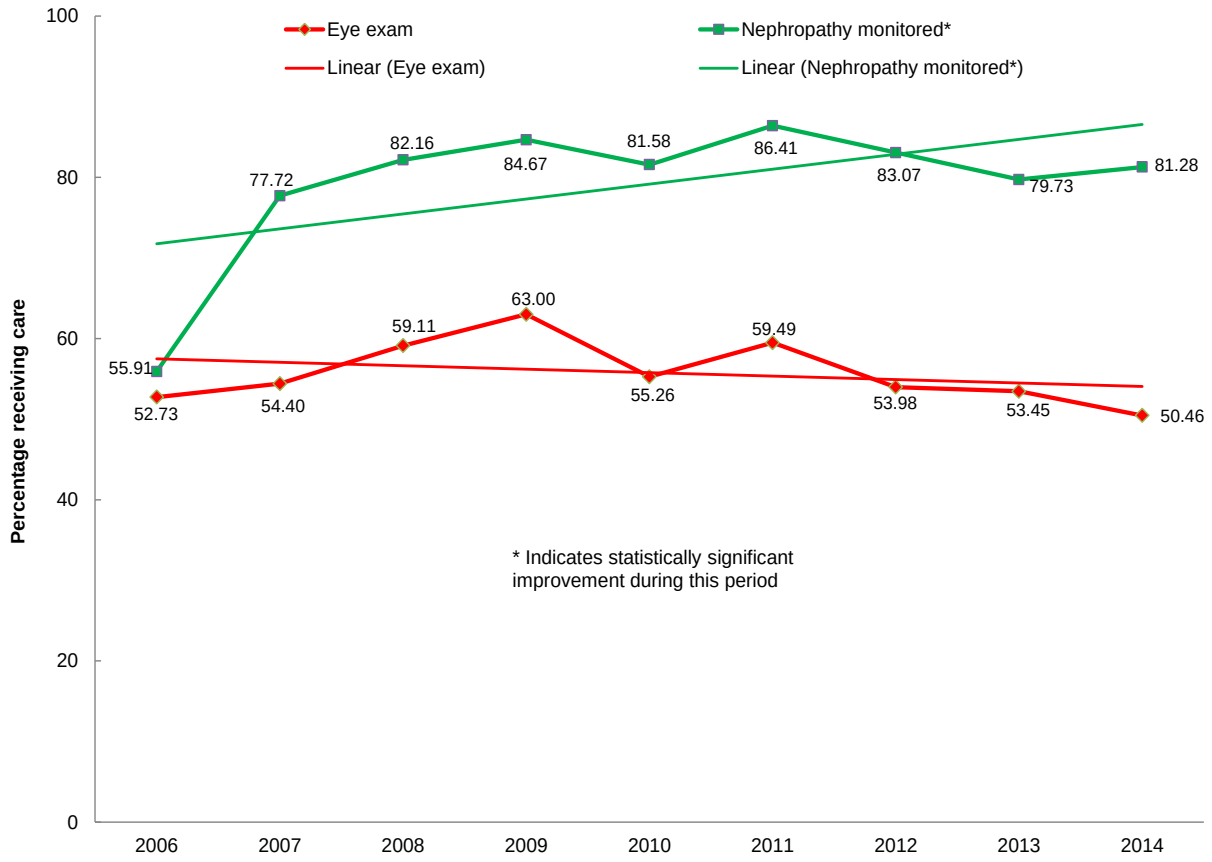


Figure 15 shows the long-term trends in LDL-C screening, LDL-C control, and blood pressure control for WMIP enrollees. LDL-C screening trended gradually downward throughout the program, and the percentage of enrollees with good control of their LDL-C levels remained essentially flat despite year-to-year fluctuations. Blood pressure control dropped sharply in the program's final year, when only about 41% of enrollees had good control. None of these long-term changes were statistically significant.

Figure 15. LDL-C-screening and control and blood pressure control for WMIP enrollees, 2006–2014.

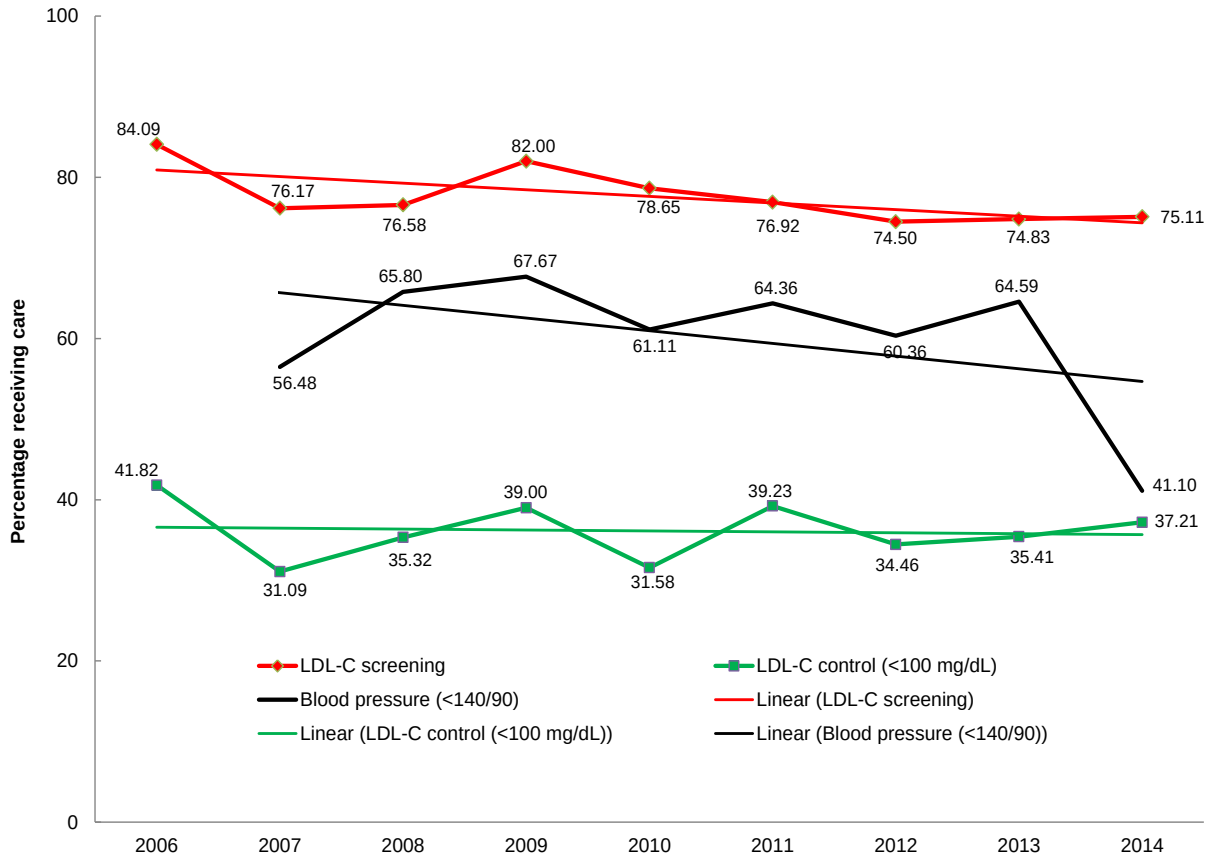
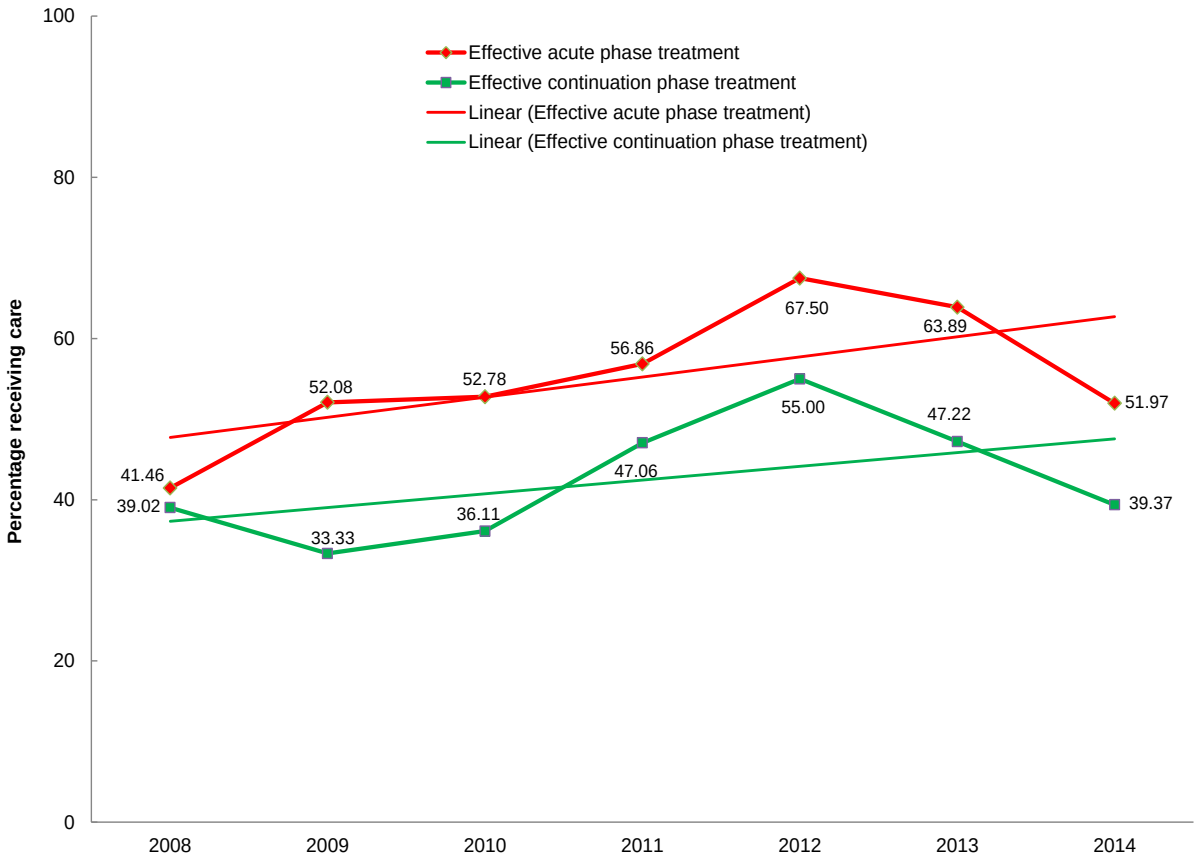


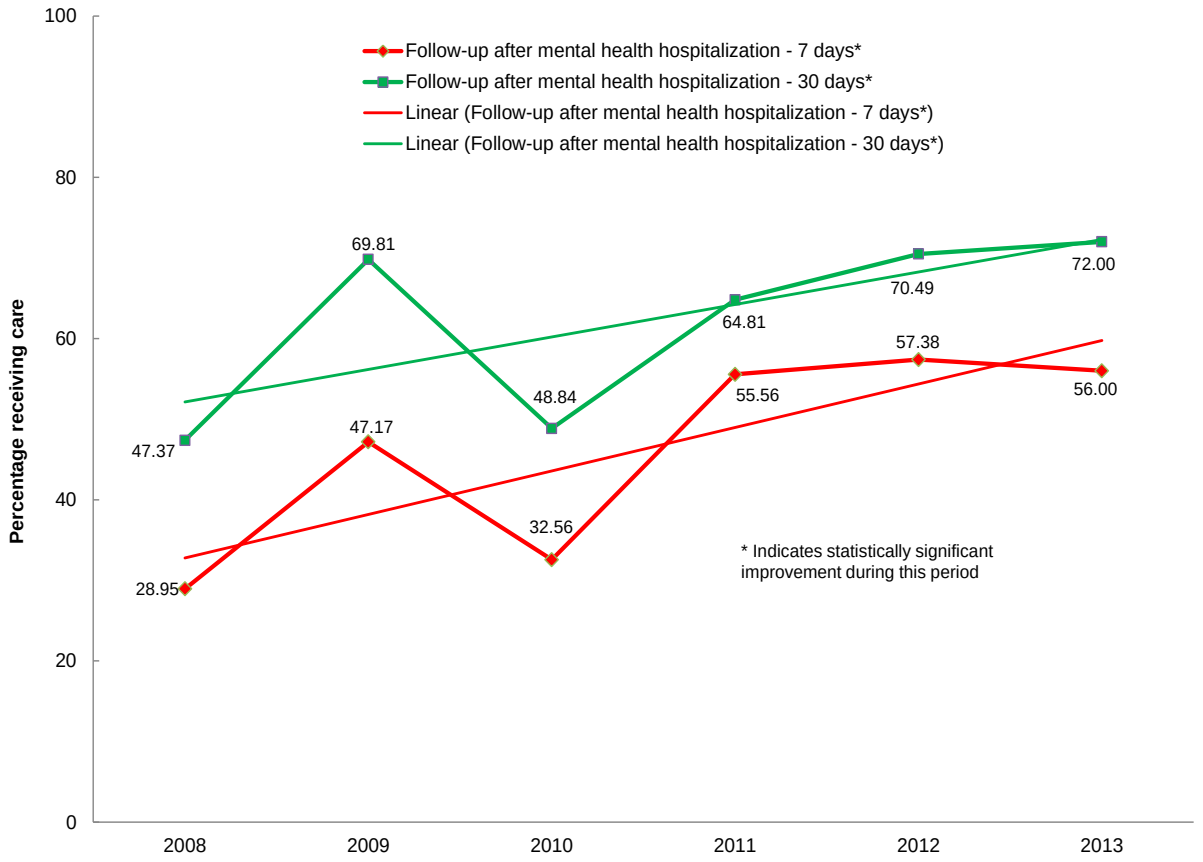
Figure 16 shows the trends in antidepressant medication management for WMIP enrollees since 2008. Both acute phase and continuation phase treatment moved in a positive direction during this period, though the improvement was not statistically significant.

Figure 16. Antidepressant medication management for WMIP enrollees, 2008–2014.



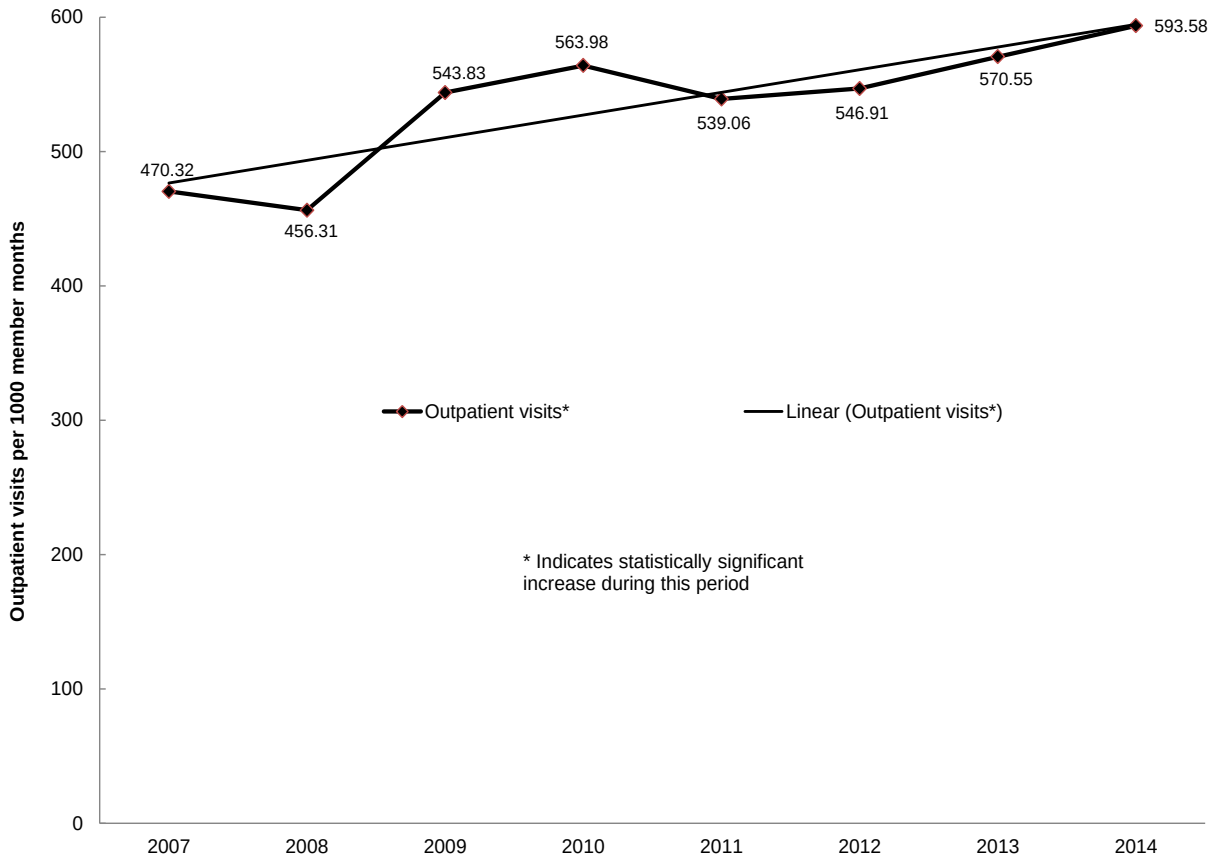
As shown in Figure 17, the measures of timely follow-up treatment for WMIP enrollees after hospitalization for mental illness improved significantly from 2008 to 2013. (Sample sizes for these measures in 2014 were not large enough to support analysis.) Improvement in these measures has represented a notable success of the WMIP program.

Figure 17. Follow-up after mental health hospitalization for WMIP enrollees, 2008–2014.



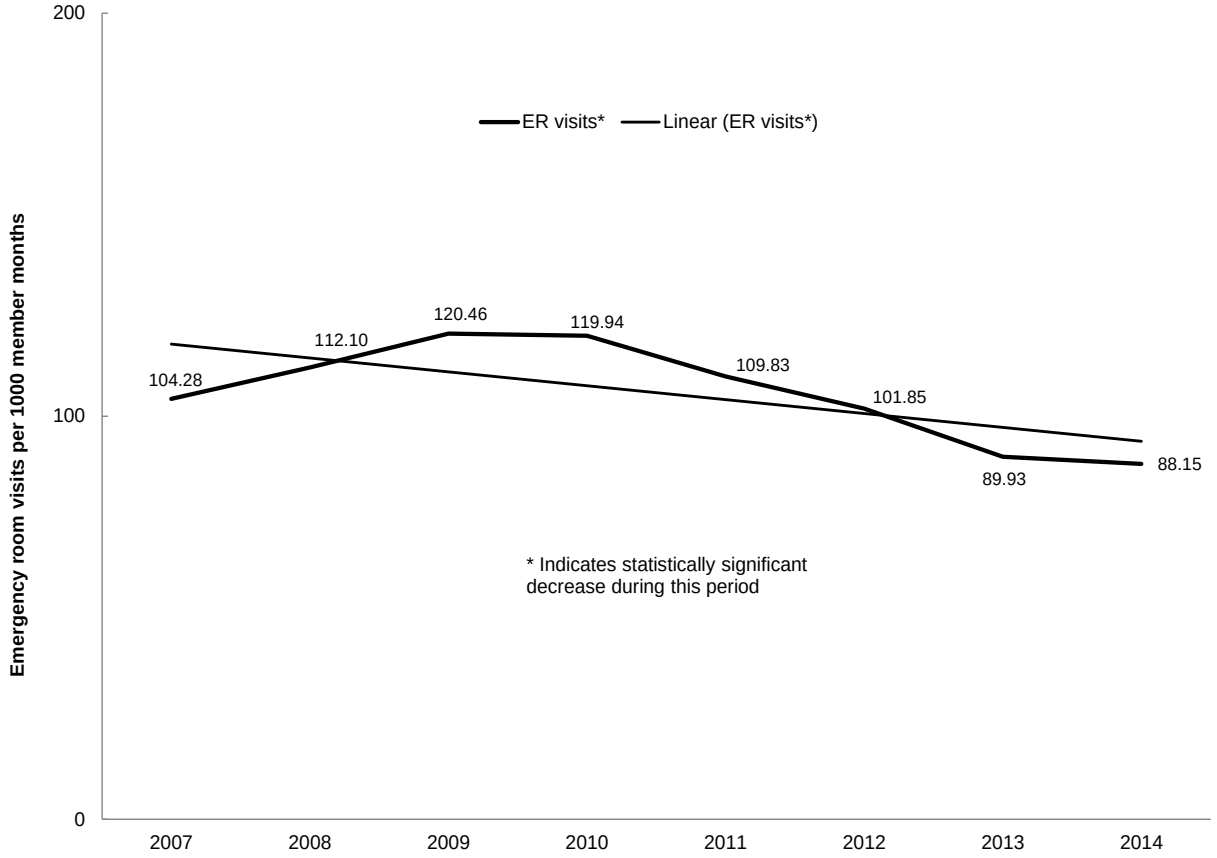
Figures 18 and 19 show the long-term trends in ambulatory care utilization for WMIP enrollees. As shown below, outpatient visit rates increased significantly during the program's existence.

Figure 18. Outpatient visit rates for WMIP enrollees, 2007–2014.



As shown in Figure 19, ER visit rates for WMIP enrollees declined significantly during 2007–2014. Coupled with the long-term trend in outpatient visit rates, this suggests that the program succeeded in treating enrollees at less intensive levels of care over time.

Figure 19. Emergency room visit rates for WMIP enrollees, 2007–2014.



Tables 26–28 present analysis of WMIP utilization data for the past several years. As shown in Table 26, discharge rates rose slightly from 2013 to 2014 for both medical and surgical care, but the changes were not statistically significant. Medical days rose significantly in 2014, while surgical days fell significantly. WMIP enrollees' average length of stay (ALOS) rose slightly for medical care and fell slightly for surgical care in 2014, but the changes were not statistically significant.

The mental health utilization measure (Table 27) summarizes the percentage of enrollees who received certain mental health services during the measurement year. "Any service" includes at least one of the following, and some enrollees received services in multiple categories:

- inpatient
- intensive outpatient/partial hospitalization
- outpatient or ER

Table 28 reports the percentage of WMIP enrollees age 65 or older who received at least one prescription for a high-risk medication, or at least two different prescriptions. From 2008 through 2012, MHW reported increasingly positive results on this measure, pointing to better management of these medications for WMIP enrollees. In 2013, NCQA revised the methodology for calculating this measure, so that the 2013 and 2014 results are not comparable with data from previous years.

Table 26. WMIP inpatient utilization, general hospital/acute care measures, 2012–2014.

	Discharges/1000MM[a]			Days/1000MM[a]			ALOS[b]		
	2012	2013	2014	2012	2013	2014	2012	2013	2014
Total inpatient	15.21	16.00	16.76	78.00	91.37	91.50	5.13	5.71	5.46
Medical	9.53	9.84	10.26	41.44	39.35	44.85 ↑	4.35	4.00	4.37
Surgical	5.24	5.75	5.80	35.23	51.03	44.83 ↓	6.73	8.87	7.73

[a]1000MM = 1000 member months. [b]ALOS = average length of stay in days.
↓↑ Indicates statistically significant difference in rates from 2013 to 2014 ($p \leq 0.05$).

Table 27. WMIP mental health utilization, 2012–2014.

	2012	2013	2014
Any service[a]	41.63	30.24	25.35 ↓
Inpatient	1.58	1.52	0.67 ↓
Intensive outpatient/partial hospitalization	1.33	0.78	1.75 ↑
Outpatient/ER	40.85	30.06	25.25 ↓

[a] "Any" service is person-based; the other categories are visit-based.
↓↑ Indicates statistically significant difference in percentages from 2013 to 2014 ($p \leq 0.05$).

Table 28. WMIP use of high-risk medications for the elderly, 2013–2014.

	One prescription		At least two prescriptions	
	2013	2014	2013	2014
Percentage of patients receiving medication	7.08	4.27	2.29	0.90

No statistically significant differences in percentages from 2013 to 2014 ($p \leq 0.05$).

Tables 29 and 30 display data on dependence treatment measures for WMIP. *Identification of alcohol and other drug (AOD) services* summarizes the percentage of enrollees with an AOD claim who received various types of chemical dependency services during the measurement year. An AOD claim contains a diagnosis of AOD abuse or dependence and a specific AOD-related service.

"Any service" includes at least one of the following, and some enrollees received services in multiple categories:

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

Initiation and engagement of AOD dependence treatment measures the percentage of enrollees with a new episode of AOD dependence who

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

In 2014, the percentage of WMIP enrollees receiving inpatient chemical dependency services fell significantly in relation to 2013; other changes in this measure were not significant. The AOD initiation and engagement measure was not calculated in 2013 or 2014 because the denominator was not large enough to support the calculation of a meaningful measure.

Table 29. WMIP identification of alcohol and other drug services, 2012–2014.

	2012	2013	2014
Any service[a]	20.38	20.46	20.58
Inpatient	75.87	68.14	41.17 ↓
Intensive outpatient/partial hospitalization	0.00	0.00	0.15
Outpatient/ER	18.18	18.64	18.52

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

↓↑ Indicates statistically significant difference in percentages from 2013 to 2014 ($p \leq 0.05$).

Table 30. WMIP initiation and engagement of alcohol and other drug dependence treatment, 2012–2014.

	2012	2013	2014
Initiation	26.32	NA	NA
Engagement	2.63	NA	NA

NA: Sample size was smaller than the minimum required during the reporting year.

WMIP compliance review

TEAMonitor reviewed MHW's compliance with managed care regulations and contractual provisions. This review addressed many of the same standards addressed by TEAMonitor's MCO compliance reviews, as well as elements related to specific WMIP contract provisions. Table 31 reports the 2014 WMIP compliance scores.

MHW fully met seven of the 13 review standards and met 80–90% of three other standards. Overall, these compliance scores represented a notable improvement over the 2013 scores. TEAMonitor reported that MHW partially met 90% of the Performance Improvement Projects standard.

Table 31. WMIP compliance scores, 2014.

Standard (# of elements)	Percentage of elements Met (M), Partially Met (PM), Not Met (NM)		
	M	PM	NM
Availability of Services (7)	**70**	20	10
Program Integrity (5)	**90**	10	0
Claims Payment (2)	**100**	0	0
Coordination and Continuity of Care (8)	**70**	20	10
Coverage and Authorization of Services (5)	**100**	0	0
Enrollment and Disenrollment (1)	**100**	0	0
Enrollee Rights (14)	**80**	10	10
Grievance Systems (19)	**100**	0	0
Performance Improvement Projects (3)	**0**	90	10
Practice Guidelines (3)	**100**	0	0
Provider Selection (4)	**100**	0	0
QA/PI Program (5)	**100**	0	0
Subcontractual Relationships and Delegation (4)	**90**	10	0

Source: TEAMonitor.

WMIP PIP validation

For 2014, MHW carried over two clinical PIPs conducted in 2012 and 2013, aimed at reducing avoidable hospital readmissions and ER visits by WMIP enrollees. Table 32 lists the scores for each PIP over the past three years. MHW also submitted a new nonclinical PIP seeking to improve screening contacts with new high-risk WMIP enrollees.

The intervention for the hospital readmissions PIP was a transitional care program in which an RN coach visited hospitalized enrollees and made follow-up home visits or phone calls to assist with post-discharge coordination of care. In the other clinical PIP, MCO or clinic staff followed up with enrollees who visited the emergency room to help them obtain resources and link them to care within the medical home. TEAMonitor scored both PIPs as Partially Met.

Strengths

- Both clinical PIPs served the majority of WMIP enrollees. Interventions were tailored to client-specific needs and focused on supporting health care compliance and preventing complications.
- The PIP on ER utilization demonstrated a decrease in total and avoidable utilization despite the increasing complexity of the WMIP population during the study time frame.

Opportunities for improvement

- For the hospital readmission PIP, MHW provided limited information to explain the need to address this topic and to link the PIP to the population served, and limited information to connect the interventions to the causes of readmission. TEAMonitor found that the study question and indicators lacked clarity and specificity. The data did not demonstrate a statistically significant decrease in readmission rates.
- For the emergency room PIP, MHW provided limited information about the connection between interventions and causes of avoidable ER use, data collection parameters, and the definition of an avoidable visit.
- The nonclinical project received a score of Not Met. The project was not designed to achieve significant improvement and did not demonstrate improvement in enrollees' health outcomes or satisfaction. Reviewers found the PIP discussion difficult to follow because the project goals, interventions, and target populations were unclear.

Table 32. WMIP PIP topics and scores, 2012–2014.

Topic	2012	2013	2014
Clinical: Decreasing Inpatient Hospital Readmission Rates	Met	Partially Met	Partially Met
Clinical: Decreasing Emergency Department Utilization	Met	Met	Partially Met
Nonclinical: Increasing Percentage of New High-Risk Members Contacted for Screening	n.a.	n.a.	Not Met

Source: TEAMonitor.

WMIP program summary

The WMIP program pioneered the integration of primary, acute, behavioral, and long-term care for dual-eligible (Medicare and Medicaid) patients in Washington. As such, this program served as a prototype for the future delivery of integrated care for Medicaid enrollees.

HCA expanded the Medicaid benefit for WMIP enrollees over time, and expanded the list of required performance measures accordingly. Although the results for this specific population in a single Washington county are not comparable with state or national Medicaid benchmarks, the program's long-term performance trends point to issues that will apply to the expanded Medicaid population in the future.

Considering diabetes care, Acumentra Health's analysis showed little or no improvement in the required screening measures over time, except that monitoring of diabetic nephropathy improved significantly. Overall, the long-term trends in outcome measures have been discouraging. At the end of this program, only 42% of enrollees had good control of their HbA1c levels; 41% had good control of their blood pressure; and 37% had good control of their LDL-C levels.

More encouragingly, the measures of timely follow-up treatment after hospitalization for mental illness improved significantly from 2008 to 2014, representing a notable program success. Antidepressant medication management for enrollees also trended in a positive direction over time, though not significantly so.

Long-term trends in ambulatory care utilization for WMIP enrollees showed a significant increase in outpatient visit rates coupled with a significant decrease in ER visit rates, suggesting that the program succeeded in treating enrollees at less intensive levels of care over time.

Discussion and Recommendations

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

In comparison with the 2013 annual report, the 2014 report analyzes a much more robust set of performance data for the MCOs. Also, the 2014 measures apply to a greatly expanded Medicaid population, including many thousands of enrollees who formerly received FFS care (e.g., disabled and blind SSI recipients and other adult clients). In essence, this report presents baseline data for monitoring changes in the quality of medical services delivered for the broad range of enrollees under Apple Health.

Medicaid managed care highlights

Children's Mental Health System Redesign. DSHS continues to implement its multi-year program to create a system of community-based, child-centered, culturally responsive mental health care for children. The redesign plan responds to commitments based on the *T.R. et al. v. Quigley and Teeter* agreement and state legislative mandates. DBHR is working to implement screening tools and protocols for referring children to mental health services; evidence-based practices such as wraparound and intensive services; a workforce development model to support access to services; and statewide performance measures that rely on standardized encounter reporting.[8]

DBHR has directed all RSNs to implement the Children's Mental Health System Principles in serving children, adolescents, and young adults with behavioral health challenges. Key features include the WISe program, the CANS assessment, and CFT meetings.

DBHR directed Acumentra Health to study and report on the status of implementation of the children's mental health principles. This special study found that most RSNs have a strong infrastructure for serving children with behavioral health challenges through intensive outpatient treatment, providers that treat co-occurring conditions, jail diversion programs, school-based therapy, and relationships with the Developmental Disabilities Administration and with substance abuse treatment services. However, many RSNs are struggling with the early phases of WISe program implementation.

Care integration. HCA's five-year State Health Care Innovation Plan, funded by a $1 million grant from the federal Center for Medicare & Medicaid Innovation, is based on coordinating and integrating health care with community services, social services, and public health. Public-private partnerships called Accountable Communities of Health are to procure Medicaid services in nine regional service areas.[9]

Washington is one of 15 states chosen by CMS to map out improved coordination between Medicare and Medicaid, with reforms that focus on system integration and better care for people with chronic conditions. HealthPath Washington, the state's Medicare-Medicaid integration project, features health homes and full integration capitation, targeting an estimated 40,000 of the most vulnerable enrollees.

Since July 1, 2013, the state has rolled out health homes in 37 of 39 counties. Qualified health homes are paid through a managed FFS model to coordinate care for each client on the basis of a Health Action Plan. A full integration capitation project in King and Snohomish counties seeks to integrate medical and behavioral health care and long-term services and supports for elderly and disabled clients, similar to the goals of the now-ended WMIP project. UHC and Regence Blue Shield will manage care coordination services

under a capitated model in a three-way contract with HCA and CMS.

HCA requires the contracted MCOs to provide a full range of health home services for enrollees with SHCN, in coordination with qualified community health homes or by contracting with RSNs and other organizations. TEAMonitor's review revealed partial compliance with these requirements by the MCOs in 2014.

E2SSB 6312, enacted in 2014, takes a first step toward integrating mental health and chemical dependency services under managed care. Currently, the state purchases mental health services from RSNs and chemical dependency services from counties. Beginning in 2016, these services will be purchased by regionally operated Behavioral Health Organizations. By 2020, the community behavioral health program must be fully integrated into a managed care system that provides mental health, chemical dependency, and medical services for Medicaid enrollees.

Access to care. The Apple Health MCOs showed mixed results on HEDIS measures of access. In providing PCP visits for children and adolescents, the MCOs significantly outperformed the U.S. average for all but one age range (25 months to 6 years). More than 97% of enrollees ages 12–24 months had a PCP visit during the measurement year. The MCOs also performed well on the CAHPS measure of Getting Needed Care in 2014, ranking between the 75th and 89th percentile of national Medicaid scores. In contrast, the statewide average WCC visit rates remained significantly below the U.S. averages for all age groups.

TEAMonitor's 2014 review found that the MCOs, as a group, fully complied with at least 70% of the elements of all access standards, except for Coverage and Authorization of Services (65%).

Acumentra Health did not assess the RSNs' compliance with access and timeliness standards in 2014. Several RSNs have begun initiatives to improve access to crisis services, post-hospital stabilization, and school-based services.

Quality of care. As a group, the Washington MCOs continued to perform significantly below the U.S. average rates for childhood immunization. The MCOs reported adolescent immunization rates for the first time in 2014; the average Combo 1 rate for this age group was also significantly lower than the U.S. average. Looking at diabetes care, the statewide rate of HbA1c testing significantly exceeded the U.S. average rate. Comparisons were less favorable for other care indicators, including the newly reported measure of weight assessment and counseling for children and adolescents.

TEAMonitor's review found that the MCOs, as a group, substantially improved their compliance with many state and federal quality standards in 2014. The MCOs continued to struggle to meet requirements for ensuring coordination and continuity of care for at-risk enrollees, and for conducting robust QA/PI programs.

Acumentra Health's compliance review found that the RSNs are meeting nearly all regulatory and contractual requirements regarding enrollee rights and grievance systems. All RSNs conduct clinical record reviews to ensure the presence of consumer voice, including treatment plans, crisis plans, clinician notes, and assessments.

The path to future improvements: Mental health care

DBHR should focus resources on the following opportunities to improve mental health care.

Quality strategy. DBHR collaborated with HCA in drafting an updated joint Quality Strategy in 2012. To date, the agencies have not yet approved the joint strategy, although DBHR has been able to implement some processes to address the goals of the 2012 draft.

- ***DBHR needs to develop, adopt, and implement a Quality Strategy that the RSNs understand and support.***

Access to care. Faced with a large increase in enrollment due to the state's Medicaid expansion, the RSNs have found it difficult to maintain and recruit adequate numbers of qualified staff to meet the contractual timelines for both intakes and follow-up appointments.

- ***DBHR needs to explore ways to facilitate training and recruitment of mental health clinicians to to meet Medicaid enrollees' access needs.***

Children's mental health. DBHR has directed all RSNs to implement the state Children's Mental Health System Principles in serving children, adolescents, and young adults with behavioral health challenges. Key components include the Wraparound with Intensive Services (WISe) program, providing comprehensive behavioral health services and supports; the Child and Adolescent Needs and Strengths assessment; and Child and Family Team meetings, an intensive outpatient service aimed at diverting children from out-of-home placements.

RSN staff interviewed by Acumentra Health said they found it difficult to retool their mental health delivery systems in an environment of constant change with regard to the state's WISe Manual, WISe program expectations, and turnover of state staff in the children's program.

- ***DBHR needs to provide clear direction and technical assistance for the RSNs as they implement the Children's Mental Health System Principles.***
- ***DBHR needs to continue to update the WISe Manual and program expectations.***

All RSNs expressed concern that the direct service staff of community partners (e.g., DSHS, juvenile justice, schools) knew little about the children's mental health principles and WISe. Most RSNs said it will take time to change the local culture of using out-of-home placement for youth with serious emotional disturbances.

- ***DBHR needs to work with the RSNs to***
  - ***develop strategies to strengthen participation by allied partners in implementing the WISe program***
  - ***continue community education and training for allied partners and their direct staff regarding the WISe program and in-home community placement with service options***
  - ***ensure that the RSNs have developed the necessary infrastructure to implement WISe successfully***

Compliance issues. The following issues were singled out in previous years' compliance reviews but still have not been addressed.

Many RSNs failed to demonstrate that their outpatient service providers observed policies and procedures regarding the use of seclusion and restraints. In general, the RSNs did not have specific procedures in place for behavior de-escalation to ensure that providers can handle volatile situations appropriately.

- ***DBHR needs to ensure that all RSNs and their contracted providers maintain and observe policies and procedures on the use of seclusion and restraint, as well as de-escalation practices.***

Many RSNs do not track requests at the provider agencies for translation or interpreter services and for written information in alternative formats, outside of claims data. Monitoring such requests can help RSNs identify potential needs associated with changes in their service populations.

- ***DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.***

Information Systems Capabilities Assessment (ISCA) follow-up. The 2013 review of DBHR's information system identified many issues related to data quality, processing, system documentation, and staffing. Since then, DBHR has made some

progress in cleaning the data entered into its CIS. However, data do not pass through validity or accuracy checks in ProviderOne, the state's Medicaid management information system, to reject invalid or incomplete data upon receipt. As a result, ProviderOne continues to receive and house invalid and inaccurate data.

- ***DBHR needs to address previous state-level ISCA recommendations related to CIS and ProviderOne data quality, accuracy, and completeness.***
- ***DBHR needs to ensure that appropriate staffing resources are allocated to ensure accurate, complete, and timely processing of Medicaid data.***

The RSN ISCA follow-up reviews, which included provider agency interviews, revealed that data security practices remain inconsistent across RSNs and provider agencies. Most agencies had not implemented data security practices required by the DBHR contract.

- ***DBHR needs to monitor the RSNs to ensure that all requirements for data security are implemented at the RSN and provider agency levels.***

Eligibility verification practices are inconsistent across RSNs. Some RSNs verify enrollee eligibility before they submit encounters to DBHR; others rely solely on their provider agencies to check eligibility on ProviderOne. Some providers do not check eligibility at each visit.

- ***DBHR needs to define and communicate clear expectations for RSNs and provider agencies regarding uniform procedures and frequency for verifying enrollment and eligibility.***

Performance measure validation. Acumentra Health could not verify that DBHR calculated and reviewed the statewide performance measure of routine service within seven days of discharge from a psychiatric inpatient setting. No frozen data set was available for validation by the RSNs or by Acumentra Health.

Finding: 42 CFR §438.358 requires annual validation of performance measures for managed care entities that serve Medicaid enrollees. DBHR did not calculate and freeze the data for the performance measure of routine service within seven days of discharge from a psychiatric inpatient setting, and therefore failed to meet CMS validation requirements.

Encounter data validation (EDV). A separate performance measure requires each RSN to ensure the accuracy of encounters submitted to DBHR by conducting an annual EDV per DBHR guidelines. Acumentra Health audits and verifies each RSN's EDV process, and conducts an independent check of the RSNs' EDV results.

Overall, the RSNs have developed appropriate systems to validate encounter data. Because of the wide variety of EDV procedures and results, this performance measure partially complies with CMS requirements.

Acumentra Health's EDV found that overall agreement between the enrollee chart data and the state's encounter data set was lower than required by the DBHR contract. The matching rate for service duration was only 52.5%, attributable to conversions performed during data processing in ProviderOne. If the data sent to CMS from ProviderOne contain the errors that Acumentra Health detected, DBHR could be at risk of recoupment of program dollars by CMS.

- ***DBHR needs to require the RSNs to report only units of service, or DSHS needs to modify ProviderOne to accept minutes of service.***

Response to 2013 recommendations

The 2013 EQR report offered recommendations as to how DBHR and the RSNs could work together to improve access to mental health care and the quality and timeliness of care. Table 33 outlines DBHR's response to those recommendations.

Table 33. DBHR response to 2012–2013 EQR recommendations for mental health.		
Recommendations	**DBHR response**	**EQRO comments**
Children's mental health treatment (2013)		
Work with the RSNs to ensure that mental health clinicians include coordination-of-care objectives in individualized care plans for children, when allied service agencies are involved in the child's care.	This item is closely linked to the EQRO's focused study of children's mental health in 2014. All RSNs have had to more strongly address multi-system case needs in treatment planning, or create plans to address deficiencies.	DBHR needs to continue to address this issue with the RSNs, as many providers still are not including coordination-of-care objectives in children's care plans.
Work with the RSNs to ensure that children's treatment plans include a multidisciplinary team-based approach, when appropriate.	This area is similar to the issue above, tied to CFT team treatment planning and the development of WISe services.	DBHR needs to monitor children's treatment plans to ensure that each RSN uses the CFT approach in adopting the WISe program.
Work with the RSNs to ensure that providers update enrollees' assessments at least annually to reflect changes in the enrollee's functioning and life circumstances.	RSN provider agencies typically update enrollee needs with updated treatment plans addressing the needs originated in the assessment. The assessment document and process itself is not redone unless cases are closed and reopened after a longer period.	DBHR needs to ensure that updated treatment plans incorporate any changes in the enrollee's functioning and life circumstances.
Direct the RSNs to work with their providers to ensure that children's progress notes fully document the child's response to interventions and progress toward stated goals.	This is an ongoing requirement for RSNs to train provider agencies in adequately linking progress notes to the treatment plan, interventions used, and progress toward goals. DBHR will address this again in the November 2014 Children's Mental Health Committee meeting.	DBHR's response is in progress.
Program integrity (2012)		
Ensure that each RSN has an independent compliance committee that meets regularly to review issues of fraud, waste, and abuse, not only associated with encounter data but also related to internal financial practices, HIPAA, and other areas of risk that might have a negative impact on the RSN, providers, and enrollees. All issues need to be tracked, reviewed, investigated, and resolved in a timely manner.	DBHR stated in 2013 that it would implement new contract language requiring independent compliance committees that meet regularly to maintain overview of fraud, waste, and abuse.	DBHR has revised the RSN contract to include the requested requirements.

Table 33. DBHR response to 2012–2013 EQR recommendations for mental health (cont.).

Recommendations	DBHR response	EQRO comments
Access to mental health care (2012)		
Continue to work with the RSNs to identify solutions to issues with routine access.		Awaiting response. DBHR needs to continue to work with RSNs to resolve routine access issues.
Timeliness of mental health care (2012)		
Establish a recommended period during which a PIP should be completed.	DBHR stated in 2013 that it would implement new contract language requiring RSNs to limit PIP activities to a three-year life cycle.	DBHR needs to follow through with its stated intention.
Quality of mental health care (2012)		
Continue to work with the RSNs to ensure consistency of review criteria for quality and appropriateness of care.	DBHR stated in 2013 that it would review RSN service authorization policies and help the RSNs establish mechanisms to ensure consistent application of review criteria for authorizations and utilization management decision making.	DBHR needs to follow through with its stated intention.
Encourage RSNs to invest adequate resources in PIPs. RSNs should design network-wide interventions that are likely to work and can sustain improvement.	DBHR stated in 2013 that it would work with the EQRO to develop PIP criteria and to implement a statewide approval process for all PIPs.	DBHR needs to follow through with its stated intention.
PIP topics, design, and conduct (2012)		
• Work with the RSNs to select PIPs with a higher likelihood of improving enrollee satisfaction, processes, or outcomes of care. • Ensure that the RSNs understand the elements of a sound PIP design and common challenges to validity of study results. • Encourage more analysis in PIP planning. RSNs should examine the proposed target population—including individuals, providers, and other relevant stakeholders, systems, and resources—to identify specific risk factors and barriers to improvement, and use that information to evaluate the possibilities for improvement.	DBHR stated in 2013 that it would work with the EQRO to develop PIP criteria and to implement a statewide approval process for all PIPs.	DBHR needs to follow through with its stated intention to work with the EQRO to ensure that: • PIPs have a high likelihood to improve enrollee satisfaction, processes or outcomes of care • RSNs understand the elements of a sound PIP design • RSNs perform more analysis when planning PIPs

Table 33. DBHR response to 2012–2013 EQR recommendations for mental health (cont.).		
Recommendations	**DBHR response**	**EQRO comments**
Compliance: Coordination and continuity of care (2012)		
Ensure that all RSNs have developed and implemented policies and procedures on providing direct access to specialists.	DBHR stated in 2013 that it would: • work with identified RSNs to develop policies and procedures for providing direct access to specialists • develop a comprehensive policy review checklist to ensure that the policies and procedures are updated regularly • oversee implementation through routine contract monitoring activities	DBHR needs to follow through with its stated intention.
Compliance: Practice guidelines (2012)		
Ensure that all RSNs routinely review and update practice guidelines to ensure they still apply to enrollees' needs and include current clinical recommendations.	DBHR stated in 2013 that it would work with RSNs to develop policies and procedures that include periodic review of practice guidelines.	DBHR needs to follow through with its stated intention.
Ensure that all RSNs have policies in place on the dissemination of practice guidelines.	DBHR stated in 2013 that it would work with the RSNs to develop policies and procedures that include dissemination of practice guidelines.	DBHR needs to follow through with its stated intention.
Mental health encounter data validation (2013)		
Either DBHR needs to require the RSNs to report only units of service, or DSHS needs to modify ProviderOne to accept minutes of service.		DBHR has made some progress in cleaning the data entered into the CIS. However, the data do not pass through validity and accuracy checks in ProviderOne to reject invalid or incomplete data upon receipt. As a result, ProviderOne continues to receive and house invalid and inaccurate data.
Work with the RSNs to standardize data collection and analytical procedures for encounter data validation to improve the reliability of encounter data submitted to the state.	DBHR stated in 2013 that it would consult with the EQRO to discuss development of a standardized database system to display the demographic and encounter data elements to be checked, and to record the EDV results.	DBHR has determined that it will not use a standardized database.

Table 33. DBHR response to 2012–2013 EQR recommendations for mental health (cont.).		
Recommendations	**DBHR response**	**EQRO comments**
Provide guidance for RSNs as to when services can be bundled under a single service code and when services should be unbundled into separate service codes.	DBHR stated in 2013 that it would modify the SERI to clarify when services can be bundled under a single service code and when services should be unbundled.	DBHR has distributed an updated SERI to the RSNs. Acumentra Health has not reviewed the changes to determine if this recommendation is addressed.
Mental health performance measure validation (2012)		
DBHR should work with Looking Glass Analytics to extend the functionality of its performance measure reporting.	Measures now include data for previous quarters so that the current performance measure can be evaluated against previous quarters.	DBHR agrees that extended functionality of performance measure reporting, as well as additional statistical analysis, would be of significant benefit to internal analytic staff. DBHR will explore options to expand on its reporting and opportunities for statistical and trend testing when new performance measures are implemented. DBHR's response is in progress.
DBHR should have a system in place to replicate the performance measure analyses performed by Looking Glass Analytics. This would allow DBHR to validate the Looking Glass calculations, creating greater confidence in the reported results.	The current mechanism for replicating and validating the performance measure calculations is to capture the data extracts used for the calculations and share them with the RSNs to review and validate the results. Concerns with the data or results are then reviewed and resolved. This process recently has been impeded by staff turnover.	DBHR indicates that this is an ongoing issue but that other changes to CIS may have improved the data quality. DBHR should continue to monitor to ensure complete data in the numerator and the denominator. DBHR's response is in progress.
Looking Glass Analytics should develop detailed documentation of the calculation of each performance measure. Data flow diagrams should be created for each metric, showing the state data source, which variables are extracted and calculations performed, which new datasets are created and where they are stored, and which program uses those new datasets to calculate the measure. SAS code used to process the data and calculate the measures should include notes explaining what each portion of code does.	Detailed documentation with SAS code has been shared with the EQRO. In anticipation of changing its IT systems in the near future, DBHR has decided not to allocate resources to document all systems. DBHR agrees that as new systems are established, appropriate documentation should be developed to support those processes.	Looking Glass maintains a data flow diagram identifying files used in calculating the measures. However, neither DBHR nor Looking Glass had documentation to support the process used to calculate the measures, including checks for missing or incomplete data. DBHR and Looking Glass disagree with the recommendation to include notes in the SAS code. These recommendations stand.

Table 33. DBHR response to 2012–2013 EQR recommendations for mental health (cont.).		
Recommendations	**DBHR response**	**EQRO comments**
Information Systems Capabilities Assessment (2013)		
The 2013 EQR report presented 12 recommendations related to information systems, staffing, hardware, security, administrative data, enrollment, and performance measure reporting.	See report pages 54–57 for DBHR response to those recommendations.	DBHR disagrees with one recommendation and requested time to perform additional research on one recommendation. DBHR's response is in progress.
Address state-level ISCA recommendations related to CIS data quality, accuracy, and completeness.	See report pages 54–57 for DBHR response.	DBHR needs to follow through with its stated intention.
Define clear expectations for RSNs and provider agencies regarding uniform procedures and frequency for verifying enrollment and eligibility.	See report pages 54–57 for DBHR response.	DBHR needs to follow through with its stated intention.
Work with RSNs to ensure that all requirements for data security are implemented at the RSN and provider agency levels.	See report pages 54–57 for DBHR response.	DBHR needs to follow through with its stated intention.

The path to future improvements: Physical health care

Clinical performance measures. The Apple Health MCOs continue to underperform on many HEDIS measures of clinical services for both child and adult enrollees, relative to national Medicaid benchmarks.

- ***HCA should designate incentive measures for which MCOs can receive quality incentive payments for top performance.***
- ***HCA should continue to provide supplemental data on Early and Periodic Screening, Diagnosis, and Treatment to assist the MCOs in calculating HEDIS well-child measures.***
- ***HCA should seek to align performance measures with other state and federal reporting requirements to reduce burden on providers and promote efficient use of health care resources.***
- ***HCA should consider adding a contract requirement for the MCOs to provide HEDIS-specific performance feedback to clinics and providers on a frequent and regular schedule.***

Consumer satisfaction. CAHPS scores for 2014 revealed that the MCOs, as a group, performed poorly in meeting adult enrollees' expectations for high-quality care. Ratings of the MCOs' customer service and several other measures of consumer satisfaction were below the 50th percentile of satisfaction scores nationally.

- ***MCOs need to assist providers in examining and improving their abilities to manage patient demand. As an example, MCOs can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments to increase physician availability.***
- ***MCOs need to identify and eliminate access barriers that prevent patients from obtaining necessary and timely care, locating a personal doctor, and receiving adequate assistance when calling a physician office.***
- ***MCOs should explore additional methods for obtaining direct patient feedback on services, such as by developing comment cards for enrollees to fill out after a physician office visit.***

Technical assistance.

- ***During 2015, HCA should sponsor formal training for all MCOs on care transitions and coordination, program integrity, and access issues, to assist the MCOs in meeting related contractual and regulatory requirements.***
- ***HCA should encourage MCOs with emerging best practices to share those practices at the regularly scheduled joint MCO/RSN quality meetings, in order to reduce performance gaps among MCOs for specific measures.***

Data quality and completeness. In 2015, the MCOs will be required to submit member-level HEDIS data to HCA or to the EQRO for analysis. Prior review of MCOs' data files revealed missing or incomplete data fields that limited analysis.

- ***HCA should help MCOs overcome barriers to collecting complete member-level encounter data, including race/ethnicity data, so that the MCOs can use these data to assess resources for improving the quality of care and establish appropriate interventions to address health care disparities.***

Response to 2013 recommendations

Table 34 outlines HCA's response to the recommendations presented in the 2013 EQR annual report.

Table 34. HCA response to 2013 EQR recommendations for physical health.		
2013 recommendations	**HCA response**	**EQRO comments**
Care coordination		
HCA should ensure that all MCOs incorporate EQR recommendations into their quality improvement plans.	HCA will take this recommendation under consideration as time and resources allow.	The EQRO considers this response appropriate and continues to recommend implementation of this recommendation.
MCOs should explore strategies to incorporate the state's Predictive Risk Intelligence System (PRISM) into their care coordination activities.	HCA has shared this recommendation with the MCOs for their consideration. The MCOs currently use PRISM scores of 1.5 and higher to refer enrollees for Health Home services.	The EQRO considers this action responsive. HCA might also consider monitoring the use of PRISM data through the TEAMonitor reviews.
Technical assistance		
In 2014, HCA should sponsor formal training for all MCOs on care transitions and coordination, program integrity, and access issues, to help the MCOs meet contractual and regulatory requirements.	HCA holds regular ongoing meetings with the MCOs to offer technical assistance to the MCOs to address these areas of concern.	The EQRO considers this response appropriate and encourages continued education as MCOs and BHOs move to integrated care.
HCA should encourage MCOs with emerging best practices to share those practices at the regularly scheduled joint MCO/RSN quality meetings.	HCA has shared this recommendation with the MCOs for their consideration.	The EQRO considers this action responsive.
Data quality and completeness		
HCA should continue to monitor efforts with the EQRO to ensure the reliability of data integration and overall integrity of MCO data systems.	HCA has worked with the EQRO to improve the monitoring of the reliability of data integration and overall integrity of MCO data systems.	The EQRO considers this action responsive and recommends continued monitoring of new MCOs and updated education for existing MCOs.
MCOs need to closely monitor and evaluate incoming data and data transmission from vendors that perform delegated functions.	HCA has shared this recommendation with the MCOs for their consideration.	The EQRO considers this action responsive.
HCA should continue to work with state policy analysts to determine the best approach to collect reliable race and ethnicity data for Medicaid enrollees.	HCA will take this recommendation under consideration as time and resources allow.	The EQRO considers this action responsive. HCA should continue to monitor this data completeness issue.
MCOs should dedicate resources to improve the collection, retention, and completeness of race/ethnicity data.	HCA has shared this recommendation with the MCOs for their consideration.	The EQRO considers this action responsive. HCA should continue to monitor this data completeness issue.

Table 34. HCA response to 2013 EQR recommendations for physical health.		
2013 recommendations	**HCA response**	**EQRO comments**
ER utilization		
MCOs should incorporate utilization reports from the Emergency Department Information Exchange (EDIE) into their care coordination and transition programs to ensure that enrollees receive timely care at the appropriate levels.	HCA has shared this recommendation with the MCOs for their consideration. Many MCOs have addressed this recommendation and use EDIE information as part of their care coordination and transition programs.	The EQRO considers this action responsive.
Performance measure feedback to clinics		
To help facilitate targeted interventions, HCA should require the MCOs to provide performance measure feedback to clinics and providers regularly and often.	HCA has taken this recommendation under advisement and shared it with the MCOs. Many MCOs already provide performance measure feedback to clinics and providers.	The EQRO considers this action responsive and will continue to monitor this quality data reporting issue.
Washington Medicaid Integration Partnership		
MHW should continue efforts to reduce WMIP ER visit rates and hospital readmissions through its two clinical PIPs, and respond to TEAMonitor's request for more detailed documentation of the interventions for the hospital readmissions PIP.	The WMIP contract between HCA and MHW ended in June 2014. HCA will take no additional action on this recommendation.	NA
MHW should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.	The WMIP contract between HCA and MHW ended in June 2014. HCA will take no additional action on this recommendation.	NA
MHW should ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and current, to meet standards for continuity and coordination of care.	The WMIP contract between HCA and MHW ended in June 2014. HCA will take no additional action on this recommendation.	NA
MHW should conduct a root cause analysis or other investigation to determine why WMIP enrollees' utilization of mental health services decreased from 2012 to 2013.	The WMIP contract between HCA and MHW ended in June 2014. HCA will take no additional action on this recommendation.	NA
The WMIP program should explore ways to increase enrollees' ongoing engagement in alcohol and drug dependence treatment.	The WMIP contract between HCA and MHW ended in June 2014. HCA will take no additional action on this recommendation.	NA

REFERENCES

[1] Acumentra Health. *2014 Performance Measure Comparative Analysis Report*. Washington State Department of Social & Health Services, Health Care Authority. November 2014.
[2] Health Services Advisory Group. *2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS® Report*. November 2014.
[3] Berk ML, Schur CL. Measuring access to care: improving information for policymakers. *Health Aff*. 998;17(1):180–186.
[4] Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, DC: National Academy Press, 2001.
[5] Sinay T. Access to quality health services: determinants of access. *J Health Care Finance*. 2002;28(4):58–68.
[6] *Coverage Matters*.
[7] National Committee for Quality Assurance. *NCQA Quality Compass® 2014*. Washington, DC. 2014.
[8] Washington Department of Social & Health Services. 2013–14 Children's Mental Health Key Activities. Available at www.dshs.wa.gov/pdf/dbhr/mh/cmhkeyactivities12_13_12.pdf. Accessed November 19, 2014.
[9] Washington State Health Care Innovation Plan. January 2014. Available at www.hca.wa.gov/hw/Documents/SHCIP_InnovationPlan.pdf. Accessed November 19, 2014.

Appendix A. RSN Profiles

The profiles in this appendix summarize each RSN's overall performance in measures of access, timeliness, and quality, and in meeting regulatory and contractual standards, including those for PIPs. Information for each RSN was abstracted from individual EQR reports delivered to DBHR throughout the year.

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Chelan-Douglas Regional Support Network (CDRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	90	Grievance system: General	100
Information requirements	100	General requirements and filing requirements	100
Notification timing	100	Language and format of notice of action	90
Notification content	100	Content of notice of action	90
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	100	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	90	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
CDRSN's website includes a well-written section on access to services, covering how to obtain service authorization, what is and is not a covered service, how to get a second opinion, and, if needed, how to get services outside the network. .		CDRSN needs to finish reviewing and revising its policies and procedures to ensure that they meet current state and federal requirements.	
Grievance Systems			
CDRSN has provided extensive training to the contracted agencies to ensure that they log all grievances they receive into the RSN's Avatar database.		CDRSN needs to update all forms of information given to enrollees on the grievance system, including the website, Ombuds brochure, and any written information.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Improving the Penetration Rate of Child and Family Team Participation for Medicaid Children: Substantially Met (67 out of 85)			
CDRSN cited authoritative sources and analyzed local data in selecting its study topic.		CDRSN needs to provide additional details related to the improved clinical outcomes it anticipates as a result of this PIP.	
Nonclinical PIP—Crisis Intervention Follow up: Fully Met (68 out of 85)			
CDRSN identified a gap and developed a new discharge protocol for the local agency that provides crisis care.		CDRSN needs to track and monitor its intervention to help ensure that its new discharge protocol for crisis service is being adhered to by agency providers.	
CDRSN, headquartered in East Wenatchee, contracts with providers to deliver managed mental health services in Chelan and Douglas counties. The RSN's governing board, comprising six local elected officials, makes recommendations to the Douglas County Board of Commissioners, which acts as the legal authority. During 2013, CDRSN had about 23,600 enrollees.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Chelan-Douglas Regional Support Network (continued)

Activity

Children's Clinical Record Review (45 charts reviewed)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	100.0		Natural support(s)	4.3	
Cross-system care plan includes:			Agency staff	82.6	
Statement of treatment/service goals	95.6		Allied providers	97.8	
Supports designed to achieve goals	22.2		Youth	100.0	
Clinical interventions	100.0		Family/youth partner	97.8	
Evaluation of progress	57.8		**Members present in meeting**		
Family's needs and goals	82.2		Natural support(s)	0.0	
Youth's needs and goals	75.6		Agency staff	57.3	
Crisis plan	33.3		Allied providers	18.1	
Family wellness plan	2.2		Youth	35.9	
Frequency of team meetings listed	0.0		Family/youth partner	72.0	

	CFT		Wraparound	
Team meeting documentation (90 meetings)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	51.1	43.3		
Minutes provided to team within a week after meeting	2.2	0.0		
Sign-in sheet is present	19.5	0.0		
Date of documentation matches reported encounter date	96.56	0.0		
Encounter meets SERI code definition	0.0	100.0		
Team meets with frequency listed in cross-system care plan	0.0	100.0		

Encounter Data Validation (36 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (244 records)**	**Acumentra Health**	**RSN**
First name	97.2	100.0	Provider name*	95.1	97.5
Last name	100.0	100.0	Provider type*	96.4	97.5
Date of birth	97.2	DNR	Service duration*	50.0	97.1
Gender	100.0	100.0	Service location*	91.8	94.7
Sexual orientation	86.1	DNR	Procedure code*	97.1	96.3
Race	100.0	DNR	Service date*	97.5	97.5
Ethnicity	94.4	100.0	Progress note matches service code*	95.2	DNR
Language	94.4	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in a Not Met score in the area of security. CDRSN has expanded its annual provider monitoring process to include IT security questions that align with DBHR contract requirements, and has addressed many recommendations.

Grays Harbor Regional Support Network (GHRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	90	Grievance system: General	100
Information requirements	80	General requirements and filing requirements	100
Notification timing	80	Language and format of notice of action	80
Notification content	80	Content of notice of action	100
Information on grievance process and time frames	80	Timing of notice of action	60
Respect and dignity	80	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	90
Advance directives	80	Format and content of notice of appeal resolution	100
Seclusion and restraint	90	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	90
		Effectuation of reversed appeal resolutions	90
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
GHRSN has improved oversight of its provider network since the previous compliance review.		GHRSN needs to monitor provide agencies' compliance concerning documentation in the clinical record of an enrollee's medical and mental health advance directives. GHRSN relies on the state Benefits Booklet to inform enrollees of their rights and how to obtain services. Because the Benefits Booklet does not address all required items, GHRSN needs to inform enrollees proactively about a variety of required items.	
Grievance Systems			
GHRSN followed up on a community complaint regarding customer service at the Crisis Center and implemented training to address the complaint.		GHRSN needs to establish a mechanism to routinely inform enrollees 10 days prior to any changes to its provider panel and to inform enrollees about their rights in this area.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Providing Youth Discharging from Juvenile Detention with Non-crisis Mental Health Services Within 7 Days of Release: Partially Met (45 out of 85)			
GHRSN identified the disproportionately high incarceration rate of juveniles for status offenses as an opportunity for improvement within its local community.		GHRSN has not yet implemented its intervention. The RSN needs to substantiate the perception in the community that youth in juvenile detention are not receiving mental health services at the time of incarceration.	
Clinical PIP—Reducing Self-Reported Symptoms of Depression Through Group Psychotherapy: Substantially Met (65 out of 85)			
GHRSN identified the second most commonly diagnosed mental health condition in its community, Major Depressive Disorder, as an area of need and opportunity for improvement.		Due to the small population and insignificant improvement, GHRSN has discontinued this PIP.	
GHRSN, headquartered in Aberdeen, authorizes Medicaid-funded mental health services in Grays Harbor County. The RSN contracts with Sea Mar Community Health Centers and Behavioral Health Resources (BHR) to provide outpatient services, and contracts with Behavioral Health Options for utilization management. BHR operates a crisis clinic in Hoquiam. During 2013, GHRSN had about 16,200 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Grays Harbor Regional Support Network (continued)

Activity

Children's Clinical Record Review (CFT=25 charts, Wraparound=9 charts)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team members in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	8.0	66.7	Natural support(s)	8.0	0.0
Cross-system care plan includes:			Agency staff	88.0	100.0
Statement of treatment/service goals	84.0	100.0	Allied providers	100.0	66.7
Supports designed to achieve goals	76.0	100.0	Youth	100.0	100.0
Clinical interventions	84.0	100.0	Family/youth partner	100.0	100.0
Evaluation of progress	44.0	100.0	**Members in meeting**	**(% Yes)**	**(% Yes)**
Family's needs and goals	68.0	88.9	Natural support(s)	100.0	0.0
Youth's needs and goals	60.0	88.9	Agency staff	88.6	83.1
Crisis plan	72.0	100.0	Allied providers	67.4	35.3
Family wellness plan	0.0	66.7	Youth	31.0	88.0
Frequency of team meetings listed	0.0	0.0	Family/youth partner	73.8	72.5

	CFT		Wraparound	
Team meeting documentation (CFT=25, Wraparound=25)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	48.0	24.0	96.0	0.0
Minutes provided to team within a week after meeting	4.0	0.0	0.0	0.0
Sign-in sheet is present	0.0	0.0	64.0	0.0
Date of documentation matches reported encounter date	95.8	0.0	100.0	0.0
Encounter meets SERI code definition	0.0	100.0	0.0	100.0
Team meets with frequency listed in cross-system care plan	0.0	95.8	64.0	36.0

Encounter Data Validation (32 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (99 records)**	**Acumentra Health**	**RSN**
First name	100.0	DNR	Provider name*	86.9	0.0
Last name	96.9	DNR	Provider type*	89.9	98.0
Date of birth	96.9	DNR	Service duration*	75.8	99.0
Gender	100.0	DNR	Service location*	90.9	93.9
Sexual orientation	74.2	DNR	Procedure code*	76.8	95.0
Race	90.6	DNR	Service date*	90.9	99.0
Ethnicity	3.1	DNR	Progress note matches service code*	100.0	100.0
Language	93.8	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in a Not Met score in the area of security. As of the 2014 ISCA update, GHRSN had made little progress toward meeting DBHR contract requirements. Three of the recommendations from the 2013 ISCA had no updates, and several recommendations had been only partially implemented.

Greater Columbia Behavioral Health (GCBH)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	96	Grievance system: General	100
Information requirements	80	General requirements and filing requirements	100
Notification timing	100	Language and format of notice of action	100
Notification content	100	Content of notice of action	100
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	90
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	100	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
GCBH has an excellent website that presents policies and procedures, brochures, audits/reviews, practitioner lists, enrollee rights, committee membership and meeting minutes, and the RSN's quality management program plan.		Although GCBH has a large Spanish-speaking enrollee population, many of the RSN's provider agencies do not have receptionists available to handle calls from Spanish-speaking enrollees. GCBH needs to monitor the agencies' abilities to adequately handle all calls and ensure that all callers are treated with respect and dignity.	
Grievance Systems			
GCBH reviews all audit findings to identify trends that may require system-level intervention, and reports any such needs to the QMOC for follow-up action. Providers are required to address any noncompliance found during auditing through their QI processes and to provide evidence of sustained improvement.		GCBH has no written policy to address how the RSN will handle grievances and appeals in the absence of the customer service representative. GCBH should consider developing a policy and procedure to address this circumstance.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Lowered Inpatient Readmission Rates in a High-Risk Population through the Development of Enhanced Communication with Inpatient Providers: Fully Met (68 out of 85)			
Since initiating this PIP, GCBH continues to strive to improve enrollee outcomes through increased RSN involvement in inpatient planning and services.		GCBH needs to report the frequency of its validation efforts, and update the data analysis plan to specify dates for the second measurement.	
Clinical PIP—Increasing Inclusion of Health Care Information and PCP Involvement into Outpatient Mental Health Treatment Through Provider Training and Shared PRISM Health Information: Substantially Met (57out of 85)			
GCBH identified the opportunity with this PIP to integrate physical health information into mental health treatment plans.		GCBH needs to continue to refine the study indicators to make them specific and measurable.	
GCBH, headquartered in Kennewick, provides public mental health services for 10 counties and the Yakama Nation in south central Washington. A citizen's advisory board advises the GCBH board of directors, reviews and provides recommendations on plans and policies, and serves on RSN workgroups and committees. During 2013, GCBH had about 163,000 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Greater Columbia Behavioral Health (continued)

Activity

Children's Clinical Record Review (44 charts reviewed)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	90.9		Natural support(s)	4.5	
Cross-system care plan includes:			Agency staff	54.5	
Statement of treatment/service goals	88.6		Allied providers	93.2	
Supports designed to achieve goals	56.8		Youth	100.0	
Clinical interventions	84.1		Family/youth partner	86.4	
Evaluation of progress	54.6		**Members present in meeting**		
Family's needs and goals	38.6		Natural support(s)	0.0	
Youth's needs and goals	40.9		Agency staff	62.2	
Crisis plan	61.4		Allied providers	45.7	
Family wellness plan	2.3		Youth	66.0	
Frequency of team meetings listed	2.3		Family/youth partner	77.0	

	CFT		Wraparound	
Team meeting documentation (50 meetings)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	54.4	30.4		
Minutes provided to team within a week after meeting	0.0	0.0		
Sign-in sheet is present	6.5	0.0		
Date of documentation matches reported encounter date	90.9	0.0		
Encounter meets SERI code definition	0.0	100.0		
Team meets with frequency listed in cross-system care plan	2.3	93.0		

Encounter Data Validation (36charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (155 records)**	**Acumentra Health**	**RSN**
First name	97.2	DNR	Provider name*	98.1	DNR
Last name	100.0	DNR	Provider type*	96.8	100.0
Date of birth	100.0	100.0	Service duration*	35.5	69.7
Gender	100.0	100.0	Service location*	95.5	69.7
Sexual orientation	91.7	97.1	Procedure code*	77.4	100.0
Race	91.7	97.1	Service date*	98.1	DNR
Ethnicity	88.9	100.0	Progress note matches service code*	98.1	100.0
Language	100.0	100.0			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Not Met in the area of security and Partially Met in information systems, staffing, vendor data integration, and provider data. As of the 2014 follow-up review, GCRSN reported that it had updated several policies and procedures relating to the Security section. GCBH provided no update on four recommendations, and the RSN's response to the 2013 recommendations was incomplete.

King County Regional Support Network (KCRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	100	Grievance system: General	100
Information requirements	100	General requirements and filing requirements	60
Notification timing	100	Language and format of notice of action	100
Notification content	100	Content of notice of action	100
Information on grievance process and time frames	80	Timing of notice of action	100
Respect and dignity	90	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	90	Format and content of notice of appeal resolution	100
Seclusion and restraint	100	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	90	Information to providers and subcontractors	80
		Record keeping and reporting requirements	80
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
KCRSN's website presents the RSN's member handbook and year-end evaluations, and informs enrollees of their right to request and obtain detailed information about mental health professionals in the service network.		KCRSN needs to update its policies and procedures, website, and member brochure to reflect recent changes in grievance, appeal, and state fair hearing processes.	
Grievance Systems			
KCRSN has developed useful educational materials related to enrollee rights, including DVDs and CDs.		KCRSN needs to monitor and report all grievances in its network provider-level system, and analyze the type, frequency, and resolution of grievances to identify needed improvements.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Improved Coordination with Primary Care for Children and Youth: Partially Met (41 out of 85)			
This PIP seeks to improve care coordination between mental health and physical health services through data sharing protocols.		KCRSN needs to conduct a thorough root cause analysis to clarify the nature and extent of the opportunity for improvement and to justify selection of the study topic.	
Clinical/Nonclinical PIP—Lifestyle Intervention to Reduce Weight for Adults with Serious Mental Illnesses: Substantially Met (56 out of 85)			
KCRSN incorporated feedback from enrollees and staff regarding modifications made to the Diabetes Prevention Program.		KCRSN has focused on the same study topic and target population for seven years. KCRSN agreed to end this PIP and pick a different topic for 2015.	
KCRSN, managed by the county's Mental Health, Chemical Abuse and Dependency Services Division, serves adults with chronic mental illness and severely emotionally disturbed children living in King County. A citizen advisory board provides policy direction, prioritizes and advocates for service needs, and oversees evaluation of services. During 2013, KCRSN had about 237,000 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

King County Regional Support Network (continued)

Activity

Children's Clinical Record Review (CFT=19 charts, Wraparound=22 charts)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	94.7	90.9	Natural support(s)	0.0	13.0
Cross-system care plan includes:			Agency staff	89.5	91.3
Statement of treatment/service goals	44.4	52.4	Allied providers	68.4	87.0
Supports designed to achieve goals	83.3	95.2	Youth	100.0	100.0
Clinical interventions	61.1	28.6	Family/youth partner	89.5	91.3
Evaluation of progress	66.7	47.6	**Members present in meeting**		
Family's needs and goals	5.5	76.2	Natural support(s)	0.0	42.9
Youth's needs and goals	61.1	80.9	Agency staff	35.2	58.6
Crisis plan	94.4	76.2	Allied providers	22.5	46.7
Family wellness plan	0.0	42.9	Youth	58.6	65.0
Frequency of team meetings listed	0.0	19.0	Family/youth partner	42.2	58.8

	CFT		Wraparound	
Team meeting documentation (27=CFT, 40=Wraparound)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	73.1	26.9	87.5	7.5
Minutes provided to team within a week after meeting	0.0	0.0	40.0	0.0
Sign-in sheet is present	8.0	0.0	65.0	0.0
Date of documentation matches reported encounter date	100.0	0.0	95.0	0.0
Encounter meets SERI code definition	0.0	100.0	0.0	100.0
Team meets with frequency listed in cross-system care plan	0.0	100.0	27.0	73.0

Encounter Data Validation (66 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (436 records)**	**Acumentra Health**	**RSN**
First name	93.9	DNR	Provider name*	82.3	82.8
Last name	100.0	DNR	Provider type*	79.4	83.0
Date of birth	98.5	DNR	Service duration*	46.3	82.3
Gender	97.0	DNR	Service location*	93.8	81.4
Sexual orientation	83.1	DNR	Procedure code*	85.6	82.8
Race	93.9	DNR	Service date*	95.4	83.7
Ethnicity	89.4	DNR	Progress note matches service code*	83.4	DNR
Language	6.1	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Not Met in the area of security and Partially Met in information systems and vendor data integration. As of the 2014 follow-up review, KCRSN reported that it was updating several policies and procedures relating to the security section, but did not submit evidence of these updates. KCRSN has expanded its provider agency review tool to include IT security questions that align with DBHR contract requirements.

North Sound Mental Health Administration (NSMHA)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	80	Grievance system: General	100
Information requirements	80	General requirements and filing requirements	100
Notification timing	100	Language and format of notice of action	100
Notification content	80	Content of notice of action	100
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	100	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	80	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
NSMHA has redesigned its crisis system by adding nursing staff to the crisis centers, expanding voluntary crisis services, and lowering thresholds to enable the crisis teams intervene sooner.		NSMHA has not reviewed or updated many of its policies and procedures. NSMHA stated that it plans to begin reviewing and revising its policies and procedures. NSMHA needs to complete that initiative to ensure that it meets current state and federal requirements.	
Grievance Systems			
NSMHA's written responses to grievances were detailed, well written, and addressed each concern expressed by enrollees.			
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Improving the Quality of Care Coordination for High-Risk Transition Age Youth: Substantially Met (61 out of 85)			
NSMHA selected a study topic that showed clear relevance and importance to the local Medicaid population, and clearly described its selection and prioritization process.		NSMHA needs to conduct a new root cause analysis or choose a new study topic, given that the RSN eliminated two study indicators and found lack of support for its assumptions related to the remaining indicator.	
Clinical PIP—WRAP + MAP: Integrating Care Coordination and Clinical Practice Models for Medicaid Children and Youth: Substantially Met (55 out of 85)			
NSMHA, working in conjunction with the University of Washington, has conducted MAP trainings and developed an evaluation plan for this PIP.		NSMHA needs to clarify the study indicator definitions and the data analysis plan measurement periods, in addition to collecting baseline data and implementing the intervention.	
NSMHA, headquartered in Mount Vernon, serves public mental health enrollees in Island, San Juan, Skagit, Snohomish, and Whatcom counties. A nine-member board of directors drawn from each county's executive and legislative branches of government sets the RSN's policy direction, and a citizen advisory board provides independent advice to the board and feedback to local jurisdictions and service providers. During 2013, NSMHA had about 157,000 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

North Sound Mental Health Administration (continued)

Activity

Children's Clinical Record Review (CFT=3 charts, Wraparound=42 charts)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	66.7	97.6	Natural support(s)	33.3	23.8
Cross-system care plan includes:			Agency staff	100.0	100.0
Statement of treatment/service goals	100.0	66.7	Allied providers	100.0	83.3
Supports designed to achieve goals	33.3	83.3	Youth	100.0	100.0
Clinical interventions	33.3	64.3	Family/youth partner	100.0	100.0
Evaluation of progress	33.3	33.3	**Members present in meeting**		
Family's needs and goals	66.7	83.3	Natural support(s)	0.0	23.8
Youth's needs and goals	0.0	50.0	Agency staff	44.4	43.9
Crisis plan	66.7	76.2	Allied providers	0.0	23.6
Family wellness plan	33.3	33.3	Youth	55.6	59.8
Frequency of team meetings listed	0.0	0.0	Family/youth partner	66.7	43.3

	CFT		Wraparound	
Team meeting documentation (8=CFT, 86=Wraparound)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	25.0	37.5	27.9	31.4
Minutes provided to team within a week after meeting	0.0	0.0	2.3	0.0
Sign-in sheet is present	0.0	0.0	1.2	0.0
Date of documentation matches reported encounter date	100.0	0.0	97.6	0.0
Encounter meets SERI code definition	0.0	100.0	0.0	100.0
Team meets with frequency listed in cross-system care plan	0.0	100.0	0.0	100.0

Encounter Data Validation (35 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (144 records)**	**Acumentra Health**	**RSN**
First name	100.0	97.1	Provider name*	97.2	84.0
Last name	100.0	97.1	Provider type*	96.5	84.0
Date of birth	100.0	97.1	Service duration*	29.9	84.0
Gender	100.0	DNR	Service location*	96.5	84.0
Sexual orientation	100.0	DNR	Procedure code*	93.8	84.0
Race	80.0	DNR	Service date*	97.2	84.0
Ethnicity	91.4	91.7	Progress note matches service code*	97.2	NA
Language	91.4	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Not Met in the area of security and Partially Met in information systems, administrative data, and provider data. As of the 2014 follow-up review, NSMHA reported that it had updated several policies and procedures related to security, but did not add sufficient detail to those documents to align with DBHR contract requirements. NSMHA provided no update on five recommendations and made little progress toward meeting DBHR contract requirements.

OptumHealth Pierce Regional Support Network (OPRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	100	Grievance system: General	100
Information requirements	100	General requirements and filing requirements	100
Notification timing	100	Language and format of notice of action	100
Notification content	100	Content of notice of action	100
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	100	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	90
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
OPRSN conducted a two-day training session on Person Centered Treatment for the provider agencies, aimed at ensuring that enrollees have more voice and partnership in treatment planning.			
Grievance Systems			
OPRSN's notice of action letter is well written and specifies the type of action being taken, the reason for the action, the enrollee's rights and recourses regarding the action, and the services of the Ombuds and other supports.			
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Effects of the WISe Model on Caregiver Strain: Substantially Met (57 out of 85)			
In selecting the study topic, OPRSN solicited feedback from local stakeholders and identified a gap in measurement.		OPRSN needs to clarify and provide additional information about the numerator for this PIP, in addition to implementing the intervention and collecting first remeasurement data.	
Nonclinical PIP—Residential Satisfaction in Integrated Community Settings: Fully Met (91 out of 100)			
This PIP involved an ambitious effort to develop integrated community housing and resulted in at least 16 people moving into community-based supported housing.		OPRSN did not report statistical analysis results for the second remeasurement period and did not explain a sharp reduction in the reported study population during the second remeasurement.	
OptumHealth, a subsidiary of UnitedHealth Group, has operated the Pierce County RSN since 2009, with headquarters in Tacoma. A mental health advisory board, approved by the seven-member governing board, reviews issues of concern and relevance to mental health consumers and their families. OPRSN has more than 5 million public-sector members nationwide, including about 136,000 in Pierce County during 2013.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

OptumHealth Pierce Regional Support Network (continued)

Activity

Children's Clinical Record Review (47 charts reviewed)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present		97.2	Natural support(s)		2.1
Cross-system care plan includes:			Agency staff		91.7
Statement of treatment/service goals		85.4	Allied providers		95.8
Supports designed to achieve goals		77.1	Youth		100.0
Clinical interventions		64.6	Family/youth partner		100.0
Evaluation of progress		33.3	**Members present in meeting**		
Family's needs and goals		50.0	Natural support(s)		0.0
Youth's needs and goals		64.6	Agency staff		26.6
Crisis plan		97.9	Allied providers		9.2
Family wellness plan		18.8	Youth		65.1
Frequency of team meetings listed		91.7	Family/youth partner		56.2

	CFT		Wraparound	
Team meeting documentation (126 meetings)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals			40.5	41.3
Minutes provided to team within a week after meeting			0.0	0.0
Sign-in sheet is present			0.0	0.0
Date of documentation matches reported encounter date			99.2	0.8
Encounter meets SERI code definition			0.0	100.0
Team meets with frequency listed in cross-system care plan			2.4	97.6

Encounter Data Validation (35 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (27 records)**	**Acumentra Health**	**RSN**
First name	97.1%	97.1%	Provider name*	96.3%	100.0%
Last name	97.1%	97.1%	Provider type*	92.6%	92.6%
Date of birth	97.1%	97.1%	Service duration*	66.7%	100.0%
Gender	97.1%	97.1%	Service location*	96.3%	100.0%
Sexual orientation	85.7%	DNR	Procedure code*	96.3%	100.0%
Race	88.6%	97.1%	Service date*	96.3%	100.0%
Ethnicity	94.3%	88.6%	Progress note matches service code*	96.3%	NA
Language	97.1%	97.1%			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Not Met in the area of security and Partially Met in vendor data integration. As of the 2014 follow-up review, OPRSN had begun more rigorous monitoring of provider agencies' adherence to DBHR contract requirements, and resumed data meetings that allow agencies to discuss data issues regularly.

Peninsula Regional Support Network (PRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	100	Grievance system: General	100
Information requirements	100	General requirements and filing requirements	100
Notification timing	100	Language and format of notice of action	100
Notification content	100	Content of notice of action	100
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	90
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	100	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
During the provider facility walkthrough, PRSN monitors for auditory privacy, HIPAA compliance, and treatment of enrollees with respect and dignity.			
Grievance Systems			
Annually, PRSN analyzes trends in grievances and appeals and forwards the results to its Quality Improvement Committee, which uses this information to evaluate potential system improvements. System changes are implemented through staff training and monitored by provider audits.		To ensure adherence to grievance process timelines, PRSN needs to ensure that more than one staff member is trained on the grievance process.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Improving Identification of Intensive Needs Children and Youth: Substantially Met (67 out of 85)			
PRSN identified the lack of a standardized approach in agencies' identification of children and youth with intensive mental health needs.		During the first three months of implementation, only one agency identified two children/youth who met study criteria. PRSN needs to determine whether it needs to modify the inclusion criteria.	
Nonclinical PIP—Weight Monitoring: Fully Met (100 out of 100)			
OPRSN identified an area of need in the local community and achieved statistically significant improvement during the first remeasurement period.		A decline in the study indicator occurred between the first and second remeasurement periods, but the decline was not statistically significant.	
PRSN, headquartered in Port Orchard, is a consortium of the mental health programs of Clallam, Jefferson, and Kitsap counties, administered by Kitsap County. The executive board, comprising nine county commissioners, sets policy and has oversight responsibilities. During 2013, PRSN had about 47,000 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Peninsula Regional Support Network (continued)

Activity

Children's Clinical Record Review (CFT=39 charts, HIT=5 charts)

Code used	CFT	HIT	Code used	CFT	HIT
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	38.5	60.0	Natural support(s)	5.1	0.0
Cross-system care plan includes:			Agency staff	69.2	80.0
Statement of treatment/service goals	84.6	100.0	Allied providers	87.2	60.0
Supports designed to achieve goals	89.7	100.0	Youth	100.0	100.0
Clinical interventions	94.9	100.0	Family/youth partner	97.4	100.0
Evaluation of progress	84.6	100.0	**Members present in meeting**		
Family's needs and goals	76.9	80.0	Natural support(s)	0.0	0.0
Youth's needs and goals	74.4	40.0	Agency staff	77.3	72.2
Crisis plan	53.9	100.0	Allied providers	59.1	10.5
Family wellness plan	2.6	0.0	Youth	58.1	7.6
Frequency of team meetings listed	5.1	0.0	Family/youth partner	80.3	31.8

	CFT		HIT	
Team meeting documentation (74=CFT, 12=HIT)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	48.7	39.2	16.7	50.0
Minutes provided to team within a week after meeting	0.0	0.0	0.0	0.0
Sign-in sheet is present	20.6	0.0	0.0	0.0
Date of documentation matches reported encounter date	98.7	0.0	100.0	0.0
Encounter meets SERI code definition	0.0	100.0	0.0	100.0
Team meets with frequency listed in cross-system care plan	0.0	98.6	0.0	75.0

Encounter Data Validation (35 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (144 records)**	**Acumentra Health**	**RSN**
First name	100.0	DNR	Provider name*	100.0	100.0
Last name	100.0	DNR	Provider type*	97.9	100.0
Date of birth	100.0	DNR	Service duration*	77.1	100.0
Gender	100.0	DNR	Service location*	99.3	100.0
Sexual orientation	100.0	DNR	Procedure code*	99.3	100.0
Race	100.0	DNR	Service date*	100.0	100.0
Ethnicity	100.0	DNR	Progress note matches service code*	95.1	100.0
Language	100.0	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Partially Met in information systems, security, and enrollment. As of the 2014 follow-up review, PRSN had made progress with most recommendations. However, PRSN still needs to develop its IT monitoring strategy to identify and resolve IT issues at the RSN and provider levels.

Southwest Washington Behavioral Health (SWBH)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	100	Grievance system: General	100
Information requirements	90	General requirements and filing requirements	100
Notification timing	90	Language and format of notice of action	100
Notification content	90	Content of notice of action	100
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	80	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	80
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
SWBH implemented a facilitated referral process to ensure timely access to care. If an agency cannot provide an intake within 14 days, that agency's customer service representative checks the SWBH Service Availability Tool and offers the individual an appointment at another agency. If the individual accepts, the customer service representative schedules the appointment and tracks it on a log for the RSN.		SWBH's credentialing and recredentialing activities need to include review of behavioral de-escalation training, policies, and procedures for all providers.	
Grievance Systems			
SWBH publishes a robust Ombuds brochure, including grievance information and contact information for two Ombuds covering different agencies and service areas.		SWBH has drafted but not finalized a policy on services furnished and not furnished while an appeal is pending. The RSN needs to finalize and implement this policy.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Reduction in Out-of-Home Placements for Medicaid-Enrolled Youth Participating in Wraparound Intensive Services: Substantially Met (51 out of 85)			
SWBH is committed to being an early adopter of the WISe model and has taken an active role in the Children's Mental Health Redesign project.		SWBH needs to provide additional data and information related to needs or gaps in its community to support selection of the study topic for a PIP.	
Nonclinical PIP—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Fully Met (92 out of 100)			
SWBH identified an area of need for the local population. The intervention activates outpatient providers with face-to-face contacts and client reminders.		This PIP did not result in statistically significant improvement in either remeasurement period. SWBH needs to discontinue this project as a PIP and select a new topic for 2015.	
SWBH, headquartered in Vancouver, administers and coordinates public mental health services in Clark, Cowlitz, and Skamania counties as a multi-county RSN through an interlocal agreement. Commissioners from each county comprise the RSN's three-member governing board. During 2012, SWBH had about 72,000 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Southwest Washington Behavioral Health (continued)

Activity

Children's Clinical Record Review (CFT=22 charts, Wraparound=15 charts)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	86.4	58.8	Natural support(s)	0.0	11.8
Cross-system care plan includes:			Agency staff	90.9	76.5
Statement of treatment/service goals	90.9	73.3	Allied providers	95.5	47.1
Supports designed to achieve goals	72.7	66.7	Youth	100.0	100.0
Clinical interventions	90.9	86.7	Family/youth partner	90.9	64.7
Evaluation of progress	31.8	13.3	**Members present in meeting**		
Family's needs and goals	72.7	60.0	Natural support(s)	0.0	0.0
Youth's needs and goals	72.7	46.7	Agency staff	56.7	51.7
Crisis plan	4.6	33.3	Allied providers	42.1	33.3
Family wellness plan	0.0	26.7	Youth	37.0	40.0
Frequency of team meetings listed	4.6	0.0	Family/youth partner	87.1	41.9

	CFT		Wraparound	
Team meeting documentation (25=CFT, 33=Wraparound)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	24.0	52.0	21.9	31.3
Minutes provided to team within a week after meeting	0.0	0.0	0.0	0.0
Sign-in sheet is present	0.0	0.0	0.0	0.0
Date of documentation matches reported encounter date	84.0	0.0	93.6	0.0
Encounter meets SERI code definition	0.0	100.0	0.0	100.0
Team meets with frequency listed in cross-system care plan	0.0	88.0	0.0	61.3

Encounter Data Validation (61 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (219 records)**	**Acumentra Health**	**RSN**
First name	100.0	100.0	Provider name*	89.0	98.2
Last name	100.0	100.0	Provider type*	82.2	98.2
Date of birth	98.4	100.0	Service duration*	66.2	97.3
Gender	100.0	100.0	Service location*	90.4	98.2
Sexual orientation	96.7	100.0	Procedure code*	85.4	98.2
Race	93.4	100.0	Service date*	90.4	98.6
Ethnicity	96.7	100.0	Progress note matches service code*	100.0	97.7
Language	91.8	100.0			

* Minimum data elements: these are the fields required by contract to be validated.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Not Met in the area of security and Partially Met in information systems, hardware systems, and vendor data integration. As of the 2014 follow-up review, SWBH had begun addressing several recommendations and aligning with DBHR contract requirements by updating its provider agency monitoring tool. SWBH has made progress on most recommendations.

Spokane County Regional Support Network (SCRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	100	Grievance system: General	100
Information requirements	90	General requirements and filing requirements	100
Notification timing	100	Language and format of notice of action	100
Notification content	100	Content of notice of action	100
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	80	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
With the implementation of its school-based provider program, SCRSN has experienced both an increase in referrals for treatment of children and positive feedback from parents and teachers.		SCRSN needs to ensure that all providers, including outpatient providers, have policies and procedures regarding the use of seclusion and restraints.	
Grievance Systems			
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Increase in Access to Treatment for Children Residing in Rural Underserved Areas as a Result of School-Based Outpatient Services: Substantially Met (63 out of 85)			
SCRSN selected the PIP study topic, in part, on the basis of feedback from local stakeholders (school administrators), and has presented baseline data.		SCRSN needs to track and monitor the implementation of its intervention to determine whether access to services has been adequately improved.	
Clinical PIP—Reducing Hospital Readmissions to Eastern State Hospital: Fully Met (84 out of 85)			
SCRSN provided baseline data to support selection of the topic, and used root cause analysis and literature review to select the intervention.		This PIP did not result in statistically significant improvement between baseline and first remeasurement, possibly due to a small population size.	
SCRSN administers public mental health funds for Spokane County and seven other counties in the former North Central Washington RSN service area. SCRSN contracts with several dozen providers of community support, adult residential, and inpatient mental health services for Medicaid enrollees, and contracts with Behavioral Health Options for utilization management. In 2013, SCRSN had about 149,000 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Spokane County Regional Support Network (continued)

Activity

Children's Clinical Record Review (43 charts reviewed)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**% Yes)**	**(% Yes)**
Cross system care plan is present	95.5		Natural support(s)	2.3	
Cross-system care plan includes:			Agency staff	72.7	
Statement of treatment/service goals	97.7		Allied providers	93.2	
Supports designed to achieve goals	65.9		Youth	100.0	
Clinical interventions	59.1		Family/youth partner	72.7	
Evaluation of progress	93.2		**Members present in meeting**		
Family's needs and goals	70.4		Natural support(s)	0.0	
Youth's needs and goals	79.5		Agency staff	89.5	
Crisis plan	18.2		Allied providers	52.7	
Family wellness plan	n/a		Youth	50.0	
Frequency of team meetings listed	2.3		Family/youth partner	59.1	

	CFT		Wraparound	
Team meeting documentation (58 meetings)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	51.7	43.1		
Minutes provided to team within a week after meeting	12.1	0.0		
Sign-in sheet is present	12.1	0.0		
Date of documentation matches reported encounter date	100.0	0.0		
Encounter meets SERI code definition	0.0	100.0		
Team meets with frequency listed in cross-system care plan	12.1	87.9		

Encounter Data Validation (66 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (432 records)**	**Acumentra Health**	**RSN**
First name	100.0	DNR	Provider name*	75.5	100.0
Last name	100.0	DNR	Provider type*	60.2	100.0
Date of birth	98.5	DNR	Service duration*	33.8	99.5
Gender	98.5	DNR	Service location*	75.2	94.7
Sexual orientation	40.9	DNR	Procedure code*	68.1	98.4
Race	50.0	DNR	Service date*	78.2	100.0
Ethnicity	54.6	DNR	Progress note matches service code*	75.7	99.8
Language	66.7	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in Partially Met scores in security and vendor data integration. As of the 2014 follow-up review, SCRSN had either addressed or made significant progress toward addressing all recommendations.

Thurston-Mason Regional Support Network (TMRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	100	Grievance system: General	80
Information requirements	80	General requirements and filing requirements	100
Notification timing	100	Language and format of notice of action	100
Notification content	100	Content of notice of action	100
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	80	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	100	Format and content of notice of appeal resolution	100
Seclusion and restraint	80	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
TMRSN annually reviews and revises its policies and procedures to ensure that they are up to date and comply with federal and state regulations.		TMRSN tracks the use of interpreter services by reviewing clinical records and pulling interpreter codes from the database. TMRSN should require its providers to keep a log of all requests for interpreter services to enable the RSN to better analyze any unmet needs in its service counties.	
Grievance Systems			
TMRSN does not delegate the grievance process to provider agencies, but handles all grievances at the RSN level. The RSN's quality manager, along with the Ombuds, receives, investigates, mitigates, and resolves grievances, and communicates resolutions to the enrollees.		Although TMRSN can query the database as to when notices of action (NOAs) are sent to enrollees, TMRSN should consider developing a log, similar to its grievance log, to track when authorizations are requested, decisions are made, and NOAs are mailed to enrollees, to ensure meeting the required timelines.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—High-Fidelity Wraparound: Fully Met (89 out of 100)			
The study topic addresses an area of need for Medicaid enrollees and involves collaboration with community partners.		This PIP showed statistically significant improvement between baseline and 6 months, but not between baseline and 12 months, possibly due to the small study population.	
Nonclinical PIP— Implementing LOCUS to Increase Service Episodes for Adult Medicaid Clients: Substantially Met (65 out of 85)			
TMRSN presented baseline data and identified that its Medicaid-enrolled adults are receiving fewer than anticipated core outpatient service hours per month during the first 90 days following an intake.		TMRSN needs to track and monitor implementation of its intervention to determine whether service episodes for adult Medicaid enrollees following intake have been adequately increased.	
TMRSN, headquartered in Olympia, administers public mental health services for Thurston and Mason counties. The RSN contracts with Olympia-based Behavioral Health Resources and Seattle-based Sea Mar Community Health Centers to provide outpatient, crisis, residential, and inpatient services. During 2013, TMRSN had about 47,700 enrollees in its service area.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Thurston-Mason Regional Support Network (continued)

Activity

Children's Clinical Record Review (41 charts reviewed)

Code used	CFT	Wraparound	Code used	CFT	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**% Yes)**	**(% Yes)**
Cross system care plan is present	100.0		Natural support(s)	17.1	
Cross-system care plan includes:			Agency staff	95.1	
Statement of treatment/service goals	100.0		Allied providers	78.1	
Supports designed to achieve goals	100.0		Youth	100.0	
Clinical interventions	97.6		Family/youth partner	100.0	
Evaluation of progress	95.1		**Members present in meeting**		
Family's needs and goals	100.0		Natural support(s)	27.3	
Youth's needs and goals	97.6		Agency staff	81.1	
Crisis plan	100.0		Allied providers	37.9	
Family wellness plan	56.1		Youth	55.4	
Frequency of team meetings listed	9.7		Family/youth partner	75.5	

	CFT		Wraparound	
Team meeting documentation (98 meetings)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	89.8	6.1		
Minutes provided to team within a week after meeting	0.0	0.0		
Sign-in sheet is present	90.8	0.0		
Date of documentation matches reported encounter date	100.0			
Encounter meets SERI code definition	0.0	100.0		
Team meets with frequency listed in cross-system care plan	72.5	27.5		

Encounter Data Validation (35 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (140 records)**	**Acumentra Health**	**RSN**
First name	100.0	DNR	Provider name*	78.6	67.9
Last name	100.0	DNR	Provider type*	47.9	87.9
Date of birth	97.1	DNR	Service duration*	66.4	95.0
Gender	100.0	DNR	Service location*	76.4	97.1
Sexual orientation	62.9	DNR	Procedure code*	79.3	96.4
Race	91.4	DNR	Service date*	80.0	93.6
Ethnicity	68.6	DNR	Progress note matches service code*	100.0	95.7
Language	88.6	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Not Met in the area of security and Partially Met in information systems, hardware, and vendor data integration. As of the 2014 follow-up review, TMRSN had made little progress in the information systems section, where four recommendations still stand. TMRSN had made some progress toward addressing all other recommendations.

Timberlands Regional Support Network (TRSN)

Activity			
Regulatory and Contractual Standards			
Enrollee Rights	**% Met**	**Grievance Systems**	**% Met**
Enrollee rights: General	100	Grievance system: General	100
Information requirements	100	General requirements and filing requirements	90
Notification timing	100	Language and format of notice of action	100
Notification content	100	Content of notice of action	90
Information on grievance process and time frames	100	Timing of notice of action	100
Respect and dignity	100	Handling of grievances and appeals	100
Treatment options	100	Expedited resolution of appeals	100
Advance directives	90	Format and content of notice of appeal resolution	100
Seclusion and restraint	90	Action after denial of request for expedited resolution	100
Compliance with other state and federal laws	100	Information to providers and subcontractors	100
		Record keeping and reporting requirements	100
		Continuation of benefits during appeal	100
		Effectuation of reversed appeal resolutions	100
Strengths		**Opportunities for Improvement**	
Enrollee Rights			
TRSN supplies language line reference cards to the provider agencies and requires assessment of the enrollee's language capability at intake to identify difficulty with written information.		TRSN's oversight of providers related to seclusion and restraint is limited to ensuring that providers have policies that prohibit the use of seclusion and restraint. TRSN needs to develop more specific procedures for behavior de-escalation to ensure that providers can handle volatile situations appropriately.	
Grievance Systems			
TRSN's quality manager and administrator monitor the grievance and appeal system and present the information to its quality committee. In case of any noncompliance, TRSN would complete a root cause analysis to identify system/process issues and take corrective action to address the issues.		Although TRSN is monitoring the grievance process at the agencies and is initiating and following up on any corrective actions plans as the result of monitoring, the RSN needs to describe in its contracts or in delegation agreements the process for delegating grievances, and monitor the delegation process.	
Performance Improvement Projects (PIPs)			
Strengths		**Opportunities for Improvement**	
Children's PIP—Improving Identification and Clinical Outcomes for Children in Need of Intensive Home and Community-Based Mental Health Services: Fully Met (70 out of 85)			
TRSN determined that its two-level system of care was not sensitive enough to adequately identify children and youth who need intensive mental health services.		Fewer children and youth were identified as needing intensive home and community mental health services than expected. TRSN needs to determine the cause for this lower than expected result.	
Nonclinical PIP—Improving Coordination of Care Outcomes for Individuals with Major or Severe Physical Health Co-Occurring Disorders: Substantially Met (63 out of 85)			
This PIP builds on lessons learned from a previous PIP and standardizes how enrollees are identified as having major or severe physical health problems.		TRSN needs to track and monitor its intervention to help ensure that provider agencies are adhering to its revised coordination-of-care protocol.	
TRSN, headquartered in Cathlamet, administers mental health services for Medicaid enrollees in Lewis, Pacific, and Wahkiakum counties. In 2013, TRSN had about 21,400 Medicaid enrollees in its service area. TRSN contracts with Behavioral Healthcare Options for utilization management services.			
Data source: RSN 2014 External Quality Review Report (Acumentra Health).			

Timberlands Regional Support Network (continued)

Activity

Children's Clinical Record Review (40 charts reviewed, all RSN identified)

Code used	RSN	Wraparound	Code used	RSN	Wraparound
Cross-system care plan	**(% Yes)**	**(% Yes)**	**Team membership in plan**	**(% Yes)**	**(% Yes)**
Cross system care plan is present	80.0		Natural support(s)	2.5	
Cross-system care plan includes:			Agency staff	67.5	
Statement of treatment/service goals	85.0		Allied providers	87.5	
Supports designed to achieve goals	42.5		Youth	100.0	
Clinical interventions	85.0		Family/youth partner	75.0	
Evaluation of progress	15.0		**Members present in meeting**		
Family's needs and goals	42.5		Natural support(s)	n/a	
Youth's needs and goals	67.5		Agency staff	n/a	
Crisis plan	27.5		Allied providers	n/a	
Family wellness plan	0.0		Youth	n/a	
Frequency of team meetings listed	0.0		Family/youth partner	n/a	

	RSN			
Team meeting documentation (no meetings were held)	**% Yes**	**% Partial**	**% Yes**	**% Partial**
Minutes document agreement and progress toward goals	n/a			
Minutes provided to team within a week after meeting	n/a			
Sign-in sheet is present	n/a			
Date of documentation matches reported encounter date	n/a			
Encounter meets SERI code definition	n/a			
Team meets with frequency listed in cross-system care plan	n/a			

Encounter Data Validation (37 charts reviewed)

	% Match			% Match	
Demographic data	**Acumentra Health**	**RSN**	**Encounter data (107 records)**	**Acumentra Health**	**RSN**
First name	100.0	DNR	Provider name*	95.3	97.6
Last name	97.3	DNR	Provider type*	94.4	97.6
Date of birth	100.0	DNR	Service duration*	67.3	96.9
Gender	100.0	DNR	Service location*	93.5	96.9
Sexual orientation	97.3	DNR	Procedure code*	92.5	90.0
Race	97.3	DNR	Service date*	95.3	97.6
Ethnicity	97.3	DNR	Progress note matches service code*	95.3	DNR
Language	56.8	DNR			

* Minimum data elements: these are the fields required by contract to be validated. DNR = Did not report.

Information Systems Capabilities Assessment (ISCA)

The 2013 ISCA resulted in scores of Not Met in security and Partially Met in staffing. As of the 2014 follow-up review, TRSN had begun working with provider agencies to ensure adherence to DBHR contract requirements. TRSN has made progress on most recommendations and is collaborating with other RSNs to streamline processes and develop enterprise IT solutions.

Appendix B. MCO Profiles

The profiles in this appendix summarize each MCO's overall performance in measures of access, timeliness, and quality, and in meeting regulatory and contractual standards, including those for PIPs.

MCO scores for compliance with regulatory and contractual standards were calculated from ratings in the TEAMonitor reports, and strengths and opportunities for improvement were derived from the written TEAMonitor reviews.

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Amerigroup Washington (AMG)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	45.26% ▼	Access to PCPs, age 12–24 months	93.45% ▼
Child WCC Visits	58.33% ▼	Access to PCPs, age 25 months–6 years	77.52% ▼
Adolescent WCC Visits	34.95%	Access to PCPs, age 7–11 years	NA
		Access to PCPs, age 12–19 years	NA
Quality of Care*			
Childhood Immunizations (Combo 2)[a]	53.89% ▼	Diabetes Care (HbA1c test)	81.64% ▼
Childhood Immunizations (Combo 3)[b]	50.30% ▼	Diabetes Care (dilated retinal exam)	38.72% ▼
Adolescent Immunizations (Combo 1)[c]	54.84% ▼	Diabetes Care (LDL-C screening)	70.80%
Weight Assessment/Counseling (BMI)	28.07%	Diabetes Care (monitoring for nephropathy)	78.98%
Weight Assessment/Counseling (nutrition)	44.55%	Appropriate Testing for Pharyngitis	68.16%
Weight Assessment/Counseling (physical)	37.82%	Appropriate Use of Asthma Medications	NA
Consumer Satisfaction (Access, Quality, Timeliness)**			
Getting Needed Care	☆☆	Rating of Personal Doctor	☆
Getting Care Quickly	☆☆☆	Rating of Specialist	☆☆☆
How Well Doctors Communicate	☆☆	Rating of All Health Care	☆
Customer Service	☆	Rating of Health Plan	☆
Regulatory and Contractual Standards—Percent of elements met***			
Availability of Services	80%	Enrollee Rights	60%
Furnishing of Services (Timely Access)	100%	Enrollment and Disenrollment	100%
Program Integrity	100%	Grievance Systems	66%
Claims Payment	100%	Practice Guidelines	33%
Coordination and Continuity of Care	63%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	80%	QA/PI Program	20%
Coverage and Authorization of Services	50%	Subcontractual Relationships/Delegation	100%
Emergency and Post-stabilization Services	50%	Health Homes	25%
Performance Improvement Projects (PIPs)***			
Clinical		**Nonclinical**	
Well-Child Visits During the First 15 Months of Life (5 or More Visits)	Not Met	Statewide Transitional Healthcare Services	Partially Met

AMG works to improve health care access and quality for more than 114,000 Washingtonians through innovative care management programs and services. Through ongoing outreach and education, the MCO encourages healthy behaviors that can reduce illness and improve quality of life. AMG believes that solutions to the health care challenges facing our members begin when we put our care and compassion to work, one individual at a time.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.
[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.
[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.
NA: Sample size was less than the minimum required.
*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Amerigroup Washington (continued)

Strengths	Opportunities for improvement
Access to Care*,*	
	• Scored significantly below the state average for infant and child WCC visits. • Scored significantly below the state average for access to PCPs for children ages 12 months to 6 years. • Scored below the 50th percentile for Getting Needed Care, though not statistically different from the average of five Apple Health MCOs.
Timeliness of Care**	
• Scored in the 50th–74th percentile for Getting Care Quickly, not statistically different from the average of five Apple Health MCOs.	
Quality of Care*,**	
• Scored above the state average for appropriate testing for pharyngitis, though not significantly higher. • Scored in the 50th–74th percentile for Rating of Specialist, not statistically different from the average of five Apple Health MCOs.	• Scored significantly below the state average for childhood immunizations (Combo 2 and 3), adolescent immunizations (Combo 1), HbA1c tests, and dilated retinal exams. • Scored below the state averages for weight assessment/ counseling, LDL-C screening, and monitoring of nephropathy, though not significantly lower. • Scored below the 50th percentile for How Well Doctors Communicate, though not statistically different from the average of five Apple Health MCOs. • Scored below the 25th percentile for Customer Service, Rating of Personal Doctor, Rating of All Health Care, and Rating of Health Plan.
Regulatory and Contractual Standards***	

• Met 100% of elements for:
  ○ Furnishing of Services (Timely Access)
  ○ Program Integrity
  ○ Claims Payment
  ○ Enrollment and Disenrollment
  ○ Provider Selection
  ○ Subcontractual Relationships/Delegation
• Met 80% of elements for:
  ○ Availability of Services
  ○ Patient Review and Coordination
	• Met ≤50% of elements for:
	  ○ Coverage and Authorization of Services
	  ○ Emergency and Post-stabilization Services
	  ○ Practice Guidelines
	  ○ QA/PI Program
	  ○ Health Homes

Performance Improvement Projects (PIPs)***	
• For the clinical PIP, AMG submitted a list of barriers to improving WCC visit rates and a list of education-based interventions to address them. • For the statewide nonclinical PIP, interventions were appropriate for the topic and the population served.	• It was unclear whether the list of interventions submitted for the clinical PIP were actually implemented or simply planned. AMG reported no results to the state. • For the statewide nonclinical PIP, gaps in documentation included the absence of a data analysis plan, interpretation of the initial results, and discussion of the next steps.

*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Community Health Plan of Washington (CHP)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	60.10%	Access to PCPs, age 12–24 months	97.14%
Child WCC Visits	66.18%	Access to PCPs, age 25 months–6 years	86.22% ▼
Adolescent WCC Visits	42.34%	Access to PCPs, age 7–11 years	89.39% ▼
		Access to PCPs, age 12–19 years	88.49% ▼
Quality of Care*			
Childhood Immunizations (Combo 2)[a]	76.89% ▲	Diabetes Care (HbA1c test)	91.79% ▲
Childhood Immunizations (Combo 3)[b]	73.48% ▲	Diabetes Care (dilated retinal exam)	51.82% ▲
Adolescent Immunizations (Combo 1)[c]	71.29% ▲	Diabetes Care (LDL-C screening)	75.91%
Weight Assessment/Counseling (BMI)	53.04% ▲	Diabetes Care (monitoring for nephropathy)	80.84%
Weight Assessment/Counseling (nutrition)	52.80% ▲	Appropriate Testing for Pharyngitis	59.18% ▼
Weight Assessment/Counseling (physical)	51.58% ▲	Appropriate Use of Asthma Medications	84.08%
Consumer Satisfaction (Access, Quality, Timeliness)**			
Getting Needed Care	☆	Rating of Personal Doctor	☆☆
Getting Care Quickly	☆	Rating of Specialist	☆
How Well Doctors Communicate	☆☆☆☆	Rating of All Health Care	☆
Customer Service	☆	Rating of Health Plan	☆
Regulatory and Contractual Standards—Percent of elements met***			
Availability of Services	100%	Enrollee Rights	66%
Furnishing of Services (Timely Access)	100%	Enrollment and Disenrollment	100%
Program Integrity	80%	Grievance Systems	83%
Claims Payment	0%	Practice Guidelines	100%
Coordination and Continuity of Care	63%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	80%	QA/PI Program	40%
Coverage and Authorization of Services	75%	Subcontractual Relationships/Delegation	100%
Emergency and Post-stabilization Services	50%	Health Homes	75%
Performance Improvement Projects (PIPs)***			
Clinical		**Nonclinical**	
Improving Use of Appropriate Medications for People with Asthma	Partially Met	Reducing the Volume of MCS Member Grievance Calls	Met
MCS Accountable and Collaborative Care	Partially Met	Statewide Transitional Healthcare Services	Partially Met

Founded over 20 years ago by the state's community health centers, CHP is Washington's only local, nonprofit health plan. Since 2011, the plan has been accredited by NCQA for Medicaid and Medicare products. CHP provides managed care for more than 335,000 enrollees throughout Washington, with a network of more than 516 primary care clinics, 2,418 primary care providers, 13,827 specialists, and over 100 hospitals. CHP's innovative practices include programs that reward members for taking care of themselves, pay-for-performance models for network providers, and integrating clinical information across the care continuum.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.
[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.
[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.
*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Community Health Plan of Washington (continued)

Strengths	Opportunities for improvement
Access to Care*,*	
• Scored above the state average for infant, child, and adolescent WCC visits, though not significantly higher.	• Scored significantly below the state average for access to PCPs, for age groups 25 months through 19 years. • Scored below the 25th percentile for Getting Needed Care, significantly below the average of five Apple Health MCOs.
Timeliness of Care**	
	• Scored below the 25th percentile for Getting Care Quickly, significantly below the average of five Apple Health MCOs.
Quality of Care*,**	
• Scored significantly above the state average for childhood immunizations (Combo 2 and 3) and for adolescent immunizations (Combo 1). • Scored significantly above the state average for weight assessment/counseling in all areas (BMI, nutrition, and physical activity). • Scored significantly above the state average for HbA1c testing and dilated retinal exams. • Scored in the 75th–89th percentile for How Well Doctors Communicate.	• Scored below the 50th percentile for Rating of Personal Doctor, and below the 25th percentile in Rating of Health Plan, though not statistically different from the average of five Apple Health MCOs. • Scored below the 25th percentile for Rating of Customer Service, Rating of Specialist, and Rating of All Health Care, significantly below the average of five Apple Health MCOs.
Regulatory and Contractual Standards**	

• Met 100% of elements for:
  ○ Availability of Services
  ○ Furnishing of Services (Timely Access)
  ○ Enrollment and Disenrollment
  ○ Practice Guidelines
  ○ Provider Selection (Credentialing)
  ○ Subcontractual Relationships/Delegation
• Met 80% of elements for:
  ○ Program Integrity
  ○ Patient Review and Coordination
  ○ Grievance Systems
	• Met ≤50% of elements for:
	  ○ Claims Payment
	  ○ Emergency and Post-stabilization Services
	  ○ QA/PI Program

Performance Improvement Projects (PIPs)**	
• CHP's nonclinical PIP had the useful objective of reducing the number of MCS enrollee grievances from 2012 to 2013. This PIP was well designed and implemented, and succeeded in reducing grievances even more than originally targeted. • The clinical PIP on asthma medications was generally well written and documented. • For the statewide nonclinical PIP, interventions were appropriate for the topic and the population served.	• CHP's two clinical PIPs did not have significantly favorable effects on enrollees' health outcomes or satisfaction. Neither PIP appeared to have been retooled to improve outcomes. • For the asthma medications PIP, CHP needs to reevaluate the interventions and study design to ensure that the interventions are appropriate and linked to barriers. • For the accountable and collaborative care PIP, CHP needs to improve the data analysis documenting the improvement need, description of the study population, and linkage between the data analysis and intervention. • For the statewide nonclinical PIP, gaps in documentation included the absence of a data analysis plan, interpretation of the initial results, and discussion of the next steps.

*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Coordinated Care Corp. (CCC)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	43.06% ▼	Access to PCPs, age 12–24 months	97.19%
Child WCC Visits	67.36%	Access to PCPs, age 25 months–6 years	86.13% ▼
Adolescent WCC Visits	38.19%	Access to PCPs, age 7–11 years	NA
		Access to PCPs, age 12–19 years	NA
Quality of Care*			
Childhood Immunizations (Combo 2)[a]	64.35%	Diabetes Care (HbA1c test)	86.09%
Childhood Immunizations (Combo 3)[b]	59.95%	Diabetes Care (dilated retinal exam)	47.24%
Adolescent Immunizations (Combo 1)[c]	69.21%	Diabetes Care (LDL-C screening)	72.19%
Weight Assessment/Counseling (BMI)	19.91% ▼	Diabetes Care (monitoring for nephropathy)	80.57%
Weight Assessment/Counseling (nutrition)	46.30%	Appropriate Testing for Pharyngitis	54.35% ▼
Weight Assessment/Counseling (physical)	45.14%	Appropriate Use of Asthma Medications	NA
Consumer Satisfaction (Access, Quality, Timeliness)**			
Getting Needed Care	☆	Rating of Personal Doctor	☆☆
Getting Care Quickly	☆	Rating of Specialist	☆☆
How Well Doctors Communicate	☆☆☆☆	Rating of All Health Care	☆
Customer Service	☆☆☆	Rating of Health Plan	☆
Regulatory and Contractual Standards—Percent of elements met***			
Availability of Services	60%	Enrollee Rights	66%
Furnishing of Services (Timely Access)	50%	Enrollment and Disenrollment	100%
Program Integrity	80%	Grievance Systems	94%
Claims Payment	0%	Practice Guidelines	100%
Coordination and Continuity of Care	63%	Provider Selection (Credentialing)	75%
Patient Review and Coordination	80%	QA/PI Program	40%
Coverage and Authorization of Services	25%	Subcontractual Relationships/Delegation	100%
Emergency and Post-stabilization Services	50%	Health Homes	0%
Performance Improvement Projects (PIPs)***			
Clinical		**Nonclinical**	
Increasing Compliance of Female Members Over Age 40 in Getting an Annual Screening Mammogram	Partially Met	Statewide Transitional Healthcare Services	Partially Met

Coordinated Care, a subsidiary of Centene Corporation, serves more than 170,000 members across Washington. The plan is NCQA-accredited for both its Medicaid and Ambetter products. Our mission is to improve the health of our beneficiaries through focused, compassionate, and coordinated care. This is based on the core belief that quality health care is best delivered locally.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.
[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.
[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.
NA: Sample size was less than the minimum required.
*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Coordinated Care Corp. (continued)

Strengths	Opportunities for improvement
Access to Care*,**	
• Scored above the state average for child WCC visits, though not significantly higher.	• Scored significantly below the state average for infant WCC visits and access to PCPs for ages 25 months–6 years. • Scored below the state average for adolescent WCC visits and for access to PCPs, ages 12–24 months, though not significantly lower. • Scored below the 25th percentile for Getting Needed Care, though not statistically different from the average of five Apple Health MCOs.
Timeliness of Care**	
	• Scored below the 25th percentile for Getting Care Quickly, though not statistically different from the average of five Apple Health MCOs.
Quality of Care*,**	
• Scored above the state average for adolescent immunizations (Combo 1), weight assessment/counseling (nutrition, physical activity), and diabetes care (dilated retinal exams, LDL-C screening, monitoring for nephropathy), though not significantly higher. • Scored in the 75th –89th percentile for How Well Doctors Communicate, not statistically different from the average of five Apple Health MCOs. • Scored in the 50th–74th percentile for Customer Service, not statistically different from the average of five Apple Health MCOs.	• Scored below the state average for childhood immunizations (Combo 2 and 3) and for HbA1c testing, though not significantly lower. • Scored significantly below the state average for weight assessment/counseling (BMI) and for appropriate testing for pharyngitis. • Scored below the 50th percentile for Rating of Personal Doctor and Rating of Specialist, though not statistically different from the average of five Apple Health MCOs. • Scored below the 25th percentile for Rating of all Health Care and Rating of Health Plan, not statistically different from the average of five Apple Health MCOs.
Regulatory and Contractual Standards***	

• Met 100% of elements for:
  ○ Enrollment and Disenrollment
  ○ Practice Guidelines
  ○ Subcontractual Relationships/Delegation
• Met 80% of elements for:
  ○ Program Integrity
  ○ Patient Review and Coordination
  ○ Grievance Systems
	• Met ≤50% of elements for:
	  ○ Furnishing of Services (Timely Access)
	  ○ Claims Payment
	  ○ Coverage and Authorization of Services
	  ○ Emergency and Post-stabilization Services
	  ○ QA/PI Program
	  ○ Health Homes

Performance Improvement Projects (PIPs)***	
• CCC conducted a solid clinical PIP using the HEDIS breast cancer screening measure. • For the statewide nonclinical PIP, interventions were appropriate for the topic and the population served.	• Clinical PIP documentation was submitted on the wrong validation worksheet, omitting some required elements and making interpretation of the project difficult. • For the statewide nonclinical PIP, gaps in documentation included the absence of a data analysis plan, interpretation of the initial results, and discussion of the next steps.

*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Molina Healthcare of Washington (MHW)

Measure	Score		Measure	Score	
Access to Care*					
Infant WCC Visits (6 visits)	67.77%	▲	Access to PCPs, age 12–24 months	97.78%	▲
Child WCC Visits	64.60%		Access to PCPs, age 25 months–6 years	89.04%	▲
Adolescent WCC Visits	44.37%	▲	Access to PCPs, age 7–11 years	92.24%	▲
			Access to PCPs, age 12–19 years	92.12%	▲
Quality of Care*					
Childhood Immunizations (Combo 2)[a]	67.77%		Diabetes Care (HbA1c test)	87.61%	
Childhood Immunizations (Combo 3)[b]	64.24%		Diabetes Care (dilated retinal exam)	52.70%	▲
Adolescent Immunizations (Combo 1)[c]	64.58%		Diabetes Care (LDL-C screening)	71.17%	
Weight Assessment/Counseling (BMI)	35.10%	▲	Diabetes Care (monitoring for nephropathy)	79.95%	
Weight Assessment/Counseling (nutrition)	45.03%		Appropriate Testing for Pharyngitis	67.38%	▲
Weight Assessment/Counseling (physical)	38.19%		Appropriate Use of Asthma Medications	83.14%	
Consumer Satisfaction (Access, Quality, Timeliness)**					
Getting Needed Care	☆		Rating of Personal Doctor	☆☆☆	
Getting Care Quickly	☆☆		Rating of Specialist	☆☆☆☆	
How Well Doctors Communicate	☆☆☆☆		Rating of All Health Care	☆☆	
Customer Service	☆☆		Rating of Health Plan	☆☆	
Regulatory and Contractual Standards—Percent of elements met***					
Availability of Services	60%		Enrollee Rights	86%	
Furnishing of Services (Timely Access)	50%		Enrollment and Disenrollment	100%	
Program Integrity	80%		Grievance Systems	100%	
Claims Payment	100%		Practice Guidelines	100%	
Coordination and Continuity of Care	63%		Provider Selection (Credentialing)	100%	
Patient Review and Coordination	100%		QA/PI Program	100%	
Coverage and Authorization of Services	100%		Subcontractual Relationships/Delegation	75%	
Emergency and Post-stabilization Services	100%		Health Homes	75%	
Performance Improvement Projects (PIPs)***					
Clinical			**Nonclinical**		
Improving Breast Cancer Screening	Partially Met		Statewide Transitional Healthcare Services	Partially Met	

Established in 1995, Molina Healthcare of Washington (MHW) provides coverage for Medicaid enrollees in 34 counties across Washington. MHW insures approximately 483,000 lives, 98% of whom are covered by Medicaid. About 64% of Medicaid clients are 18 years of age or younger. MHW is accredited by NCQA for its Medicaid product lines.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.
[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.
[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.
*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Molina Healthcare of Washington (continued)

Strengths	Opportunities for improvement
Access to Care*,*	
• Scored significantly above the state average for infant and adolescent WCC visits, and for access to PCPs for all age groups, 12 months through 19 years. • Scored above the state average for child WCC visits, though not significantly higher.	• Scored below the 25th percentile for Getting Needed Care, though not statistically different from the average of five Apple Health MCOs.
Timeliness of Care**	
	• Scored below the 50th percentile for Getting Care Quickly, though not statistically different from the average of five Apple Health MCOs.
Quality of Care*,**	
• Scored significantly higher than the state average for weight assessment/counseling (BMI), dilated retinal exams, and appropriate testing for pharyngitis. • Scored above the state average for childhood immunizations (Combo 2 and 3), and for diabetes care (HbA1c testing, monitoring for nephropathy), though not significantly higher. • Scored in the 75th–89th percentile for How Well Doctors Communicate and for Rating of Specialist. • Scored in the 50th–74th percentile Rating of Personal Doctor, not statistically different from the average of five Apple Health MCOs.	• Scored below the 50th percentile for Customer Service and for Rating of All Health Care, not statistically different from the average of five Apple Health MCOs. • Scored below the 50th percentile for Rating of Health Plan, though significantly better than the average of five Apple Health MCOs. • Scored below the state average for appropriate use of asthma medications, LDL-C screening, adolescent immunizations (Combo 1), and weight assessment/counseling (nutrition and physical activity), though not significantly lower.
Regulatory and Contractual Standards***	

• Met 100% of elements for:
  ○ Claims Payment
  ○ Patient Review and Coordination
  ○ Coverage and Authorization of Services
  ○ Emergency and Post-stabilization Services
  ○ Enrollment and Disenrollment
  ○ Grievance Systems
  ○ Practice Guidelines
  ○ Provider Selection (Credentialing)
  ○ QA/PI Program
• Met 80% of elements for:
  ○ Program Integrity
  ○ Enrollee Rights
	• Met 50% of elements for Furnishing of Services (Timely Access)

Performance Improvement Projects (PIPs)***	
• Clinical PIP interventions addressed the needs of special populations with cultural and/or linguistic barriers. The interventions empowered targeted provider groups to support MHW's outreach efforts by providing tailored rates and lists of enrollees overdue for screening. • For the statewide nonclinical PIP, interventions were appropriate for the topic and the population served.	• For the clinical PIP, MHW did not revise the study questions for clarity as requested by TEAMonitor last year. • For the statewide nonclinical PIP, gaps in documentation included the absence of a data analysis plan, interpretation of the initial results, and discussion of the next steps.

*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

UnitedHealthcare Community Plan (UHC)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	58.64%	Access to PCPs, age 12–24 months	93.94% ▼
Child WCC Visits	62.77%	Access to PCPs, age 25 months–6 years	82.20% ▼
Adolescent WCC Visits	35.52%	Access to PCPs, age 7–11 years	NA
		Access to PCPs, age 12–19 years	NA
Quality of Care*			
Childhood Immunizations (Combo 2)[a]	59.61% ▼	Diabetes Care (HbA1c test)	82.73%
Childhood Immunizations (Combo 3)[b]	57.66%	Diabetes Care (dilated retinal exam)	37.96% ▼
Adolescent Immunizations (Combo 1)[c]	61.31%	Diabetes Care (LDL-C screening)	68.61%
Weight Assessment/Counseling (BMI)	14.36% ▼	Diabetes Care (monitoring for nephropathy)	75.67%
Weight Assessment/Counseling (nutrition)	39.90% ▼	Appropriate Testing for Pharyngitis	66.77%
Weight Assessment/Counseling (physical)	34.55% ▼	Appropriate Use of Asthma Medications	NA
Consumer Satisfaction (Access, Quality, Timeliness)**			
Getting Needed Care	☆☆☆	Rating of Personal Doctor	☆☆
Getting Care Quickly	☆☆☆☆	Rating of Specialist	☆☆☆☆
How Well Doctors Communicate	☆☆☆☆	Rating of All Health Care	☆☆☆
Customer Service	☆	Rating of Health Plan	☆
Regulatory and Contractual Standards—Percent of elements met***			
Availability of Services	80%	Enrollee Rights	100%
Furnishing of Services (Timely Access)	50%	Enrollment and Disenrollment	100%
Program Integrity	100%	Grievance Systems	100%
Claims Payment	100%	Practice Guidelines	100%
Coordination and Continuity of Care	88%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	100%	QA/PI Program	100%
Coverage and Authorization of Services	75%	Subcontractual Relationships/Delegation	100%
Emergency and Post-stabilization Services	100%	Health Homes	75%
Performance Improvement Projects (PIPs)***			
Clinical		**Nonclinical**	
Increasing Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Partially Met	Statewide Transitional Healthcare Services	Partially Met

UHC is the largest Medicaid managed care plan in the United States, with more than 25 years of experience helping low-income adults and children and people with disabilities get access to personalized health care benefits and services. In Washington, UHC provides Medicaid coverage through Apple Health for more than 170,000 enrollees in 32 counties. UHC is also a lead entity for the Washington State Health Home Initiative and for the state's Medicare-Medicaid Eligible Demonstration Project in King and Snohomish counties.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.
[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.
[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.
NA: Sample size was less than the minimum required.
*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

UnitedHealthcare Community Plan (continued)

Strengths	Opportunities for improvement
Access to Care*,*	
• Scored in the 50th–74th percentile for Getting Needed Care, significantly better than the average of five Apple Health MCOs. • Scored higher than the state average for infant WCC visits, though not significantly higher.	• Scored significantly below the state average for access to PCPs for ages 12 months–6 years. • Scored below the state average for child and adolescent WCC visits, though not significantly lower.
Timeliness of Care**	
• Scored in the 75th–89th percentile for Getting Care Quickly, significantly better than the average of five MCOs.	
Quality of Care*,*	
• Scored above the state average for appropriate testing for pharyngitis, though not significantly higher. • Scored in the 75th–89th percentile for How Well Doctors Communicate and for Rating of Specialist. • Scored in the 50th–74th percentile for Rating of All Health Care, significantly better than the average of five Apple Health MCOs.	• Scored significantly below the state average for childhood immunizations (Combo 2), weight assessment/counseling, and dilated retinal exams. • Scored below the state average for childhood immunizations (Combo 3), adolescent immunizations (Combo 1), and diabetes care (HbA1c testing, LDL-C screening, monitoring for nephropathy), though not significantly lower. • Scored below the 50th percentile for Rating of Personal Doctor, and below the 25th percentile for Customer Service and for Rating of Health Plan, though not statistically different from the average of five Apple Health MCOs.
Regulatory and Contractual Standards**	

• Met 100% of elements for:
  ○ Program Integrity
  ○ Claims Payment
  ○ Patient Review and Coordination
  ○ Emergency and Post-stabilization Services
  ○ Enrollee Rights
  ○ Enrollment and Disenrollment
  ○ Grievance Systems
  ○ Practice Guidelines
  ○ Provider Selection (Credentialing)
  ○ QA/PI Program
  ○ Subcontractual Relationships/Delegation
• Met 80% of elements for:
  ○ Availability of Services
  ○ Coordination and Continuity of Care
	• Met 50% of elements for Furnishing of Services (Timely Access)

Performance Improvement Projects (PIPs)**	
• UHC's clinical PIP was generally well presented. • For the statewide nonclinical PIP, interventions were appropriate for the topic and the population served.	• The clinical PIP interventions were minimal, poorly described, and not linked to causes or barriers identified through data analysis and root cause analysis. • For the statewide nonclinical PIP, gaps in documentation included the absence of a data analysis plan, interpretation of the initial results, and discussion of the next steps.

*Data source: 2014 Performance Measure Comparative Analysis Report.
**Data source: 2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS Report.
***Data source: 2014 TEAMonitor report.

Appendix C: Elements of Regulatory and Contractual Standards

The interagency TEAMonitor group reviews MCOs' compliance with elements of access, quality, and timeliness required by federal managed care regulations and Apple Health contract provisions. Acumentra Health reviews RSNs' compliance with a similar set of regulations and DBHR contract provisions that apply to managed mental health care.

Table C-1 itemizes the relevant provisions in the Apple Health and DBHR contracts. Some of the listed provisions apply only to physical or to mental health care. Table C-2 lists the elements of each regulatory standard, with citations from the Code of Federal Regulations (CFR) and a summary description of each element.

Table C-1. Contract provisions related to access, timeliness, and quality.

Contract provisions	Apple Health or *DBHR* contract section(s)
Access to care	
The MCO/RSN must provide information to enable enrollees to make informed decisions and to understand benefit coverage and how to obtain care. For physical health care, written information must discuss how to choose and change PCPs and how to obtain emergency services, hospital care, and services outside the service area. The MCO must provide information on available specialists, informed consent guidelines, advance directives, grievance procedures, covered benefits, well-child care, translation and interpretation services, and how to obtain a second opinion. For mental health care, RSNs must use the DBHR-published benefits booklet to notify enrollees of their benefits, rights, and responsibilities.	3.2; *9.8*
The MCO/RSN must ensure ***equal access*** for enrollees and potential enrollees with communication barriers. For oral communication, the MCO/RSN must provide free interpreter services for those with a primary language other than English. The MCO/RSN must ensure that written materials are available in a form that can be understood by each enrollee and potential enrollee, and must translate generally available written materials into prevalent non-English languages.	3.4; *9.8.1.3–9.8.1.5*
The MCO/RSN must maintain and monitor a ***provider network*** sufficient to serve enrollee needs, including out-of-network services as medically necessary. The MCO/RSN must consider factors such as the expected service utilization by the Medicaid population, the number and types of providers required, the geographic locations of providers and enrollees, and enrollees' cultural, ethnic, racial, and language needs.	6.1–6.2; *4.1–4.4*
The MCO/RSN's provider network must meet ***distance standards*** in each service area. For physical health care, two PCPs must be available within 10 miles in an urban service area, and one PCP must be available within 25 miles in a rural service area. Similar standards exist for obstetrics, pediatric or family practice, and hospital and pharmacy services.	6.9; *4.9*
Each MCO must provide all medically necessary ***specialty care*** for enrollees in its service area, whether within or outside the provider network. The MCO must help providers obtain timely referrals to specialty care.	6.13
Timeliness of care	
The MCO/RSN must meet state standards for ***timely access*** to care. For physical health care, designated services must be available 24 hours a day, seven days a week by telephone. Preventive care office visits must be available from the enrollee's PCP or another provider within 30 calendar days; routine care visits, within 10 calendar days; urgent, symptomatic visits within 48 hours; and emergency care, 24 hours a day, seven days a week. Transitional care services must be available within 7 days of a patient's discharge from inpatient or institutional care. For mental health care, the RSN must offer a routine intake evaluation appointment within 10 business days of an enrollee's request. Emergent mental health care must occur within 2 hours of a request, and urgent care must occur within 24 hours of a request. The time period from request to first routine services appointment may not exceed 28 calendar days.	6.3–6.7; *4.8*

Contract provisions	Apple Health or *DBHR* contract section(s)
Quality of care	
"Quality" means "the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 CFR §438.320)."	1.79
The MCO/RSN must adopt ***practice guidelines***, disseminate them to providers, and use them in decision making for utilization management, enrollee education, service coverage, and other areas. The guidelines must be evidence-based, consider enrollee needs, be adopted in consultation with contracting professionals, and be reviewed and updated regularly.	7.8; *7.7*
The MCO/RSN must guarantee ***enrollee rights***, including the right to be treated with respect and with consideration for dignity and privacy; to be informed of available treatment options and alternatives; to participate in decisions regarding their health care; to be free from unnecessary restraint or seclusion; and to request and receive copies of their medical records and ask that they be amended. RSN enrollees must have individual service plans, developed with the participation of enrollees and their families. Each RSN must provide an independent mental health Ombuds to inform enrollees of their rights and help them resolve complaints and grievances.	10.1; *9.1–9.5*
The MCO/RSN must maintain written policies and procedures for ***advance directives*** that meet state and federal requirements and must provide for staff and community education concerning these policies.	10.3; *9.7*
For physical health care, the MCO must ensure that each enrollee has an ***appropriate source of primary care*** and must allow each new enrollee to choose a PCP, to the extent possible and appropriate. For mental health care, the RSN must offer each enrollee a choice of providers.	10.4; *9.9*
The MCO/RSN must have and maintain a ***utilization management program*** that includes mechanisms for detecting both underutilization and overutilization of services furnished to enrollees.	11.1; *5*
The MCO/RSN must meet state and federal requirements for ***service authorization***, including consistent application of review criteria for authorization decisions and timely notification of providers and enrollees in the event that the contractor denies an authorization request. The notice must explain the reasons for denial and the procedures for filing an appeal or requesting expedited resolution.	11.3; *5.2*
MCO/RSN ***grievance systems*** must meet state and federal standards regarding procedures and time frames for grievances, appeals, and access to the hearing process.	13; *6*
MCOs must ensure ***continuity of care*** for enrollees in an active course of treatment for a chronic or acute medical condition and must prevent the interruption of medically necessary care. RSNs must ensure coordination with other service delivery systems responsible for meeting needs identified in the enrollee's individual service plan, including primary medical care and services such as education, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections, and juvenile justice.	14.1; *10.2–10.3*
MCOs must facilitate ***transitional care*** for enrollees through operational agreements with state and community hospitals, RSNs, long-term care facilities, and substance abuse treatment programs. Agreements must include completion of a standardized discharge screening tool with a risk assessment for reinstitutionalization, rehospitalization, or treatment recidivism, plus intervention plans to mitigate such risk for enrollees.	14.5

Contract provisions	Apple Health or *DBHR* contract section(s)
MCOs must ensure ***coordination of care*** for enrollees, including initiating and coordinating referrals for specialty care. MCOs must conduct initial health screens to identify each new enrollee with special health care needs (SHCN), and must conduct initial health assessments of those enrollees to develop individual care coordination plans. The MCO must coordinate with and, if appropriate, refer SHCN enrollees to DSHS and other state and local service programs. Each RSN must help to coordinate mental health care for enrollees admitted for psychiatric inpatient services; provide follow-up care for enrollees treated in emergency rooms; facilitate communication between physical and mental health providers about Early Periodic Screening, Diagnosis, and Treatment for enrollees under age 21; and have a plan for coordinating services with chemical dependency and substance abuse, criminal justice, and other allied systems.	14.2–14.4; *10.4–10.8*
Each MCO must establish and implement a ***Health Home program*** for high-cost, high-needs enrollees by becoming or contracting with a qualified health home. Health Home services must be community-based and integrated and coordinated across medical, mental health, chemical dependency, and long-term services and supports. The MCOs must develop and implement a Health Action Plan for each enrollee, based on specified patient data and input from the enrollee and his or her family and/or caregivers. Specific requirements apply to services for comprehensive care coordination, health promotion, transitional care, individual and family support, and referral to community and special support services.	14.9, Exhibit C
Each MCO must maintain a ***Quality Assessment and Performance Improvement*** program that meets federal regulatory requirements. The program must include a Quality Improvement Committee that oversees quality functions, an annual work plan, and an annual written program evaluation. Each RSN's quality management program must include an annual review of community mental health agencies within the network.	7.1; *7.1–7.6*
The MCO/RSN must conduct ***performance improvement projects*** (PIPs) designed to achieve significant sustained improvement in areas expected to have a favorable effect on health outcomes and enrollee satisfaction. Each MCO must collaborate with peer MCOs to conduct a nonclinical statewide PIP on Transitional Healthcare Services for SHCN or high-risk enrollees. If any of the MCO's HEDIS rates for well-child care fall below designated levels, the MCO must implement a clinical PIP designed to increase the rates. Each RSN must conduct two PIPs each year, one of which must be a children's PIP.	7.2; *7.9–7.10*
For physical health care, each MCO must report HEDIS and non-HEDIS ***performance measures*** according to NCQA specifications. The contract specifies measures to be submitted each year. Each RSN must show improvement on two core performance measures specified and calculated by DBHR. If the RSN does not meet DBHR-defined improvement targets on any measure, DBHR may require corrective or remedial action. In addition, RSNs are to develop, calculate, track, and report regional performance measures based on local relevance, clinical consensus, and research evidence and with input from the local Mental Health Advisory Board.	7.3; *7.11*

Table C-2. Elements of regulatory standards for managed care.

CFR section	Description
438.206 Availability of Services 438.206(b)(1)(i-v) Delivery network 438.206(b)(2) Direct access to a women's health specialist 438.206(b)(3) Provides for a second opinion 438.206(b)(4) Services out of network 438.206(b)(5) Out of network payment	Maintain and monitor a network of providers sufficient to provide adequate access to all services covered under the contract; provide female enrollees with direct access to women's health specialists; provide for second opinions; cover out-of-network services adequately and timely if necessary; meet contract standards.
438.206(c) Furnishing of Services 438.206(c)(1)(i) through (vi) Timely access 438.206(c)(2) Cultural considerations	Meet state standards for timely access to care and services; provide hours of operation for Medicaid enrollees that are no less than the hours for any other patient; make services available 24 hours a day, 7 days a week, when medically necessary; deliver services in a culturally competent manner to all enrollees.
447.46 Timely Claims Payment by MCOs 447.46 Timely claims payment	Meet standards requiring the contractor and any subcontractors to pay or deny 95% of all claims within 60 days of receipt and to pay 99% of "clean" claims within 90 days of receipt.
438.608 Program Integrity Requirements	Maintain administrative and management arrangements or procedures, including a mandatory compliance plan, designed to guard against fraud and abuse.
438.208 Primary Care and Coordination 438.208(b) Primary care and coordination of health care services	Ensure that each enrollee has an ongoing source of appropriate primary care and a person or entity responsible for coordinating healthcare services for the enrollee; ensure that medically necessary care for enrollees is not interrupted; facilitate orderly transfers when necessary; coordinate enrollees' healthcare services with community-based organizations.
438.208(c) Additional Services for Enrollees with Special Health Care 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	Implement mechanisms to identify and assess enrollees with special healthcare needs; develop individual treatment plans for these enrollees; provide direct access to specialists as necessary.
438.210 Coverage and Authorization of Services 438.210(b) Authorization of services 438.210(c) Notice of adverse action 438.210(d) Timeframe for decisions 438.210(e) Compensation for UM decisions	Meet requirements for a formal utilization management program, oversight of practitioners, written criteria for clinical decision making, and mechanisms to detect under- and overutilization of services.
438.114 Emergency and Post-stabilization Services	Establish policies and procedures for covering and paying for emergency and post-stabilization care services.

CFR section	Description
438.100 Enrollee Rights ***(a) General rule*** 438.100(a) General rule 438.10(b) Basic rule 438.10(c)(3) Language – non-English 438.10(c)(4) and (5) Language – oral interpretation 438.10(d)(1)(i) Format, easily understood 438.10(d)(1)(ii) and (2) Format, alternative formats 438.10(f) General information 438.10(g) Specific information 438.10(h) Basic rule 438.100(b)(2)(iii) Specific rights 438.100(b)(2)(iv) and (v) Specific rights 438.100(b)(3) Specific rights 438.100(d) Compliance with other federal/state laws	Federal regulations include comprehensive language governing enrollee rights; Healthy Options contract requirements address advance directives, enrollee choice of primary care provider, access to specialty care for enrollees with special healthcare needs, prohibition on charging enrollees for covered services, and affirmation of provider/enrollee right to communicate freely regarding needs and services.
438.226 Enrollment and Disenrollment 438.226 and 438.56(b)(1) - (3) Disenrollment requested by the MCO, PIHP 438.56(c) Disenrollment requested by the enrollee 438.56(d) Procedures for disenrollment 438.56(d)(5) MCO grievance procedures 438.56(e) Timeframe for disenrollment determinations	Establish policies, procedures, and mechanisms to ensure appropriate process for disenrollment.
438.228 Grievance Systems 438.228 Grievance systems 438.402(a) The grievance system 438.402(b)(1) Filing requirements - Authority to file 438.402(b)(2) Filing requirements - Timing 438.402(b)(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 438.408(f) Resolution and notification: Grievances and appeals-Requirements for State fair hearings 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	Meet requirements regarding a defined grievance and appeal process for enrollees, including access to the state Fair Hearing system; policies, procedures, and standard notices to enrollees; acknowledgement of grievances and investigation and resolution of all relevant issues.

CFR section	Description
438.240 Performance Improvement Projects 438.240(b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs 438.240(d) Performance improvement projects 438.240(e)(1)(ii) Program review by the state	Design PIPs to achieve, through ongoing measurement and interventions, significant improvement sustained over time, favorable effect on health outcomes and enrollee satisfaction.
438.236 Practice Guidelines 438.236(b)(1-4) Adoption of practice guidelines 438.236(c) Dissemination of [practice] guidelines 438.236(d) Application of [practice] guidelines	Promulgate and maintain practice guidelines based on reliable and valid clinical evidence, and use the guidelines to guide clinical decision making.
438.214 Provider Selection (Credentialing) 438.214(a) General Rules and 438.214(b) Credentialing and recredentialing requirements 438.214(c) and 438.12 Nondiscrimination and provider discrimination prohibited 438.214(d) Excluded providers 438.214(e) State requirements	Adhere to state policies and procedures based on NCQA credentialing standards.
438.240 Quality Assessment and Performance Improvement Program 438.240(a)(1) Quality assessment and performance improvement program - General rules 438.240(b)(2) and (c), and 438.204(c) Performance measurement 438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and underutilization of services 438.240(b)(4) Basic elements of MCO and PIHP quality assessment and performance improvement – assess care furnished to enrollees with special health care needs 438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement – evaluating the program	Meet standards for QAPI program structure with written program descriptions, work plan, and evaluation.
438.230 Subcontractual Relationships and Delegation The MCO oversees functions delegated to subcontractor: 438.230 (a) and (b) Subcontractual relationships and delegation	Meet requirements for MCO oversight of delegated entities responsible for providing care and services; subcontract language regarding solvency, provider nondiscrimination, assigned responsibilities, and other provisions consistent with federal regulations in this area, such as reimbursement rates and procedures.

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Appendix D. PIP Review Procedures

TEAMonitor reviews the performance improvement projects (PIPs) conducted by the contracted MCOs, while Acumentra Health reviews the PIPs conducted by RSNs. Although both sets of reviews are based on the federal protocol for validating PIPs, the review procedures differ somewhat (most notably in scoring methods), as outlined below.

TEAMonitor PIP Review Steps

ACTIVITY 1: Assess the Study Methodology
Step 1. Review the Selected Study Topic(s)
1.1. Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?
1.2. Is the PIP consistent with the demographics and epidemiology of the enrollees?
1.3. Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?
1.4. 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.)?
1.5. Did the PIP, over time, include all enrolled populations (i.e., special health care needs?)
Step 2: Review the Study Question(s)
2.1. Was/were the study question(s) stated clearly in writing?
Step 3: Review Selected Study Indicator(s)
3.1. Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?
3.2. Did the indicators track performance over a specified period of time?
3.3. 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 and resources to collect necessary data?
Step 4: Review the Identified Study Population
4.1. Were the enrollees to whom the study question and indicators are relevant clearly defined?
4.2. If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
Step 5: Review Sampling Methods
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
5.2. Were valid sampling techniques employed that protected against bias? *Specify the type of sampling or census used.*
5.3. Did the sample contain a sufficient number of enrollees?
Step 6: Review Data Collection Procedures
6.1. Did the study design clearly specify the data to be collected?
6.2. Did the study design clearly specify the sources of data?
6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?
6.4. Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?

6.5. Did the study design prospectively specify a data analysis plan?

6.6. Were qualified staff and personnel used to collect the data?

Step 7: Assess Improvement Strategies

7.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?

7.2. Are the interventions sufficient to be expected to improve processes or outcomes?

7.3. Are the interventions culturally and linguistically appropriate?

Step 8: Review Data Analysis and Interpretation of Study Results

8.1. Was an analysis of the findings performed according to the data analysis plan?

8.2. Were numerical PIP results and findings accurately and clearly presented?

8.3. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?

8.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?

Step 9: Assess Whether Improvement Is "Real" Improvement

9.1. Was the same methodology as the baseline measurement used when measurement was repeated?

9.2. Was there any documented, quantitative improvement in processes or outcomes of care?

9.3. Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?

9.4. Is there any statistical evidence that any observed performance improvement is true improvement?

Step 10: Assess Sustained Improvement

10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?

ACTIVITY 2. Verify Study Findings (Optional)

1. Were the initial study findings verified upon repeat measurement?

ACTIVITY 3. Evaluate Overall Validity and Reliability of Study Results

Check one:

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

PIP scoring

TeaMonitor assigned each PIP a score of "Met," "Partially Met," or "Not Met" by using a checklist of elements deemed essential for meeting the standards specified by the Centers for Medicare & Medicaid Services. The checklist appears on the following page.

To achieve a "Met" the PIP must demonstrate <u>all of the following twelve (12) elements</u>:

- ☐ The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators documented.
- ☐ Description 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 results reported.
- ☐ Consistent measurement methods used over time or if changed, the rationale for the change is documented.
- ☐ 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 question(s); selected clinical or non-clinical measures or indicators; and results.

To achieve a "Partially Met" the PIP must demonstrate <u>all of the following seven (7) elements</u>:

- ☐ The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- ☐ 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 the rationale for the change is documented.

A "Not Met" score results <u>from NOT demonstrating any one (1) of the following</u>:

- ☐ The topic of the PIP does not reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) not stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators not documented.
- ☐ A sampling method is not documented and determined prior to data collection.
- ☐ The study design and data analysis plan is 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 provided for change in measurement methods, as appropriate.

Acumentra Health PIP Review Steps

In September 2012, the Centers for Medicare & Medicaid Services (CMS) updated its PIP validation protocol. For 2014, Acumentra Health revised the PIP validation protocol for Washington to align with the updated CMS protocol, and to incorporate feedback and address challenges from past PIP reviews.

The 10 validation standards adapted by Acumentra Health from the 2012 CMS protocol define critical elements in PIP study design. Specific criteria for each standard are listed below.

Standard 1: Study Topic

To meet Standard 1, the RSN needs to establish the importance of the study topic in general; present local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population and will have a significant impact on enrollee health, functional status, or satisfaction; and demonstrate that a systematic selection and prioritization process, that includes opportunities for input by enrollees and providers, was used in choosing the topic.

1.1 Provide a brief overview of your study topic.

1.2 Discuss how the study topic is relevant to your local Medicaid population, including:

a. the incidence and/or prevalence of the issue within the local Medicaid population
b. the impact the topic/issue is currently having on the local Medicaid population
c. an estimate of the number or percentage of Medicaid enrollees within your population who are affected by the topic/issue
d. how the study topic reflects high-volume or high-risk conditions in the population served

1.3 Discuss how you identified the study topic (e.g., Quality Committee, focus group, grievances, QAPI, direct input from enrollees, other sources). Your discussion should describe opportunities for input by enrollees and providers.

1.4 Describe why you prioritized this topic over others, including considerations of quality (e.g., high risk, prevalent issue) and feasibility (e.g., data and resource availability).

1.5 Discuss how the study topic has the potential to significantly impact enrollee health, functional status, or satisfaction.

Standard 2: Study Question

To meet Standard 2, the RSN needs to present a study question that provides a clear framework for data collection, analysis, and interpretation. The study question should refer to the proposed intervention, a study population (denominator), what is being measured (a numerator), a metric (e.g., average, percentage), and a direction of desired change.

2.1 State your study question. A complete study question includes an intervention, a study population (denominator), what you are measuring (numerator), a metric (percent or average), and a desired direction of change (increase or decrease). If you have more than one study indicator, you should present a separate study question for each study indicator.

Standard 3: Study Population

To meet Standard 3, the RSN needs to provide a brief description of the study population; list all inclusion and exclusion criteria for the study population, including enrollment criteria; and provide definitions and data sources, including, codes, and calculations. If a sample is selected, the RSN needs to describe the sampling methods.

Define the following elements for each study indicator:

3.1 Provide a brief description of the study population.

3.2 List the inclusion and exclusion criteria for the study population and name each data element. Provide definitions, data sources, and any calculations (if applicable) and relevant codes. You do not need to list the inverse of the inclusion criteria as exclusions. The purpose is to demonstrate that study data will be collected consistently and accurately and can be replicated from year to year regardless of staff changes. If relevant, include:

a. continuous enrollment and allowable gap criteria
b. start/end dates for age, enrollment, and other criteria

3.3 Did you use a sample instead of the entire study population?

□ Yes □ No

If yes, complete Attachment A.

Standard 4: Study Indicator

To meet Standard 4, the RSN needs define the numerator (what is being measured) and the denominator; define key terms; describe the target goal; discuss the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care; list all inclusion and exclusion criteria for the numerator (what is being measured), including enrollment criteria; and provide definitions and data sources, including codes, and calculations.

4.1 Define the following elements for each study indicator (if you have more than one study indicator, please complete for each indicator separately).

a. State the numerator (what is being measured).
b. State the denominator.

If you are using a different type of indicator, such as a rate or pre-post calculation, describe the process and the calculation.

c. Check the box that represents the basis for the indicator and provide the rationale for your selection:

□ External (e.g., HEDIS, state performance measure, research literature, current best practices, etc.). If HEDIS or other indicators are being modified, provide a description and rationale.

□ Internal (derived from your own data sources, e.g., administrative data, claims, etc.). Provide quantitative data to support your rationale.

d. Describe your target goal in terms of anticipated time frame and degree of improvement.

e. Data on indicator available through (check all that apply):

□ Medical/treatment records □ Administrative (claims, encounter, etc.)

□ Hybrid (records and administrative data) □ Survey (attach tool) □ Other (describe)

f. Explain how the indicator measures enrollee outcomes in health, functional status, or satisfaction directly or indirectly as a proxy.

4.2 List the inclusion and exclusion criteria for the numerator (what is being measured) and name each data element. Provide definitions, data sources, and any calculations (if applicable) and relevant codes. You do not need to list the inverse of the inclusion criteria as exclusions. The purpose is to demonstrate that study data will be collected consistently and accurately and can be replicated from year to year regardless of staff changes. If relevant, include:

a. continuous enrollment and allowable gap criteria
b. start/end dates for age, enrollment, and other criteria

4.3 Have you changed any elements of the study indicator after obtaining the baseline measurement?

□ Yes □ No

If yes, complete Standard 7.1.

Standard 5: Data Collection and Data Analysis Plan

To meet Standard 5, the RSN needs to describe data collection and data validation procedures, including a plan for addressing errors and missing data, and present a clear data analysis plan, including time frames for the measurement and intervention periods and an appropriate statistical test to measure differences between the baseline and remeasurement periods.

5.1 Are you collecting data manually (chart review, registries, etc.)? □ Yes □ No

If no, go to 5.2. If yes, describe:

a. role, qualifications, and training of data collection staff
b. data collection tool and instructions (please attach)
c. inter-rater reliability procedures

5.2 If collecting administrative data, describe your systematic method for collecting study data, including the frequency of data collection and staff roles.

5.3 Describe the processes and/or procedures used to ensure that the data selected for this study are accurate and valid. (Note: the explanation should cover every data element.)

a. Address both general data elements (e.g., Medicaid eligibility) and PIP-specific data such as surveys, measurements not included in administrative data (e.g., blood pressure or weight), and assessment instruments.
b. If using claims or encounter data, provide encounter data validation results.
c. Describe how errors and missing data are addressed.
d. State the frequency for data validation procedures.

5.4 For your data analysis plan, document clear study measurement periods.

- The baseline period should end before the start date of the intervention.
- The first remeasurement period should not begin before the start date of the intervention.
- The intervention and remeasurement periods may run concurrently.
- If you are using a pre-post methodology (i.e., the PIP introduces a completely new tool or process so there is no "true" baseline), the "baseline" should be labeled "first measurement."

Document a separate data analysis plan for each study indicator, including the study period, start date, and end date for the baseline or first measurement, intervention, first remeasurement, and second remeasurement periods; statistical test and rationale and probability level.

5.5 Have you changed any data collection tools and processes and/or the data analysis plan after obtaining the baseline measurement? □ Yes □ No If yes, complete Standard 7.1.

Standard 6: Study Results

To meet Standard 6, the RSN needs to present results according to the data analysis plan, including the study indicator, the original data used to compute the indicator, and a statistical test to measure differences between the baseline and remeasurement periods; and discuss any other data analyses for factors that may affect the study.

6.1 Present raw data for the numerator, denominator, and calculated study indicator (e.g., percent, average) for the baseline and the first remeasurement period. If you have more than one study indicator, respond for each study indicator separately.

6.2 Present the results of your statistical analysis comparing baseline to the first remeasurement data. Report the probability level used to identify any statistically significant difference.

6.3 Present and discuss other data analysis results for all factors that may affect the study results. These might include demographics, provider agency analyses, and/or run charts for monitoring improvement.

Standard 7: Interpretation of Results

To meet Standard 7, the RSN needs to list any changes to the study design and discuss the effect of those changes on the comparability of data and interpretation of results; describe any factors that threaten the internal or external validity of the study; discuss whether the intervention was implemented as planned; describe any improvement in enrollee health, functional status, or satisfaction and accomplishment of target goals, discuss how the intervention influenced the results; discuss lessons learned during the PIP process; draw a conclusion about the study results based on the above factors; and describe next steps for the study.

7.1 Have you made changes to the study design? □ Yes □ No

If no, go to 7.2. If yes, indicate what has changed:

□ study question

□ study indicator (numerator, denominator, relevant terms)

□ data analysis plan (measurement periods, statistical test, probability level)

□ data collection tools or processes

□ other (not including the intervention):

Provide a rationale for each change and explain how the change will affect the comparability of initial and repeat measurements and interpretation of the study results.

7.2 Describe any factors that threaten the internal or external validity of the study and how those might affect, or did affect, the study results.

7.3 Discuss whether or not the intervention was implemented as planned. Your response should include information about the results of tracking and monitoring the intervention.

7.4 Discuss any improvement in enrollee health, functional status, or satisfaction, as well as accomplishment of target goals.

7.5 Discuss any lessons learned about this specific PIP and how you plan to address them.

7.6 Summarize points 7.1–7.5 in order to draw a conclusion about your study results.

7.7 Describe your next steps for the study (e.g., monitoring your intervention, planning for modifications based on lessons learned, other plans prior to next review).

Standard 8: Improvement Strategies

To meet Standard 8, the RSN needs to describe and document the implementation of the intervention(s) and discuss the basis for adopting the intervention; how the intervention can be reasonably expected to result in measurable improvement; the cultural and linguistic appropriateness of the intervention; a tracking and monitoring plan (providing evidence of how the intervention was or will be implemented as planned); barriers encountered during implementation of the intervention and how they were addressed; and how the intervention will be adapted, adopted, or abandoned.

8.1 Provide an overview of the interventions in chronological order. Elements include:

a. the root cause analysis or quality improvement process used to select the intervention
b. how the intervention could be expected to improve the study indicator (e.g., based on clinical knowledge, relevant research, local adoption, or previous experiences)
c. the intervention itself (dates, location, training, roles/qualifications, tools/instruments, etc.)
d. cultural and linguistic appropriateness of the intervention
e. tracking and monitoring: how you know that the intervention will be or was implemented successfully (e.g., attendance sheets, feedback at meetings, number or percent of study-eligible enrollees reached by the intervention)
f. barriers encountered during the implementation of the intervention(s) and how they were addressed
g. next steps: how the intervention will be adapted, adopted, or abandoned

Standard 9: Repeated Measurement of the Study Indicator

To meet Standard 9, the RSN needs to report complete study results for two measurement periods, including the study indicator, original data used to compute the indicator, and a statistical test of group differences; provide any other data analyses for factors that may affect the study results; and discuss how the intervention, consistency of methodology, and any confounding factors affected the study results in the second remeasurement period.

9.1 Present raw data for the numerator, denominator, and calculated study indicator (e.g., percent, average) for the baseline (or first measurement), first remeasurement, and second remeasurement periods. If you have more than one study indicator, respond for each indicator separately.

9.2 Present the results of your statistical analysis comparing:

- baseline/first measurement to the first remeasurement
- first remeasurement to second remeasurement
- baseline/first measurement to second remeasurement

Report all probability levels in order to determine whether or not there was a statistically significant difference between measurement periods.

9.3 Present other data analysis results for all factors that may affect the study results (e.g., demographics, provider agency analyses, and/or run charts for monitoring improvement).

9.4 Is it likely that the change in the study indicator in the second remeasurement is the effect of the intervention? □ Yes □ No

Discuss the consistency of methodology (measurement periods, data collection), accuracy and reliability of data, monitoring of intervention implementation, and confounding factors.

Standard 10: Sustained Improvement

To meet Standard 10, the RSN needs to describe whether or not goals were met and sustained; whether improvement in the study indicator, as well as in enrollee health, functional status, or satisfaction was achieved; discuss lessons learned for the PIP and the system as a whole; and report next steps.

10.1 Was this PIP successful over time? □ Yes □ No In your discussion, address:

a. sustained improvement demonstrated through a statistically significant improvement in the indicator over baseline and in one of the remeasurement periods. (Note: You may answer "yes" if performance declined in the second remeasurement period but the decline was not statistically significant.)
b. improvement in enrollee health, functional status, or satisfaction, and accomplishment of target goals
c. barriers encountered/lessons learned for this PIP and your system as a whole
d. whether or not you plan to continue this PIP. If you are continuing this PIP beyond the second remeasurement, provide a rationale.

PIP scoring

Acumentra Health assigns a score to each PIP standard to measure compliance with federal standards. Each standard has a potential score of 100 points, as shown in Table D-1.

Table D-1. Compliance rating for PIP standards by point range.

Rating	Definition	Points
Fully met	Meets or exceeds the essential criteria	100
Substantially met	Meets essential criteria, has minor deficiencies	75–99
Partially met	Meets criteria with deficiencies in some areas	50–74
Minimally met	Marginally meets criteria	25–49
Not met	Does not meet essential criteria	0–24

The scores for each standard are weighted and combined to determine the overall PIP score. The maximum overall score is 85 points for Standards 1–8, and 100 points for Standards 1–10, as shown in Table D-2.

Table D-2. Weighting of points on PIP standards in the overall PIP score.

Standard	Scoring Weight
1 Study Topic	15%
2 Study Question	5%
3 Study Population	10%
4 Study Indicator	15%
5 Data Collection and Data Analysis Plan	10%
6 Study Results	10%
7 Interpretation of Results	10%
8 Improvement Strategies	10%
Demonstrable Improvement Score	**85%**
9 Repeated Measurement of the Study Indicator	5%
10 Sustained Improvement	10%
Sustained Improvement Score	**15%**
Overall PIP Score	**100%**

The overall PIP score corresponds to a compliance rating that ranges from Fully Met to Not Met. Table D-3 shows the compliance ratings and associated scoring ranges for PIPs graded on the 90-point and the 100-point scale.

Table D-3. Compliance rating for PIPs by overall score.

Compliance rating	Description	100-point scale	85-point scale
Fully met	Meets or exceeds all requirements	80–100	68–85
Substantially met	Meets essential requirements, has minor deficiencies	60–79	51–67
Partially met	Meets essential requirements in most, but not all areas	40–59	34–50
Minimally met	Marginally meets requirements	20–39	17–33
Not met	Does not meet essential requirements	0–19	0–16

Table D-4 shows an example scoring calculation for a PIP on Standards 1–8 for demonstrable improvement, and on Standards 1–10 for sustained improvement.

Table D-4. Scoring worksheet example.

Standard	Compliance rating	Assigned points	Weight	Overall score
1	Fully met	100	15%	15.0
2	Fully met	100	5%	5.0
3	Substantially met	80	10%	8.0
4	Substantially met	80	15%	12.0
5	Fully met	100	10%	10.0
6	Partially met	50	10%	5.0
7	Minimally met	40	10%	4.0
8	Partially met	50	10%	5.0
Overall Score 1–8	**Substantially Met**			**64.0**
9	Substantially met	75	5%	3.75
10	Partially met	50	10%	5.0
Overall Score 1–10	**Substantially Met**			**75.0**

Note: As approved by DBHR, Acumentra Health revised the method for calculating overall scores for PIPs beginning with the 2014 evaluations. The new method assigns a greater weight to Standard 4 (Study Indicator, from 10% to 15%) and Standard 10 (Sustained Improvement, from 5% to 10%), and a smaller weight to Standard 1 (Study Topic, from 20% to 15%) and Standard 2 (Study Question, from 10% to 5%). The score for Demonstrable Improvement now represents 85% of the overall PIP score, rather than 90% as in previous years.