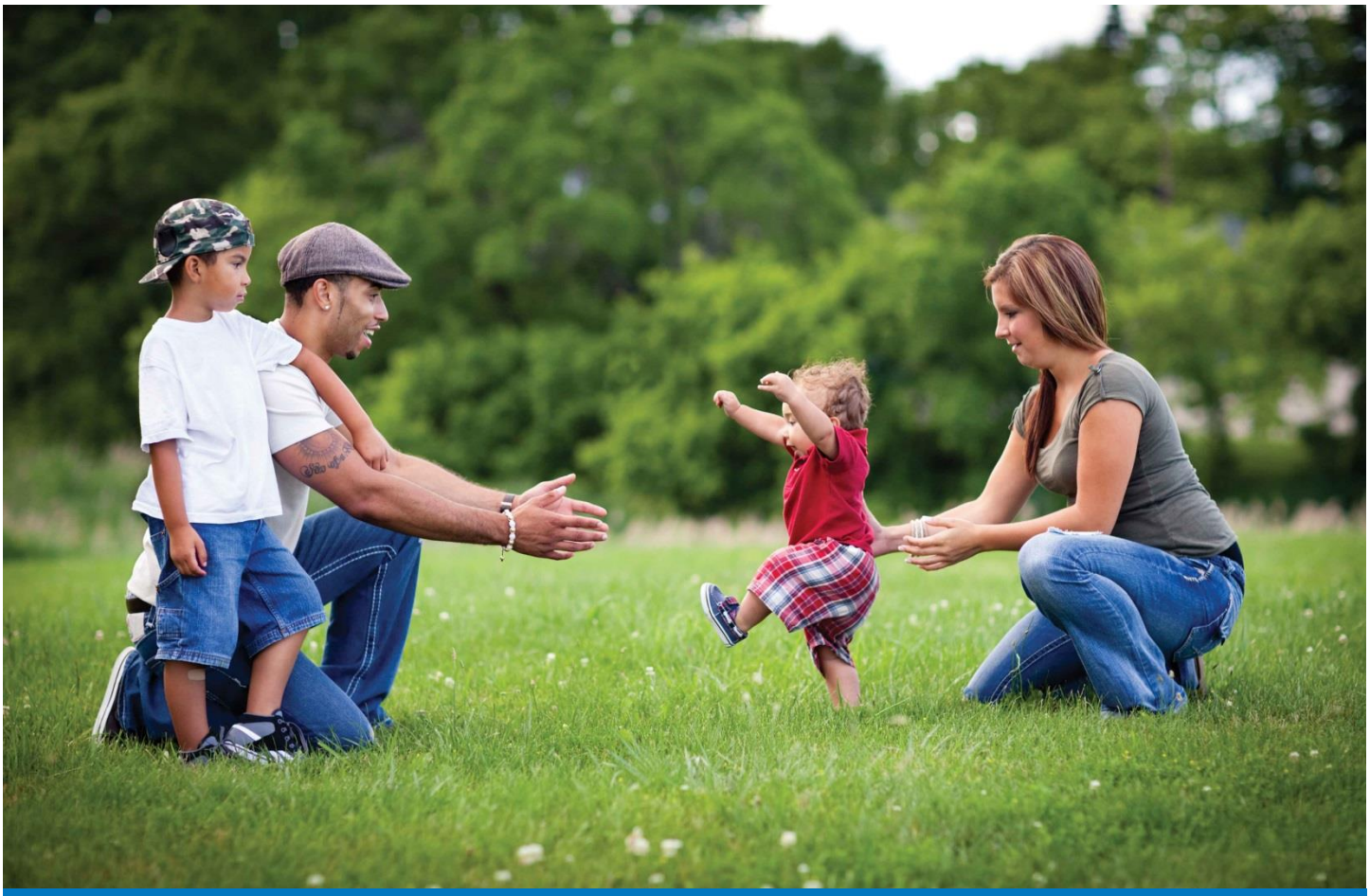

2016 Annual Technical Report

Washington Apple Health

Washington Health Care Authority

Division of Behavioral Health and Recovery

February 2017

QUALIS HEALTH™

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

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

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

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Executive Summary

Washington's Medicaid program for physical and behavioral healthcare services provides benefits for more than 1.4 million residents. The Washington State Health Care Authority (HCA) administers services for physical health through contracts with managed care organizations (MCOs), which facilitate delivery of physical healthcare services. The Washington State Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR) administers services for mental health and substance use disorder (SUD) treatment through contracts with Behavioral Health Organizations (BHOs), which facilitate behavioral healthcare services.

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review of healthcare services provided to enrollees, to assess the accessibility, timeliness, and quality of care they provide. As Washington's Medicaid external quality review organization (EQRO), Qualis Health conducted this 2016 review. This technical report describes the results of this review.

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

Background: The Changing Landscape of Washington's Medicaid Program

Washington continues on a path to transform the way healthcare is furnished in the state through multiple initiatives connected to the State Health Care Innovation Plan, Healthier Washington. The changes resulting from Healthier Washington programs will ultimately include integration of behavioral and physical healthcare services, introduction of value-based payments, greater community and consumer empowerment through Accountable Communities of Health (ACHs), and practice transformation throughout the state. By 2020, the State will fully integrate the financing and delivery of physical health, mental health, and substance use disorder treatment services in one Medicaid managed healthcare program.

In 2015, HCA and DSHS worked toward the development of the following program components, in preparation for launch in 2016:

- **Earlier Enrollment:** This is a mechanism that allows members to enroll with a managed care plan the day they become eligible for Medicaid. Previously, new or returning Apple Health members had to wait up to six weeks to be enrolled in a managed care plan.

- **Fully Integrated Managed Care (FIMC) in Southwest Washington:** As a first step toward a fully integrated care model, physical health, mental health, and substance use disorder treatment are coordinated through integrated managed care plans in the Southwest Washington region. Community Health Plan of Washington (CHPW) and Molina Healthcare of Washington (MHW) were selected as the plans to implement this first regional effort.

- **Transition from Regional Service Networks (RSNs) to Behavioral Health Organizations (BHOs):** In April 2016, the DSHS Division of Behavioral Health and Recovery began contracting

with Behavioral Health Organizations, one for each of the state's nine Regional Service Areas (RSAs) excluding the Southwest Washington RSA, to provide comprehensive and culturally appropriate mental health and SUD treatment services. The BHOs replaced the state's Regional Support Networks (RSNs) and administer services by contracting with behavioral health agencies (BHAs)—community mental health agencies and SUD providers—to provide mental health and SUD treatment and services. Previous to the BHO contracts, RSNs provided only mental health services. In combining mental and substance use disorder treatment services, this model transformed a fragmented delivery system into one region-wide system of behavioral healthcare.

- **Apple Health Core Connections:** In 2015, Coordinated Care of Washington (CCW) was selected to administer Apple Health Core Connections, the State's managed care program for children and youth in foster care, adoption support, extended foster care, and young adults previously enrolled in foster care. The goals of Core Connections are to improve access to care, provide healthcare coordination services for young members with multiple or complex healthcare needs, and provide education and assistance to those transitioning from foster care to independence so that members will not lose access to needed healthcare services.

Collectively, these efforts will contribute to an overall program that will better meet the needs of the whole person, providing better-coordinated care for Medicaid enrollees as well as more fluid access to physical and behavioral healthcare services.

Description of External Quality Review Activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols. The 2016 report includes strengths, opportunities for improvement, and recommendations reflecting the assessment results of the following:

- **MCOs**
  - audit results of Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures of clinical services provided by MCOs
  - validation of performance measures
  - audit results of compliance monitoring, including follow-up of the previous year's corrective action plans
  - validation of performance improvement projects (PIPs)
  - results of Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) consumer satisfaction surveys

- **BHOs**
  - readiness review assessing each BHO's progress in transitioning from the RSN to the BHO structure and in integrating SUD treatment services
  - results of compliance monitoring
  - results of encounter data validation (EDV)
  - follow-up of the previous year's corrective action plans
  - follow-up of the previous year's Information Systems Capabilities Assessment (ISCA)
  - validation of PIPs

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- results of EDV and grievances compliance review as part of the BHOs' implementation of the Wraparound with Intensive Services (WISe) program

Managed Care State Quality Strategy

As specified in CFR §438.340, each State that contracts with a Medicaid managed care plan must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the Medicaid managed care plan.

Description of Access, Timeliness, and Quality

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

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

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

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

Physical Health

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

Compliance Review
The State's MCOs are evaluated by TEAMonitor, the interagency unit of the Health Care Authority and the Department of Social and Health Services, on their compliance with federal and State regulatory and contractual standards. TEAMonitor's review assesses activities for the previous calendar year and

evaluates MCOs' compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCOs' contract with HCA.

Qualis Health has provided summaries and observations based on TEAMonitor's results in the Compliance chapter of the Physical Healthcare section of this report.

Performance Improvement Project Validation
MCOs are required to have an ongoing program of clinical and non-clinical performance improvement projects that are designed to improve processes, health outcomes, and enrollee satisfaction. TEAMonitor assesses and validates the MCO performance improvement projects to ensure they meet State and federal guidelines and are designed, conducted, and reported in a methodologically sound manner. MCO PIPs conducted over the past year are listed in the Performance Improvement Project Validation chapter of the Physical Healthcare section of this report.

Performance Measures
HEDIS is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow MCOs to determine where quality improvement efforts may be needed. For the 2016 reporting year (RY, measuring 2015 data), MCOs submitted data on 31 specific measures representing 102 submeasures.

Qualis Health used this data to perform comparisons among MCOs and against national benchmarks. Summary results from this analysis can be found in the Performance Measure Review chapter of the Physical Healthcare section of this report. The full analysis is available in the *2016 Comparative Analysis Report*.[3]

The CAHPS survey assesses consumers' experiences with healthcare services and support. Developed by the U.S. Agency for Healthcare Research and Quality (AHRQ), the surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of healthcare, access to specialized services, and coordination of care. In 2016, the Apple Health MCOs conducted the CAHPS 5.0H Adult Medicaid survey, collecting data from Apple Health adult members. The full analysis is available in the *2016 Apple Health Managed Care CAHPS® 5.0H Adult Medicaid Report*.[4] In addition, in 2016, a CAHPS 5.0H Child Medicaid survey of the parents/guardians of children enrolled in the Children's Health Insurance Program (CHIP) was conducted, in an effort to provide HCA with information specific to this program. A full analysis is available in the *2016 Washington Apple Health Children's Health Insurance Program CAHPS 5.0H Summary Report*.[5]

Behavioral Health

Qualis Health's external quality review of the state's nine BHOs consisted of a compliance review assessing the BHOs' adherence to State and federal regulatory and contractual requirements, an encounter data validation, an evaluation of the BHOs' performance improvement projects, a follow-up ISCA review, and a review of prior-year EQR recommendations. Validation entails the review of

[3] *2016 Comparative Analysis Report* link to be provided with final report.
[4] *2016 Apple Health Managed Care CAHPS® 5.0H Adult Medicaid Report* link to be provided with final report.
[5] *2016 Washington Apple Health Children's Health Insurance Program CAHPS 5.0H Summary Report* to be provided with final report.

information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

This year's review also included an assessment of the BHOs' implementation of the children's WISe program, as well as a readiness review evaluating each BHO's status in transitioning from an RSN and integrating substance use disorder treatment services. Additionally, for each BHO, Qualis Health interviewed two mental health agencies and two SUD providers and performed two SUD provider agency onsite walkthroughs. While external quality review generally includes reporting on performance measure results, DBHR did not require the BHOs to report on performance measures in 2016.

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

Performance Improvement Project Validation
BHOs are required to have an ongoing program of performance improvement projects that are designed to assess and improve the processes and outcomes of the healthcare the BHOs provide. BHOs must implement three PIPs, one each focused on clinical, non-clinical, and substance use disorder treatment areas (one of which must focus on children). Performance improvement projects are evaluated and validated each year to ensure they meet State and federal standards. The performance improvement review methodology used by Qualis Health (see Appendix D) explains the procedures and scoring used in evaluating performance improvement projects.

Information Systems Capabilities Assessment (ISCA) Follow-up
The ISCA evaluates the ability of the BHOs' information systems to accurately and reliably produce performance measure data, encounter data, and reports to assist with management of the care provided to BHO enrollees. The 2016 review consisted of a follow-up of recommendations and opportunities for improvement issued to each BHO (formerly RSN) as a result of the 2015 ISCA.

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

Encounter Data Validation (EDV)
EDV is a process used to validate encounter data submitted by BHOs to the State. Encounter data are the electronic records of services provided to BHO enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provide substantially the same type of information found on claim forms but not necessarily in the same format. States use encounter data to assess and improve quality, monitor program integrity, and determine capitation payment rates. As Federal programs transition toward payment reform for demonstrated quality of care, validation of encounter data in the use of performance data becomes increasingly significant.

Transparency of payment and delivery of care is an important part of health reform. Validation of encounter data can help the State reach the goals of transparency and payment reform to support its efforts in quality measurement and improvement.

DBHR requires each BHO to ensure the accuracy of encounters submitted to DBHR by conducting an annual EDV, per DBHR guidelines. Qualis Health's audit then verifies each BHO's EDV process by conducting an independent check of the BHO's EDV results.

Qualis Health obtained each BHO's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2015, and reviewed the BHOs' encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates, and fields selected for validation for conformance with the CMS protocol standards and the DBHR contract requirements.

Wraparound with Intensive Services (WISe) Focused Study
In 2016, Qualis Health also conducted the 2016 EQRO Focused Study: Review of Children's WISe Implementation. Included in this study were compliance reviews for all nine of the BHOs on WISe-related grievances and appeals, an encounter data validation for WISe services across the five BHOs that had already implemented WISe as of the time of the review, and a quality review through clinical record audits at three BHAs identified by the State. At the time of the review, BHOs did not report receiving any grievances and appeals related to WISe. A review of the statewide EDV results for WISe services and a summary of the quality review are included in the WISe chapter of the Behavioral Healthcare section of this report.

Summary of Recommendations

In its examination and assessment of the MCOs' and BHOs' successes in providing Medicaid enrollees with accessible, timely, quality care, this *2016 Annual Technical Report* explains to what extent the State's managed care plans are meeting federal and State regulations, contract requirements, and statewide goals, and where they need to improve. Following are Qualis Health's recommendations to the State intended to help guide HCA and DBHR in improving Washington's overall Medicaid system of care. Subsequent sections offer further discussion and opportunities for improvement.

Overall Recommendations

MCOs and BHOs would benefit from the guidance of an overarching State quality strategy (as required by federal regulation) that clearly defines statewide managed care program goals and targets for improvement. The State has not yet completed or released this joint quality strategy plan.

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

With the progression of fully integrated managed care, collaboration among service networks is important in ensuring continued quality care.

- As the State continues to integrate the delivery of mental and physical healthcare services, the State needs to foster communication and collaboration between state agencies, MCOs, and BHOs to create transparency, ensure procedures are communicated, and minimize significant

quality gaps. Best practices, when identified, should be shared broadly to ease FIMC implementation across the state.

Physical Health

Recommendations

Apple Health MCOs experienced substantial declines in several performance measure areas in 2016 RY, particularly relating to access to care. Adult access to care measures dropped significantly across all MCOs, likely a reflection of Medicaid expansion. Child access to care measures were not expected to be impacted by expansion, yet the state rate fell by 3.7 to 6.9 points for all age groups on this measure in 2016 RY. The decrease was a result of the performance of one MCO, Community Health Plan of Washington (CHPW), which had the lowest rates of access in the nation for all Medicaid plans for two of the four age groups. State performance on maternal health measures, already below national average performance in 2015 RY, fell further in 2016 RY to the lowest quintile (lowest 20 percent) of Medicaid plan performance nationwide, a result of poor performance across all MCOs. MCO performance on most CAHPS measures, most notably Getting Needed Care, were also in the lowest quintile of national performance. Going forward, the State will need to prioritize these areas in its continued efforts to improve delivery of care to the State's expanded Medicaid population.

Performance Measures
The most substantive needs for improvement for MCOs that surfaced during the 2016 external quality review centered on low HEDIS measure and CAHPS survey performance, in which all MCOs either performed inconsistently or poorly. The following recommendations are intended to help identify the causes of low performance and take steps to remedy low scores.

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

- HCA needs to continue to require that MCOs conduct PIPs when measure performance falls below HCA-designated standards. Additionally, HCA should consider requiring MCOs to conduct thorough root cause analyses and/or PIPs for performance measures that drop by more than 10 percentage points between reporting years.

In 2016 RY, HEDIS rates of adult access to primary care dropped for all MCOs, rates of child and adolescent access to primary care dropped for every age group at the state level, and all MCOs underperformed compared to national averages for timeliness and frequency of prenatal care. CAHPS scores for Getting Needed Care were also in the lowest quintile nationally.

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

- HCA needs to require MCOs to identify barriers relating to receipt of prenatal care (both timeliness and frequency) to determine if statewide action is necessary, including potentially requiring MCOs to complete a statewide PIP on maternal health.

- HCA needs to require CHPW to complete a PIP on child and adolescent access to care.[6]

MCOs performed in the lowest quintile nationwide for six out of eight reported CAHPS survey questions. Given the interconnectedness of the variables impacting these scores, improvement efforts directed toward one or two process measures are likely to positively impact CAHPS results as a whole.

- HCA needs to encourage MCOs to increase focus on improving two easily measurable CAHPS measures, Getting Needed Care and Getting Care Quickly, in an effort to improve CAHPS survey results globally.

Data Collection

For the 2016 reporting year, HCA provided the MCOs with auditor-approved supplemental data, which were used in determining performance rates for administrative and hybrid measures. For hybrid measures, supplemental data provided by the State reduced the number of necessary chart reviews for MCOs, as MCOs were not required to review charts for individuals who, per HCA's supplemental data, had already received the service.

- HCA needs to continue to provide supplemental quality data to MCOs to reduce the burden of chart reviews and improve the integrity of statewide performance data.

Compliance

In this year's review, MCOs' scores demonstrated overall slight improvement, notably with enrollee rights and practice guidelines standards. Compliance with coordination and continuity of care, coverage and authorization, and grievance system standards continue to be areas of weakness.

- HCA needs to consider education or training efforts to address coordination and continuity of care, and transitional care with MCOs. These areas have been historically problematic, and though MCOs have shown improvement, additional efforts may be needed to ensure adequate care for enrollees.

Performance Improvement Projects

MCOs did not receive timely feedback related to their contractually required performance improvement projects in 2016.

- HCA needs to provide MCOs with timely feedback on the design and implementation of each performance improvement project so that MCOs have the opportunity to address issues potentially impacting improvement to processes, healthcare outcomes, and enrollee satisfaction.

Opportunity for Improvement

Review of compliance reports indicated that MCOs provided enrollees with outdated or incorrect materials, including those related to grievances and appeals and notices of action.

- HCA should require MCOs to implement version control tracking systems to ensure that communications distributed to enrollees, such as denial letters, notices of adverse action, and those related to grievances and appeals, are current, HCA-approved versions. Such a system could also ensure language inserts are included with enrollee notices.

[6] HCA's 2017 contract with Apple Health MCOs will require participation in a statewide collaborative performance improvement project related to child/adolescent access to care.

Behavioral Health

The following recommendations and selected strengths were found as a result of Qualis Health's external quality review of BHOs. Additional strengths, as well as opportunities for improvement, and how they relate to access, timeliness, and quality, may be found in the Behavioral Health Organization section of this report.

Strengths

- DBHR is working collaboratively with the BHOs to reframe, refine, and define grievance system policies, procedures, and reporting mechanisms. All BHOs have policies and procedures in place to inform enrollees of their right to access the grievance and appeal process and the State's fair hearing system. Most of the policies and procedures are culturally, linguistically, and age appropriate and include provisions for enrollee assistance. Many of the BHOs respond to enrollee grievances and appeals within 24 hours.
- Most BHOs are in compliance with enrollee rights and provide enrollees with a copy of their rights at intake and annually thereafter. All BHOs have policies and procedures in place that require contracted BHAs to inform enrollees, at the time of intake, of their rights regarding mental health advance directives and medical advance directives.
- Most BHOs reported that the BHAs do not employ seclusion and restraint and have policies and procedures in place to ensure the efficacy of this policy. BHOs require their contracted BHAs to use no-force behavior management techniques as preventative measures, using evidence-based practices.
- Over the course of 2016, DBHR has implemented a PIP review and approval process that includes communication with the EQR team and clear feedback to the BHOs regarding study topic submissions. Most BHOs are receptive and responsive to feedback and technical assistance regarding the formulation and implementation of PIPs, and the majority of the PIPs that had reached the point of data analysis received overall scores of fully met, with high confidence in reported results. Overall the PIPs demonstrated the BHOs' commitment to providing quality and comprehensive care to enrollees.
- Most of the BHOs have conducted weekly and monthly workgroups with both the mental health and SUD treatment providers to review, revise, and rewrite each BHO's policies to ensure the policies are inclusive of both the mental health and SUD treatment providers.
- Most of the BHOs have provided training to all BHO and BHA staff on all aspects of compliance, including fraud and abuse. Many BHOs' compliance officers are certified in health compliance (CHC).

Recommendations

Compliance—Enrollee Rights

Several of the BHOs lack evidence that they have performed annual administrative reviews onsite at the BHAs to monitor and ensure the BHAs are in compliance with standards regarding enrollee rights.

- DBHR needs to ensure the BHOs are performing annual administrative onsite reviews of their contracted BHAs to make certain the BHAs are in compliance with standards regarding enrollee rights.

Several of the BHOs do not collect and track the use of interpreter services either at the BHO or at the BHAs in order to analyze unmet enrollee needs.

- DBHR needs to make sure the BHOs have a process in place to collect and track the use of interpreter services in order to analyze unmet enrollee needs.

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 BHO's service area. Several BHOs do not collect this information from their provider agencies to distribute to enrollees upon request.

- DBHR needs to ensure that all BHOs 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 BHO's service area.

All BHOs stated they do not participate in physician incentive plans, but several BHOs lack a policy and procedure on ensuring the BHO and its BHAs are not providing incentive plans for the utilization of services.

- DBHR needs to make certain the BHOs have both a policy and procedure for ensuring that neither the BHO nor the BHAs are providing incentive plans for utilization of services.

Several BHOs are not monitoring their contracted BHAs to confirm enrollees are given information on their rights regarding both medical and mental health advance directives and/or how and where to file complaints concerning non-compliance with advance directives.

- DBHR needs to ensure that all BHOs are informing and documenting in the enrollee's chart that the enrollee was given information on both medical and mental health advance directives as well as how and where to file complaints concerning non-compliance with advance directives.

Several BHOs did not understand the importance of monitoring and requiring all contracted BHAs to have policies and procedures in place on the use of seclusion and restraint. Enrollees have the right to be free from seclusion and restraint at all provider facilities.

- DBHR needs to clarify its expectation for the BHOs to monitor the use of seclusion and restraint and behavioral de-escalation processes through annual administrative reviews, annual provider chart reviews, grievance reporting, Ombuds reports, enrollee satisfaction surveys and quarterly Provider Performance Reports. The BHOs need to require all BHAs to have policies and procedures in place on the use of seclusion and restraint.

Although several BHOs conducted risk assessments, identified the top potential areas of risk and implemented action plans to mitigate the risks, many of the BHOs did not.

- DBHR needs to ensure that all BHOs are performing annual risk assessments and sharing the results with the BHO's executive team, governing board and appropriate committees. The leadership discussions need to include developing action plans to regularly monitor risks and vulnerable areas, and seek interventions where appropriate to mitigate risks. Additionally, DBHR needs to ensure the BHOs include the results of the annual risk assessment in the annual BHO program evaluation.

Most of the BHOs lacked both evidence of receiving any reported cases of suspected fraud, waste and abuse and evidence they were recording and logging any of cases of suspected fraud, waste and abuse. Additionally, most of the BHOs lacked evidence that the formal logs were reviewed by the compliance committee and incorporated into the committee's meeting agenda as a standing agenda item.

- DBHR needs to ensure BHOs continually educate and maintain effective lines of communication with their staff and the staff at the BHAs on what should be reported to the BHO regarding

suspected cases of fraud, waste or abuse as well as any other compliance issues that may be identified. Additionally, DBHR must make certain all suspected reports of fraud, waste and abuse are recorded in a formal log to be reviewed by the BHO's compliance committee and incorporated into the committee's meeting agenda as a standing agenda item.

Many of the BHOs lacked written compliance programs containing the seven essential elements of a compliance program, and current WAC and BHO contract language.

- DBHR needs to ensure the BHOs update their formal compliance programs to contain current BHO contract language, WAC language, and the seven elements: implementing policies and procedures, designating a compliance officer, conducting effective training and education, developing effective lines of communication, conducting internal monitoring and auditing, enforcing standards through well publicized guidelines, responding promptly to detected problems, and undertaking corrective action.

Some of the BHOs lacked evidence that they were annually monitoring their BHAs to ensure the BHAs have effective compliance programs for providing guidance, enforcing internal controls, and mitigating risks related to healthcare compliance.

- DBHR needs to make certain the BHOs annually monitor their BHAs to ensure each has an effective compliance program in order to provide guidance, enforce internal controls, and mitigate risks related to healthcare compliance.

Many BHOs are not requiring annual compliance training for fraud, waste and abuse for their board of directors, BHO staff and BHA staff. Furthermore, many of the BHOs are not maintaining attestations of attendance that include the training date, who attended the training, and evidence of the effectiveness of the training.

- DBHR needs to ensure the BHOs are conducting annual compliance training for fraud, waste, and abuse, for their board of directors, BHO staff and BHA staff and make certain the BHOs are retaining attestations of attendance for these annual compliance trainings.

Many BHOs do not have a chartered compliance committee that meets monthly or at least quarterly to focus on developing and managing an organization-wide compliance program and to cover the wide array of compliance topics that touch every aspect of the BHO, including but not limited to training and education, monitoring and auditing, reporting and investigation, response and prevention, risk assessment and mitigation, enforcement and discipline, and assessment of effectiveness.

- DBHR needs to require BHOs to have a formal chartered compliance committee, and make certain the committee meets monthly or at least on a quarterly basis. The committee should maintain committee meeting minutes that document the BHO's focus on developing and managing an organization-wide compliance program.

Compliance—Grievance System

Many of the BHOs continue to have challenges in capturing and logging all grievances, which impacts their ability to identify opportunities to improve the care and services provided to enrollees and to generate reports for making informed management decisions.

- DBHR needs to continue to work with the BHOs to develop and implement reliable procedures for capturing all grievances in order to analyze and integrate the information to improve the care and

services provided to enrollees and to generate reports for making informed management decisions.

Many of the BHOs did not include in their NOAs the clarification that interpreter services are available at no cost to the enrollee.

- DBHR needs to ensure that all BHOs are informing enrollees that interpreter services are provided at no cost to the enrollee.

Several BHOs do not require or monitor their BHAs to ensure the BHAs have policies and procedures in place for the proper recordkeeping of grievance and appeals.

- DBHR needs to work with all BHOs to require and monitor their contracted BHAs to ensure the BHAs have policies and procedures in place for proper recordkeeping of grievances and appeals.

Compliance—Certifications and Program Integrity

Although all BHOs have policies and procedures in place indicating and ensuring that staff are not listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation, as required by federal or State laws, or found to have a conviction or sanction related to healthcare as listed in the Social Security Act, Title 11, many of the BHOs' policies do not include the BHOs' and the BHAs' intention to report to DSHS within ten business days any excluded individuals or entities discovered in the screening process.

- DBHR needs to confirm all BHOs have policies and procedures in place that include the intention of the BHOs and BHAs to report to DSHS within ten business days any excluded individuals and entities discovered in the screening process.

Although several BHOs conducted risk assessments, identified the top potential areas of risk and implemented action plans to mitigate the risks, many of the BHOs did not.

- DBHR needs to ensure that all BHOs are performing annual risk assessments and sharing the results with the BHO's executive team, governing board and appropriate committees. The leadership discussions need to include developing action plans to regularly monitor risks and vulnerable areas, and seek interventions where appropriate to mitigate risks. Additionally, DBHR needs to ensure the BHOs include the results of the annual risk assessment in the annual BHO program evaluation.

Most of the BHOs lacked both evidence of receiving any reported cases of suspected fraud, waste and abuse and evidence they were recording and logging any of cases of suspected fraud, waste and abuse. Additionally, most of the BHOs lacked evidence that the formal logs were reviewed by the compliance committee and incorporated into the committee's meeting agenda as a standing agenda item.

- DBHR needs to ensure BHOs continually educate and maintain effective lines of communication with their staff and the staff at the BHAs on what should be reported to the BHO regarding suspected cases of fraud, waste or abuse as well as any other compliance issues that may be identified. Additionally, DBHR must make certain all suspected reports of fraud, waste and abuse are recorded in a formal log to be reviewed by the BHO's compliance committee and incorporated into the committee's meeting agenda as a standing agenda item.

Many of the BHOs lacked written compliance programs containing the seven essential elements of a compliance program, and current WAC and BHO contract language.

- DBHR needs to ensure the BHOs update their formal compliance programs to contain current BHO contract language, WAC language, and the seven elements: implementing policies and procedures, designating a compliance officer, conducting effective training and education, developing effective lines of communication, conducting internal monitoring and auditing, enforcing standards through well publicized guidelines, responding promptly to detected problems, and undertaking corrective action.

Some of the BHOs lacked evidence that they were annually monitoring their BHAs to ensure the BHAs have effective compliance programs for providing guidance, enforcing internal controls, and mitigating risks related to healthcare compliance.

- DBHR needs to make certain the BHOs annually monitor their BHAs to ensure each has an effective compliance program in order to provide guidance, enforce internal controls, and mitigate risks related to healthcare compliance.

Many BHOs are not requiring annual compliance training for fraud, waste and abuse for their board of directors, BHO staff and BHA staff. Furthermore, many of the BHOs are not maintaining attestations of attendance that include the training date, who attended the training, and evidence of the effectiveness of the training.

- DBHR needs to ensure the BHOs are conducting annual compliance training for fraud, waste, and abuse, for their board of directors, BHO staff and BHA staff and make certain the BHOs are retaining attestations of attendance for these annual compliance trainings.

Many BHOs do not have a chartered compliance committee that meets monthly or at least quarterly to focus on developing and managing an organization-wide compliance program and to cover the wide array of compliance topics that touch every aspect of the BHO, including but not limited to training and education, monitoring and auditing, reporting and investigation, response and prevention, risk assessment and mitigation, enforcement and discipline, and assessment of effectiveness.

- DBHR needs to require BHOs to have a formal chartered compliance committee, and make certain the committee meets monthly or at least on a quarterly basis. The committee should maintain committee meeting minutes that document the BHO's focus on developing and managing an organization-wide compliance program.

Many BHOs lacked a policy and procedure requiring the BHO and the BHAs to retain for six years all records disclosing the extent of services the provider furnishes to enrollees, including but not limited to records pertaining to credentialing and recredentialing; incident reporting; requests for services; authorizations; clinical records; complaints; grievances; appeals; referrals for fraud, waste and abuse; and outcomes of fraud, waste and abuse. The policy needs to include a mechanism to ensure the BHO monitors for compliance with the policy.

- DBHR needs to make certain BHOs have policies and procedures on retaining for six years all records disclosing the extent of services the provider furnishes to enrollees, including but not limited to records pertaining to credentialing and recredentialing; incident reporting; requests for services; authorizations; clinical records; complaints; grievances; appeals; referrals for fraud, waste and abuse; and outcomes of fraud, waste and abuse. The policy needs to include mechanisms for ensuring BHO and BHA compliance with the policy.

Some BHOs lacked a mechanism to monitor their BHAs for disclosure of ownership or controlling interest in the organization with five percent or more interest.

- DBHR needs to make sure BHOs have updated administrative monitoring tools to include monitoring their BHAs for disclosure of ownership or controlling interest in the organization with five percent or more interest.

Some BHOs have not developed or updated their policies and procedures to reflect the monitoring and suspension of payments in cases of fraud.

- DBHR needs to ensure BHOs have developed and implemented current policies and procedures specific to monitoring vendors, providers or subcontractors for suspension of payments in cases of fraud.

Most BHOs lacked a policy and procedure to monitor vendors, providers or subcontractors for civil money penalties and assessments.

- DBHR needs to ensure that all BHOs develop policies and procedures to monitor their vendors, providers and subcontractors for civil money penalties and assessments.

Performance Improvement Project Validation

The requirement for BHOs to implement a third PIP focusing on SUD services is new for 2016. All of the BHOs faced challenges regarding SUD data collection. Without complete and accurate data, the BHOs found it difficult to fully understand the needs of enrollees related to substance use disorder and what gaps might exist in the SUD program. The formulation of a PIP needs to include the collection and analysis of internal and external data related to the study topic. Without this data, the BHOs are unable to analyze the data and identify a study topic.

- DBHR needs to develop procedures to ensure the BHOs are able to receive reliable SUD treatment service data.

Several BHOs chose PIP study topics that were State performance measures and contract requirements.

- DBHR needs to clearly communicate to the BHOs that State performance measures and contract requirements are separate obligations and cannot be used as PIP study topics.

Some BHOs struggled with choosing new PIP topics.

- DBHR needs to ensure that when selecting a PIP study topic, the BHOs:
    - ensure there are data to support the focus of the PIP as an area that truly needs improvement
    - do not attempt to create a PIP around a program or process that does not show evidence of needing improvement. PIPs are meant to improve the care and treatment of enrollees in areas that are in need of advancement, not highlight programs or processes that are successful.
    - fully and clearly define the intended intervention(s)

Several BHOs' PIPs were in place for extended measurement periods with only minimal explanation or updates to the PIP submission.

- DBHR needs to ensure that the BHOs' PIP measurement periods are clearly stated and appropriate in length. Data need to be reviewed at least on a quarterly basis to ensure the PIP is moving in a successful direction. Any changes in the study periods need to be clearly documented with thorough and valid explanations of deviations from the initial plan.

Many of the BHOs have staff who are unfamiliar or unsure of the PIP process. Many of these staff need continued technical assistance with understanding the CMS protocol for conducting performance improvement projects.

- DBHR and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.

Encounter Data Validation

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

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

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

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

Many BHOs are submitting coding errors to ProviderOne. The State reported that ProviderOne does not contain any edits to reject any codes and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to have processes in place in which ProviderOne create edits to reject encounters that are submitted incorrectly to the State.

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

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

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

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

Encounter Data Validation—WISe Focused Study

Many BHOs are submitting coding errors to ProviderOne. The State reported that ProviderOne does not contain any edits to reject any codes and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to have processes in place in which ProviderOne create edits to reject encounters that are submitted incorrectly to the State.
- DBHR needs to have a process in place in which ProviderOne flags encounters that are excessive in duration

While onsite, providers reported that there was a lack of WISe training throughout the state; therefore WISe services were not always submitted with the U8 modifier.

- DBHR needs to create regular WISe trainings offered throughout the state to ensure all WISe services are able to be captured.

Physical Healthcare Provided by Apple Health Managed Care Organizations

Introduction

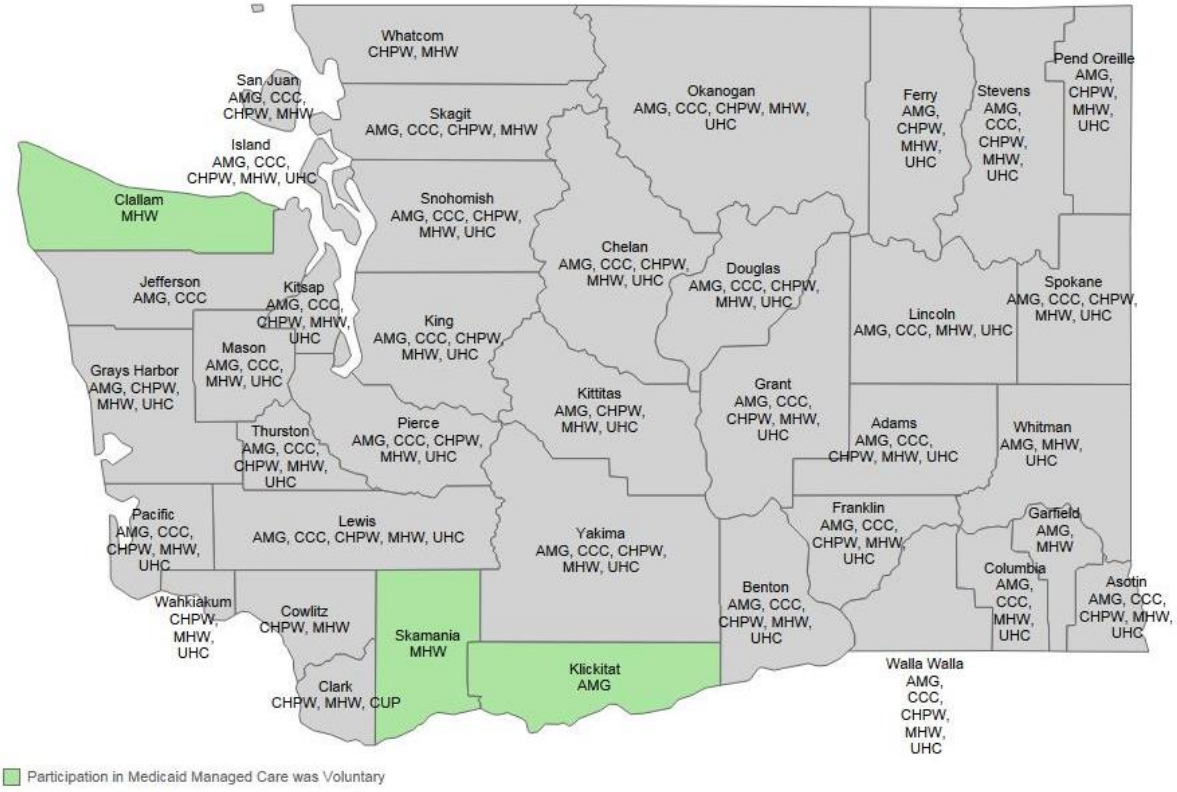
Throughout calendar year (CY) 2015, six managed care organizations (MCOs) delivered healthcare services to Apple Health managed care (Medicaid) enrollees across the State of Washington:

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

Columbia United Providers served over 55,000 Clark County enrollees during 2015 CY. In November, Molina Healthcare of Washington acquired CUP's network and members, effective January 1, 2016. Given this change, no performance measure data are available for CUP for the 2015 reporting year.

Figure 1, next page, identifies the MCOs and the counties they serve, as of December 31, 2015. In Clallam, Skamania, and Klickitat counties, enrollment was voluntary because only one MCO was in operation or because the contracted MCOs did not have sufficient capacity to serve all enrollees.

Figure 1: Washington Apple Health MCO Coverage, by County



Overview of Apple Health Enrollment Trends

Medicaid expansion took effect on January 1, 2014, and over 520,000 individuals were enrolled in the Apple Health Adult Coverage program in December 2015. MCOs differ in size and composition and have been impacted by expansion efforts differently. For example, 55.8 percent of individuals enrolled in AMG were part of the Apple Health Adult Coverage program (Medicaid expansion), compared to 26.9 percent of MHW. This difference is important because there is some evidence that individuals enrolled in Medicaid expansion programs nationwide differ demographically from individuals enrolled in traditional Medicaid. Table A-1 shows how individuals enrolled in Apple Health Adult Coverage may differ from individuals who are enrolled in Healthy Options (traditional Medicaid) and Healthy Options Blind/Disabled (HOBD) programs.

Table A-1: Select Demographic Characteristics of Apple Health Enrollees by Enrollment Program, 2016 RY

	Apple Health Adult Coverage (Medicaid Expansion)	Healthy Options (Traditional Medicaid)	Healthy Options Blind/Disabled	Total Apple Health
Median Age	36	10	44	21
Percent Female	50.8%	54.8%	48.5%	52.7%
Percent English as Primary Language	94.1%	81.9%	74.5%**	86.1%
Percent Rural*	21.1%	23.8%	21.9%	22.6%

*Based on Census Bureau classification of enrollee ZIP code of residence.
**22.4 percent of individuals enrolled in the Healthy Options Blind/Disabled program have missing language data in the state database, representing over 90 percent of all individuals with unknown language data.

More study is needed to understand how the different health characteristics of the expansion population may impact measure performance.

Individuals enrolled in the HOBD program constitute between 5.5 percent (MHW) and 6.4 percent (AMG) of each MCO, representing a significant shift from calendar year 2013, when the majority of individuals enrolled through HOBD were covered by only two MCOs. With the population spread out more evenly among plans, no MCO's performance on quality measures is likely unduly influenced by a disproportionate share of individuals enrolled in HOBD. The distribution of enrollment programs among the MCOs is outlined in Table A-2.

Table A-2: Apple Health Program Enrollment, by MCO, as of December 31, 2015

	AMG	CUP	CHPW	CCW	MHW	UHC	Total
Apple Health Adult Coverage (Medicaid Expansion)	79,055	14,639	99,635	79,145	152,181	98,919	523,574
Healthy Options (Traditional Medicaid)	51,098	38,507	169,971	87,662	366,039	87,003	800,280
Healthy Options Blind/Disabled	9,026	2,487	18,034	11,516	31,183	12,709	84,955
Healthy Options Foster Care	111	126	453	198	1,630	337	2,855
State Children's Health Insurance Program	2,281	1,542	5,462	3,280	15,168	4,534	32,267
Other/Unknown	0	0	586	0	0	576	1,162
Total	141,571	57,301	294,141	181,801	566,201	204,078	1,445,093

Source: Enrollment data provided by Washington State Health Care Authority

Most plans continued to see significant expansion across 2015 CY, as seen in Table A-3. While not as significant as in 2014 CY, the growth may have stretched existing provider networks.

Table A-3: Apple Health Enrollment, December 2014 vs December 2015[7]

	December 2014 Enrollment	December 2015 Enrollment	Percent Change
AMG	128,369	141,571	9.33%
CUP	N/A	57,301	N/A
CCW	175,353	181,801	3.55%
CHPW	332,456	294,141	-13.03%
MHW	486,524	566,201	14.07%
UHC	180,225	204,078	11.69%
Total	1,302,927	1,445,093	9.84%

Summary of Results

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

This performance measure review reflects data collected in 2016 measuring the experience of members in 2015, indicated in this report by 2016 reporting year (RY) and 2015 calendar year (CY), respectively.

Noteworthy in the review of physical healthcare services provided by MCOs was the disparity in results between TEAMonitor's compliance review of MCOs and MCOs' reported performance measures, which could be a reflection of the rapid enrollment and subsequent pressure on provider networks that MCOs continued to experience during 2015 CY. MCOs generally performed very well in the compliance portion of the review, fully meeting nearly all standards related to availability of services and improving in most other areas. Performance measure data, however, continue to show MCOs in marked need for improvement in several areas, particularly with regard to access to care and maternal health measures.

Adult access to care measures dropped significantly across all MCOs, likely a reflection of Medicaid expansion. Child access to care measures were not expected to be impacted by expansion, yet the state rate fell by 3.7 to 6.9 points for all age groups on this measure in 2016 RY. The decrease was a result of the performance of one MCO, CHPW, which had the lowest rates of access in the nation for all Medicaid plans for two of the four age groups. State performance on maternal health measures, already below national average performance in 2015 RY, fell further in 2016 RY to the lowest quintile (lowest 20 percent) of Medicaid plan performance nationwide, a result of poor performance across all MCOs. MCO performance on most CAHPS measures, most notably Getting Needed Care, were also in the lowest quintile of national performance.

Going forward, the State will need to prioritize these areas in its continued efforts to improve delivery of care to the state's expanded Medicaid population. The recommendations included in the following sections intend to highlight changes that, when implemented, could impart great improvements to MCO performance statewide.

[7] www.hca.wa.gov/about-hca/apple-health-medicaid-reports

Compliance Review

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

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

Methodology

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

Scoring

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

This year, to align with NCQA scoring standards, TEAMonitor changed its file review scoring methodology in an effort to ensure plan improvement in needed areas. Achieving a score of Met, which previously required 80–100 percent compliance, now requires 90–100 percent compliance. For a score of Partially Met, 60–89 percent is now required. Not Met scores, based on 59 percent or below, remained the same. In the following presentation of results, total scores have been converted to percentages, which, for the above score of 10/12, would produce a score of 83 percent.

Summary of Compliance Results

Table A-4 provides a summary of all MCO scores by compliance standard. Bars and percentages reflect total scores for each standard (total scores for all elements combined, converted to percentages). MCOs with elements scored as Partially Met or Not Met were required to submit CAPs to HCA. MCOs were scored on these elements in the first half of the review year. MCOs may have implemented corrective action plans since that time to address specific issues, and therefore scores may not be indicative of current performance.

Table A-4: MCO Compliance with Regulatory and Contractual Standards, by Plan

Standard	# of Elements	MCO	# Met 3 points	# Partially Met 2 points	# Not Met 0–1 point	# Not Scored	Total Score (% of points attained)
Availability of Services	7	AMG	6	1	0	0	95
		CCW	7	0	0	0	100
		CHPW	7	0	0	0	100
		MHW	7	0	0	0	100
		UHC	7	0	0	0	100
Program Integrity Requirements	5	AMG	4	1	0	0	93
		CCW	5	0	0	0	100
		CHPW	5	0	0	0	100
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Timely Claims Payment	2	AMG	2	0	0	0	100
		CCW	2	0	0	0	100
		CHPW	2	0	0	0	100
		MHW	2	0	0	0	100
		UHC	2	0	0	0	100
Coordination and Continuity of Care	13	AMG	10	2	0	1	94
		CCW	8	2	2	1	83
		CHPW	8	3	1	1	86
		MHW	8	2	2	1	83
		UHC	10	1	1	1	92
Patient Review and Restriction	5	AMG	5	0	0	0	100
		CCW	5	0	0	0	100
		CHPW	5	0	0	0	100
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Coverage and Authorization	7	AMG	6	1	0	0	95
		CCW	3	3	1	0	76
		CHPW	3	3	1	0	76
		MHW	4	3	0	0	86
		UHC	5	1	1	0	86
Enrollment/ Disenrollment	2	AMG	2	0	0	0	100
		CCW	2	0	0	0	100
		CHPW	2	0	0	0	100
		MHW	2	0	0	0	100
		UHC	2	0	0	0	100

Standard	# of Elements	MCO	# Met 3 points	# Partially Met 2 points	# Not Met 0–1 point	# Not Scored	Total Score (% of points attained)
Enrollee Rights	15	AMG	11	3	0	1	93
		CCW	13	1	0	1	98
		CHPW	14	0	0	1	100
		MHW	13	1	0	1	98
		UHC	14	0	0	1	100
Grievance System	18	AMG	10	4	4	0	78
		CCW	13	5	0	0	91
		CHPW	14	1	3	0	85
		MHW	14	4	0	0	93
		UHC	15	2	1	0	93
Practice Guidelines	3	AMG	3	0	0	0	100
		CCW	3	0	0	0	100
		CHPW	3	0	0	0	100
		MHW	3	0	0	0	100
		UHC	3	0	0	0	100
Provider Selection	4	AMG	3	1	0	0	92
		CCW	4	0	0	0	100
		CHPW	4	0	0	0	100
		MHW	4	0	0	0	100
		UHC	4	0	0	0	100
QA/PI Program	5	AMG	5	0	0	0	100
		CCW	5	0	0	0	100
		CHPW	3	2	0	0	87
		MHW	5	0	0	0	100
		UHC	5	0	0	0	100
Subcontractual Relationships/ Delegation	4	AMG	4	0	0	0	100
		CCW	4	0	0	0	100
		CHPW	4	0	0	0	100
		MHW	4	0	0	0	100
		UHC	4	0	0	0	100
Health Information Systems	3	AMG	3	0	0	0	100
		CCW	3	0	0	0	100
		CHPW	3	0	0	0	100
		MHW	3	0	0	0	100
		UHC	3	0	0	0	100
Health Homes	7	AMG	3	4	0	0	81
		CCW	4	2	1	0	76
		CHPW	5	2	0	0	90
		MHW	6	1	0	0	95
		UHC	6	1	0	0	95

In this year's review, MCOs' scores demonstrated overall slight improvement, notably with enrollee rights and practice guidelines standards. Compliance with coordination and continuity of care, coverage and authorization, and grievance system standards continue to be areas of weakness.

Availability of Services

- MCOs maintained nearly full compliance for the availability of services standards.

Coordination and Continuity of Care

- While many of the elements in this category were fully met, none of the MCOs fully met standards related to assessment and treatment plans. Multiple issues involved initial health screenings, assessment and treatment plans, documentation of goals and interventions, access to other services, and identification of special care needs, among others. Two plans partially met and MHW failed to meet the identification element, which ensures that enrollee health information is shared between providers or with the enrollee in a manner that facilitates coordination of care while protecting confidentiality and enrollee privacy. Most of the plans only partially met the transitional care element, with findings related to lack of documentation or provision of transitional healthcare services. Similarly, three plans received findings for issues related to lack of documentation of coordination and referral of services for the coordination between contractor and external entities element.

Coverage and Authorization

- MCOs continue to struggle with authorization of services, notice of adverse action, and timeframe for decisions. Four plans only partially met the authorization of services element, receiving corrective action plans requiring they review and evaluate their utilization management processes. For notice of adverse action, three plans failed to meet this element as a result of sending outdated appeal inserts with incorrect information in denial letters. Failure to include language inserts with denial letters was also noted.

Grievance System

- MCOs received a number of findings impacting a variety of elements within the grievance system standards, including procedures, handling of grievances and appeals, enrollee communication, and timeframes. A theme throughout this review also showed MCOs sending outdated materials and/or failing to include language inserts with notices.

Health Homes

- MCOs were reviewed on more Health Homes elements than in 2015; no MCO fully met all standards, indicating implementation issues not yet resolved. Two plans, MHW and UHC, were cited as having best practices, MHW for notifying Care Coordination Organizations (CCO) and Care Coordinators (CC) of inpatient stays and emergency department (ED) visits using the PreManage tool, and UHC for its audit tools and use of a feedback process that allows CCOs to focus on areas that need attention and provides trending information.

Recommendation

In this year's review, MCOs' scores demonstrated that compliance with coordination and continuity of care, coverage and authorization, and grievance system standards continue to be areas of weakness.

- HCA needs to consider education or training efforts to address coordination and continuity of care, and transitional care with MCOs. These areas have been historically problematic, and

though MCOs have shown improvement, additional efforts may be needed to ensure adequate care for enrollees.

Opportunity for Improvement

Review of compliance reports indicated that MCOs provided enrollees with outdated or incorrect materials, including those related to grievances and appeals and notices of action.

- HCA should require MCOs to implement version control tracking systems to ensure that communications distributed to enrollees, such as denial letters, notices of adverse action, and those related to grievances and appeals, are current, HCA-approved versions. Such a system could also ensure language inserts are included with enrollee notices.

All compliance elements scored as Partially Met and Not Met require a corrective action plan. In addition to scoring current-year compliance efforts, TEAMonitor's assessment includes reviewing the CAPs assigned in the previous review year and determining if CAPs have been completed. MCOs are not eligible to receive a score of met for elements for which a previous-year CAP was incomplete or inadequately completed. Table A-5 identifies the number of MCOs required to submit CAPs as a result of the 2016 review. The numbers preceding each element below denote the section within the Code of Federal Regulations (CFR) in which the element appears. The numbers that follow each element denote the corresponding Apple Health Managed Care contract requirement.

Table A-5: TEAMonitor Compliance Review Summary of Issues

Compliance Area	42 CFR and Apple Health Contract Citation	Number of Plans with Findings
Availability of Services		
	438.206 (b)(1)(i-v) Delivery network 438.207(b)(1)(2) Assurances of adequate capacity and services, 6.1. 6.2, 6.3, 6.5	1
Program Integrity		
	438.608(a)(b) Program integrity requirements, 12.6	1
Coordination and Continuity of Care		
	438.208(c)(1) Identification, 14.2 and 14.3	3
	438.208(c)(26) Assessment and treatment plans and care coordination for individuals with special health care needs, 14.3 and 14.10	5
	Apple Health—Continuity of care, 14.1	1
	Apple Health—Coordination between contractor and external entities, 14.4	3
	Apple Health—Transitional care, 14.5	4
Coverage and Authorization		
	438.210(b)(1)(2)(3) Authorization of services, 11.1, 11.3	4
	438.210(c) Notice of adverse action, 11.3.4.2	3
	438.210(d) Timeframe for decisions (1) (2), 11.3.5	3
	Apple Health—Outpatient mental health,16.5.13	4
Enrollee Rights		

	438.100(a) General rule, 10.1.1	1
	438.10(b) Basic rule, 3.4.2	2
	438.10(f) (2-6) General information, 3.2 and 6.15.2	1
	438.106 Liability for payment, 2.13 and 10.5	1
Grievance Systems		
	438.402(a) The grievance system, general requirements	1
	438.402(b)(1) Filing requirements—Authority to file, 13.3.1	1
	438.402(b)(3) Filing requirements—Procedures	1
	438.404(b) Notice of action—Language and format,11.3.4.2.1	3
	438.404(b) Notice of action—Content of notice,11.3.4.2	4
	438.404(c) Notice of action—Timing of notice, 11.3.5 and 13.3.9	1
	438.406(a) Handling of grievances and appeals—General requirements, 13.1.2 and 13.1.5	2
	438.406(b) Handling of grievances and appeals—Special requirements for appeals, 13.1.3 and 13.3.7	1
	438.408(a) Resolution and notification: Grievances and appeals—Basic rule, 11.3 and 11.4.1	2
	438.408(b) and (c) Resolution and notification: Grievances and appeals—Specific timeframes and extension of timeframes, 13.2.7 and 13.3.9	3
	438.408(d) and (e) Resolution and notification: Grievances and appeals—Format of notice and content of notice of appeal resolution, 13.2.9 and 13.3.10	4
	438.410 Expedited resolution of appeals, 13.4.3	1
Provider Selection (Credentialing)		
	438.214(a) General Rules 438.214(b) Credentialing and re-credentialing requirements, 9.13	1
Quality Assessment and Performance Improvement		
	438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement—Detect both over- and underutilization of services, 7.1.1.2.4.3	1
	438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement—Evaluating the program, 7.1.1.2.4 and 7.3.9	1
Health Homes—Section 2703 Affordable Care Act		
	Apple Health Contract—Health Care Authority Encounter Data Reporting Guide (Administrative)	2
	Apple Health Contract 9.7—Health Action Plan, Exhibit C 3.3 (Administrative)	2
	Apple Health—Exhibit C, 3.8.7 and 3.8.9.2 (Assignment, Engagement and Participation)	2
	Apple Health—Exhibit C, 3.8.7 and 3.8.9.2 (Assignment, Engagement and Participation))	2
	Apple Health—Exhibit C, 3.11, 3.12 and 3.13 (Transitional Care Services)	2
	Apple Health—14.9, Exhibit C, 2.1.6 (Staff)	1

Performance Improvement Project Validation

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

Apple Health MCOs were required to conduct the following PIPs in 2016:

- One clinical PIP piloting a mental health intervention
- Additional PIPs if the MCO's HEDIS rates were below the contractually required threshold for 2015 RY.
- One non-clinical PIP: a statewide collaborative on transitional healthcare services for individuals who have special healthcare needs or who are at risk for re-institutionalization, re-hospitalization, or substance use disorder recidivism.

As a component of its review, the interagency TEAMonitor conducted a validation of the MCOs' PIPs. Table A-6 displays the MCOs' PIP study topics. Because evaluation was still in process at the time of this report's publication, results of this assessment were not available for inclusion.

Table A-6: MCO PIP Study Topics

MCO	Study Topic		Result
AMG	Clinical PIP	WSIPP MH: Primary Care in Integrated Settings	
	HEDIS PIP	Immunizations—Combo 2	
	HEDIS PIP	Well-child visits—0–15 months	
	HEDIS PIP	Well-child visits—3–6 years	
	HEDIS PIP	Well-child visits—adolescents	
	Non-clinical PIP	Transitional Healthcare Services	
CCW	Clinical PIP	Children's ADD medications	
	HEDIS PIP	Well-child visits—3–6 years	
	HEDIS PIP	Well-child visits—adolescents	
	HEDIS PIP	Breast cancer screening	
	Non-clinical PIP	Transitional Healthcare Services	
CHPW	Clinical PIP	Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Substance Use Disorder (SUD)	
	HEDIS PIP	Immunizations—Combo 2	
	HEDIS PIP	Well-child visits—0–15 months	
	HEDIS PIP	Well-child visits—3–6 years	
	HEDIS PIP	Well-child visits—adolescents	
	Non-clinical PIP	Transitional Healthcare Services	
MHW	Clinical PIP	Collaborative Primary Care for Depression	
	HEDIS PIP	Immunizations—2-year	
	HEDIS PIP	Well-child visits—0–15 months	

	HEDIS PIP	Well-child visits—3–6 years	
	HEDIS PIP	Well-child visits—adolescents	
	Non-clinical PIP	Transitional Healthcare Services	
UHC	Clinical PIP	WSIPP MH: Depression in TANF Females	
	HEDIS PIP	Well-child visits—0–15 months	
	HEDIS PIP	Well-child visits—3–6 years	
	HEDIS PIP	Well-child visits—adolescents	
	HEDIS PIP	Dilated eye exams for diabetes	
	Non-clinical PIP	Transitional Healthcare Services	

Source: Washington State Health Care Authority

Recommendation

MCOs did not receive timely feedback related to their contractually required performance improvement projects.

- HCA needs to provide MCOs with timely feedback on the design and implementation of each performance improvement project so that MCOs have the opportunity to address issues potentially impacting improvement to processes, healthcare outcomes, and enrollee satisfaction.

Performance Measure Review

The performance of Apple Health MCOs with respect to the accessibility, timeliness, and quality of care and services furnished to enrollees can be measured quantitatively through two nationally recognized and standardized data sources. The first source is the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA), which is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow MCOs to determine where quality improvement efforts may be needed[8]. The HEDIS data are derived from provider administrative and clinical data. The second source is the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which was developed under direction of the U.S. Agency for Healthcare Research and Quality (AHRQ). The CAHPS data measure member experience through a survey of plan members.

Healthcare Effectiveness Data and Information Set (HEDIS)

Qualis Health assessed audited MCO-level HEDIS data for the 2016 reporting year (RY) (measuring enrollee experience during calendar year 2015), including 31 measures comprising 102 specific indicators. Many measures include more than one indicator, usually for specific age groups or other defined population groups. Of the 31 measures, 29 relate to effectiveness of care, and two relate to utilization (ambulatory and inpatient physical care). These measure groups (care and utilization) account for 88 and 14 submeasures, respectively.

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

It should be noted that the HEDIS measures are not risk adjusted and may vary from MCO to MCO because of factors that are out of a health plan's control, such as medical acuity, demographic characteristics, and other factors that may impact enrollees' interaction with healthcare providers and systems. NCQA has not developed methods for risk adjustment of these measures; however, with the enrollment increase that occurred with Medicaid expansion, performance impacts that may be attributable to differences in enrollee mix are likely diminishing.

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

Data Collection and Validation

In the first half of 2016, each MCO participated in an NCQA HEDIS Compliance Audit™ to validate accurate collection, calculation, and reporting of HEDIS measures for the member populations. This audit does not analyze HEDIS results; rather, it ensures the integrity of the HEDIS measurements.

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

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

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

Supplemental Data
In calculating HEDIS rates, the Apple Health MCOs used auditor-approved supplemental data, which is information generated outside of a health plan's claims or encounter data system. This supplemental information included historical medical records, lab data, immunization registry data, and fee-for-service data on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provided to MCOs by HCA. Supplemental data was used in determining performance rates for both administrative and hybrid measures. For hybrid measures, supplemental data provided by the State reduced the number of necessary chart reviews for MCOs, as MCOs were not required to review charts for individuals who, per HCA's supplemental data, had already received the service.

Member-level Data
Additionally, HCA required MCOs to submit de-identified member-level data for all administrative and hybrid measures. Member-level data enable HCA and Qualis Health to conduct analyses relating to racial and geographic disparities to identify quality improvement opportunities. Analyses based on member-level data are included in the *2016 Comparative Analysis Report* and the *2016 Regional Analysis Report*.

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

Summary of HEDIS Performance Measure Results

The following results present the Apple Health MCO average (the state rate) as compared to national benchmarks, derived from the Quality Compass[9], the NCQA's database of HEDIS results for health plans. For comparative plan performance, readers may refer to the *2016 Comparative Analysis Report*.

[9] Quality Compass® 2016 is used in accordance with a Data License Agreement with the NCQA.

Access to Care

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

Adult and child access to care measures showed statistically significant decreases across all age groups between 2015 and 2016 RYs (Table A-7). All MCOs had decreases in adult access to care, likely resulting from Medicaid expansion. Decreases in child access at the state level, however, were driven by CHPW, which had the lowest rates of access for all Medicaid plans in the country for two of the four age groups. While the other MCOs maintained performance at or above the national median, CHPW's poor performance was sufficient to bring down the state aggregate rate.

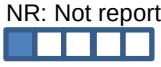
Additionally, statewide performance on all three maternal health measures fell into the lowest quintile of national performance. All MCOs performed below the national medians on all three measures. Apple Health MCOs have historically struggled in this area and did not appear to significantly improve during 2016 RY. There may be barriers to access that need to be addressed at the state level rather than at the individual MCO level, such as insufficient payment for obstetric services, unclear enrollment processes or coverage rules for pregnant women, or insufficient documentation of prenatal care provided.

Table A-7: Access to Care HEDIS Measures

	2014 State Rate	2015 State Rate	2016 State Rate	2016 National Quintile*
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	NR	77.9	71.8	
45–64 years	NR	84.6	80.4	
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	97.3	97.5	92.7	
25 months–6 years	87.5	88.8	81.9	
7–11 years	91.2	91.9	87.5	
12–19 years	90.8	91.2	87.5	
Well-Care Visits				
0–15 months, 6+ visits	64.0	56.8	60.3	
3–6 years, annual visit	65.1	66.6	66.7	
12–21 years, semi-annual visit	42.7	42.6	43.3	
Maternal Health				
Timeliness of Prenatal Care	NR	73.7	68.2	
Frequency of Prenatal Care (>81% of recommended visits)	NR	43.8	40.3	
Postpartum Care	NR	51.6	52.2	

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

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Preventive Care

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

Performance on many preventive care measures improved between 2015 and 2016 reporting years. The state performed at or above the 60th percentile of Medicaid plans nationwide on children's Combo 10 (receipt of all recommended childhood vaccines) and HPV vaccination for female adolescents. The state rate improved on children's BMI percentile assessment in 2016 RY, but performance remained in the lowest quintile of national performance. This is a measure that may benefit from additional provider education efforts. It is likely that providers are appropriately assessing child BMIs but are not adequately documenting performance. Provider education efforts relating to documentation needs may aid in improving performance on this measure. Table A-8 displays results for preventive care measures.

Table A-8: Preventive Care HEDIS Measures

	2014 State Rate	2015 State Rate	2016 State Rate	2016 National Quintile
Weight Assessment and Counseling				
Children's BMI Percentile Assessment	39.7	36.7	45.8	
Children's Nutritional Counseling	47.6	51.1	57.4	
Children's Physical Activity Counseling	43.1	45.1	53.5	
Adult BMI Percentile Assessment	NR	82.2	85.0	
Immunizations				
Children's Combo 2	70.7	70.9	71.4	
Children's Combo 10	39.4	41.6	40.8	
Adolescent Combo 1	67.0	73.7	74.2	
HPV Vaccination	NR	29.2	26.5	
Women's Health Screenings				
Breast Cancer Screening	NR	54.4	52.3	
Cervical Cancer Screening	NR	50.4	52.3	
Chlamydia Screening	NR	51.2	54.8	

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Chronic Care Management

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

Statewide performance on diabetes screening and care measures was strong in 2016 RY, as shown in Table A-9. The state rate was at or above the national median on most diabetes care measures, and was above the 80th percentile for the measure relating to diabetes screening for individuals with schizophrenia or bipolar disorder. Additional scrutiny may be necessary on select medication management measures, such as follow-up care for children prescribed ADHD medications, but overall performance on management of chronic conditions was strong.

Table A-9: Chronic Care Management HEDIS Measures

	2014 State Rate	2015 State Rate	2016 State Rate	2016 National Quintile
Diabetes Care				
HbA1c Testing	88.1	90.4	88.3	
Eye Examinations	49.6	54.8	55.5	
Medical Attention for Diabetic Nephropathy	79.9	83.4	88.9	
Blood Pressure Control (<140/90)	59.7	63.7	63.0	
HbA1c Control (<8.0%)	45.7	46.3	39.0	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NR	85.9	85.6	
Diabetes Monitoring for People with Diabetes and Schizophrenia	NR	68.6	70.3	
Other Chronic Care Management				
Controlling High Blood Pressure (<140/90)	NR	53.6	53.5	
Antidepressant Medication Management (Acute Phase)	NR	51.7	54.2	
Antidepressant Medication Management (Continuation Phase)	NR	37.0	39.4	
Medication Management for People with Asthma: 75% Compliance (Ages 5–11)	NR	21.8	22.1	
Medication Management for People with Asthma: 75% Compliance (Ages 12–18)	NR	21.3	23.2	
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	NR	37.7	38.7	
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase)	NR	39.1	48.2	

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Appropriateness of Care

Appropriateness of care measures assess whether enrollees receive non-medically indicated care. These measures assess MCO quality.

Apple Health MCOs performed well on measures relating to appropriateness of care in 2016 RY. Each of the measures in Table A-10 relates to the percentage of individuals who did not receive inappropriate services (meaning higher scores indicate better performance). Uniformly high performance on these measures indicates that Apple Health enrollees are not receiving potentially expensive unnecessary interventions.

Table A-10: Appropriateness of Care HEDIS Measures

	2014 State Rate	2015 State Rate	2016 State Rate	2016 National Quintile
Imaging for Low Back Pain	NR	77.7	76.3	
Antibiotics for Acute Bronchitis (Adults)	NR	29.3	30.3	
Antibiotics for Upper Respiratory Tract Infections (Children)	NR	92.6	93.5	

NR: Not reported during the 2014 reporting year

 Below the 20th Percentile

 20th to 39th Percentile

 40th to 59th Percentile

 60th to 79th Percentile

 At or above the 80th Percentile

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The measures included in the CAHPS surveys enable inclusion of patient- or member-reported experience, an important performance area that cannot be derived from medical record data alone.

The CAHPS data available for 2016 include results of the CAHPS 5.0H Adult Medicaid Survey conducted by Apple Health MCOs in spring of 2016 and the CAHPS 5.0H Child Medicaid with Chronic Conditions Survey conducted by the same MCOs in the spring of 2015.

Data Collection and Validation

Each MCO individually contracted with a certified CAHPS vendor to administer the CAHPS 5.0 Adult survey to its member enrollees. Respondents were surveyed in English or Spanish. The survey was administered over a 10-week period. All MCOs used a pre-approved enhanced mixed-mode protocol based on NCQA HEDIS guidelines. The four-wave mixed-mode protocol consisted of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and second reminder postcard to non-respondents, and finally a phone follow-up to non-respondents with a valid telephone number. A random sample of 8,785 cases was drawn of adult members from across the five participating MCOs. Data were gathered from 2,138 respondents; responses were analyzed and reported to HCA in August 2016.

Summary of CAHPS Performance Measure Results

The following results present the Apple Health MCO average rating as compared to national benchmarks, derived from the NCQA Quality Compass. For comparative plan performance on the CAHPS survey results, readers may refer to the *2016 Enrollee Quality Report*.

Table A-11 compares 2016 RY performance with 2014 RY performance, the last time the adult population was surveyed. Performance was statistically the same on each measure except for how well doctors communicate, which was statistically significantly higher in 2016. That was also the only measure for which Apple Health performance was higher than the national average for Medicaid plans based on data from Quality Compass.

Table A-11: CAHPS Ratings Results

	2014 Rating	2016 Rating	2016 National Quintile
Rating of Overall Health Care (Scored 9 or 10 out of 10)	45.9	48.5	
Rating of Personal Doctor (Scored 9 or 10 out of 10)	61.2	60.9	
Rating of Specialist Seen Most Often (Scored 9 or 10 out of 10)	62.9	60.0	
Rating of Plan (Scored 9 or 10 out of 10)	46.9	47.3	
Getting Needed Care	78.5	77.3	
Getting Care Quickly	80.8	78.1	
How Well Doctors Communicate	88.9	91.3	
Customer Service	84.9	83.1	

 Below the 20th Percentile
 20th to 39th Percentile
 40th to 59th Percentile
 60th to 79th Percentile
 At or above the 80th Percentile

Recommendations

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

- HCA needs to continue to require that MCOs conduct PIPs when measure performance falls below HCA-designated standards. Additionally, HCA should consider requiring MCOs to conduct thorough root cause analyses and/or PIPs for performance measures that drop by more than 10 percentage points between reporting years.

In 2016 RY, rates of adult access to primary care dropped for all MCOs, rates of child and adolescent access to primary care dropped for every age group at the state level, and all MCOs underperformed compared to national averages for timeliness and frequency of prenatal care. CAHPS scores for Getting Needed Care were also in the lowest quintile nationally.

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

- HCA needs to require MCOs to identify barriers relating to receipt of prenatal care (both timeliness and frequency) to determine what statewide action is necessary, including possibly requiring MCOs to complete a statewide PIP on maternal health.

- HCA needs to require CHPW to complete a PIP on child and adolescent access to care.[10]

MCOs performed in the lowest quintile nationwide for six out of eight reported CAHPS survey questions. Given the interconnectedness of the variables impacting these scores, improvement efforts directed toward one or two process measures are likely to positively impact CAHPS results as a whole.

- HCA needs to encourage MCOs to increase focus on improving two easily measurable CAHPS measures, Getting Needed Care and Getting Care Quickly, in an effort to improve CAHPS survey results globally.

For the 2016 reporting year, HCA provided the MCOs with auditor-approved supplemental data, which was used in determining performance rates for administrative and hybrid measures. For hybrid measures, supplemental data provided by the State reduced the number of necessary chart reviews for MCOs, as MCOs were not required to review charts for individuals who, per HCA's supplemental data, had already received the service.

- HCA should continue to provide supplemental quality data to MCOs to reduce the burden of chart reviews and improve the integrity of statewide performance data.

[10] HCA's 2017 contract with Apple Health MCOs will require participation in a statewide collaborative performance improvement project related to child/adolescent access to care.

Review of Previous-Year EQR Recommendations

Required external quality review activities include a review of the applicable state organization's responses to previously issued EQR recommendations. Table A-12 displays Qualis Health's 2015 recommendations and suggested opportunities for improvement and HCA's responses.

Qualis Health has determined that HCA is taking adequate steps to address the issues outlined below. HCA has worked diligently to improve MCO performance. Notably, the agency is developing a contractually required, all-MCO performance improvement project to improve well-child visits across the state, seeking not only to improve performance measure rates, but also to develop innovative methods for ensuring enrollees receive important preventive care. HCA has also worked extensively to ensure MCO-required performance measures align with the Washington State Common Measure Set and Healthier Washington initiatives.

Table A-12: Review of HCA Responses to 2015 EQR Recommendations

Prior-Year Recommendations	HCA Response
Clinical Performance Measures The most substantive needs for improvement for MCOs that surfaced during the 2015 EQRO review centered on low-scoring HEDIS performance measures and CAHPS surveys, in which all MCOs either performed inconsistently or poorly. The following recommendations were intended to help identify the barriers causing low performance and take steps to remedy low scores.	
HCA needs to continue to review the requirement that MCOs complete performance improvement projects addressing contracted goals the MCOs did not meet (in RY 2015, for well-child visits (0–15 months, 3–6 months and 12–21 years) and childhood immunizations (Combination 2). All MCOs were below at least one well-child visit goal, and one MCO was below the immunization Combination 2 goal. The State should approve performance improvement projects that seek to address the root cause for the low performance, including examination of provider coding practices, and improve the providers' barriers to either reporting or performing well-child visits that meet HEDIS measurement criteria.	**HCA continues to require individual MCO performance improvement projects for under-performance in well-child visit and Combo 2 rates. The contractually required collaborative MCO performance improvement project is aimed at improving well-child visit rates.**
HCA needs to note performance standards where MCOs are performing poorly statewide (within the lowest quartile) and determine whether MCOs should conduct performance improvement projects in order to improve performance.	**HCA updated the contract language in the Quality Assessment/Performance Improvement section to address specific areas of poor performance.**

HCA needs to take steps to address common challenges among MCOs by capitalizing on individual plan best practices and facilitating information-sharing among MCOs, possibly through a group learning forum.	**HCA currently calls out best practices in monitoring reviews and informally shares information with MCOs. HCA will consider formalizing this process.**
Quality Strategy MCOs and RSNs would benefit from the guidance of an overarching State quality strategy (as required by regulation) that clearly defines statewide managed care program goals and targets for improvement.	
The State needs to complete and distribute the State quality strategy to MCOs and RSNs, and hold RSNs and MCOs accountable for implementing their own quality strategy to align with the State's.	**HCA continues to work on the Quality Strategy with DSHS.**
Integration As the State prepares to integrate physical and mental health services, collaboration among service networks will be of importance in ensuring continued quality care.	
In preparation for the State's mental and physical health integration, the State needs to foster communication and collaboration between MCOs and RSNs to create transparency and ensure best practices, such as creating an email list through which MCO and RSN staff can communicate.	**HCA's Healthier Washington Team is working with the MCOs and Behavioral Health Organizations (BHOs, formerly RSNs) to improve communication and collaboration in preparation for the State's mental and physical health integration.**
Prior-Year Opportunities for Improvement	
Performance Measure Improvement HEDIS measure results indicated that the MCO performance challenges were most prominent in adult access to primary care, well-child visits, maternal health, body mass index (BMI) assessments, cervical cancer screenings, and hospital readmissions.	
MCOs should closely monitor and respond to barriers for adult members receiving primary care. Administrative data should be reviewed at least quarterly. To identify excessively low adult access rates and take steps to determine and remove barriers, the data should be appropriately disaggregated at local and regional levels consistent with local provider networks.	**HCA updated the contract language in the Quality Assessment/Performance Improvement section requiring MCOs to address underutilization of child and adult access to primary care in the annual Quality Assessment/ Performance Improvement evaluation.**

MCOs should increase efforts to get pregnant women and new mothers into provider offices for timely prenatal and postpartum care.	**HCA updated the contract language in the Quality Assessment/Performance Improvement section requiring MCOs to address underutilization of prenatal and postpartum care in the annual Quality Assessment/ Performance Improvement evaluation.**
MCOs should determine why providers are not conducting (or not appropriately recording) BMI assessments and cervical cancer screenings.	**MCOs may address this as part of their overall Quality Assessment/Performance Improvement evaluations.**
MCOs should conduct a root cause analysis and implement interventions to prevent hospital readmissions within 30 days after discharge.	**HCA has updated the contract language in the Quality Assessment/Performance Improvement section requiring MCOs to address preventable hospitalizations, including readmissions, in the annual Quality Assessment/Performance Improvement evaluation.**
Data Collection Collection and application of data relevant to various aspects of care can provide MCOs with the capability of identifying weaknesses in care and streamlining processes for improvement.	
The State should consider collecting more administrative-based information about the timeliness of care.	**HCA will work with Qualis Health to identify administrative-based information that could address this recommendation.**
Medication management measures are all based on administrative data. The State should encourage MCOs to consider whether there are ways to assist providers with identifying patterns indicating a lack of follow-up for patients who were dispensed medications.	**Medication management for people with asthma and Antidepressant medication management are currently being considered as value-based purchasing measures for MCOs.**
Consumer Experience Child and adult CAHPS surveys are an optional activity and administered only in alternate years, presenting a less useful dataset.	
HCA should encourage MCOs to administer both adult and child CAHPS surveys each year in order to more frequently track consumer experience.	**MCOs can choose to administer both adult and child CAHPS surveys to assess consumer experience as they deem necessary. The CAHPS surveys are an optional activity except as required by the Apple Health Contract.**
MCOs should consider sponsoring real-time patient surveys offered by providers to identify specific barriers or problems with getting care.	**MCOs may choose to conduct such surveys.**
Alignment of Statewide Reporting Measures	
In order to fully realize the vision of Healthier Washington, the HCA should work to better align MCO reporting requirements with the program's goals. For example, the Common	**HCA made changes to MCO 2017 required performance measures to align efforts with the Common Measure Set on Health Care Quality and Cost. Tobacco screening and cessation**

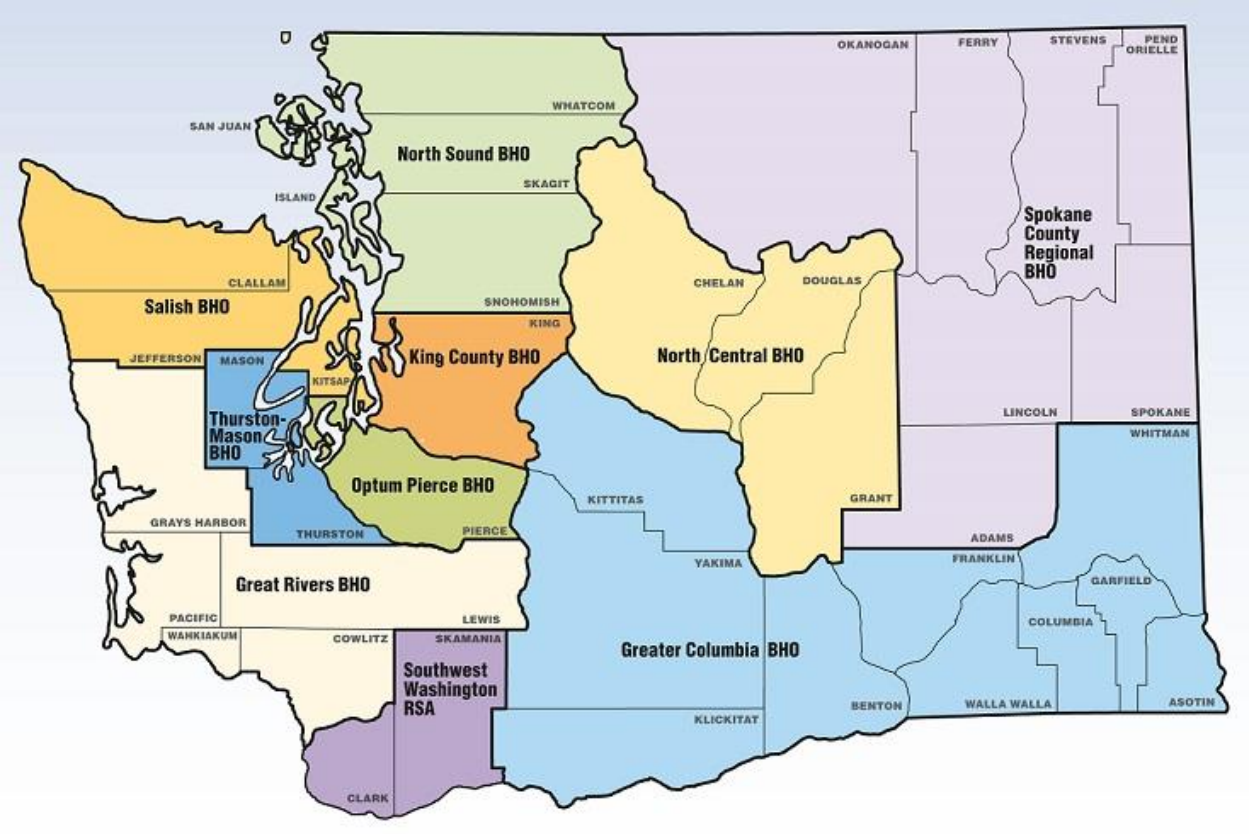
Measure Set for Healthier Washington includes multiple reported HEDIS measures, including adult and child access to primary care, well-child visits, youth obesity, comprehensive diabetes care, childhood and adolescent immunizations, and avoidance of low-value health services. Making these priority measures for MCOs may encourage improved performance on State goals. Additionally, there are several Healthier Washington goals that align with HEDIS measures that are currently not required reporting measures for MCOs, such as tobacco screening and cessation counseling, follow-up after hospitalization for mental illness, and annual monitoring for patients on persistent medications. Requiring MCOs to report these measures in the future may enable improvement on Healthier Washington goals.	**counseling is reported every other year through the adult CAHPS survey. Follow-up after hospitalization for mental illness will be reported by the Fully Integrated Managed Care plans in 2017; in-patient hospitalization is currently carved out of the Apple Health contract and covered by DSHS. Annual monitoring for patients on persistent medications was added to the list of required measures.**

Behavioral Healthcare Provided by Behavioral Health Organizations

Introduction

In April 2016, the Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) began contracting with Behavioral Health Organizations (BHOs) to provide comprehensive and culturally appropriate mental health and substance use disorder (SUD) treatment services. The BHOs replaced the state's Regional Support Networks (RSNs) and administer services by contracting with behavioral health agencies (BHAs)—community mental health agencies and SUD providers—to provide mental health and SUD services and treatment. Figure 2, displays the BHO service areas. Table B-1, next page, details the BHO service areas.

Figure 2: Behavioral Health Organization Service Areas



Source: Washington State Division of Behavioral Health and Recovery

Table B-1: BHO Service Areas

Behavioral Health Organization	Counties Served
Greater Columbia BHO (GCBHO)	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Wala, Whitman, Yakima
Great Rivers BHO (GRBHO)	Lewis, Pacific, Wahkiakum, Cowlitz, Grays Harbor
King County BHO (KCBHO)	King
North Central BHO (NCBHO)	Grant, Chelan, Douglas
North Sound BHO (NSBHO)	San Juan Island, Skagit, Snohomish, Whatcom
Optum Pierce BHO (OPBHO)	Pierce
Spokane County BHO (SCBHO)	Adams, Ferry, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens
Salish BHO (SBHO)	Callam, Jefferson, Kitsap
Thurston-Mason BHO (TMBHO)	Mason, Thurston

Qualis Health's external quality review of the state's nine BHOs consisted of a compliance review assessing the BHOs' adherence to State and federal regulatory and contractual requirements, an encounter data validation (EDV), an evaluation of the BHOs' performance improvement projects (PIPs), a follow-up Information Systems Capabilities Assessment (ISCA) review, and a review of prior-year EQR recommendations. This year's review also included an assessment of the BHOs' implementation of the children's Wraparound with Intensive Services (WISe) program, as well as a readiness review evaluating each BHO's status in transitioning from the RSN to the BHO structure and incorporating SUD services. While external quality review generally includes reporting on performance measure results, there were no data submitted by the State for the 2016 performance measures.

The results of these review components are described in detail in the following chapters.

Readiness Review

Transition Plans

Because of the transition of RSNs to BHOs in April 2016 and the concurrent integration of the mental health and SUD treatment services, DBHR directed Qualis Health to perform a readiness review for the year 2016. The readiness review included an assessment and evaluation of each BHO's transition plan submitted to the State, status in converting from an RSN to a BHO, and progress in integrating mental health and SUD treatment services within the BHO structure.

Qualis Health reviewed and evaluated each BHO's status in meeting the timeframes and goals established in its transition plan for converting from an RSN to a BHO and integrating SUD treatment providers into the behavioral health network. All BHOs were required to submit a response to the Behavioral Health Organization Detailed Plan Request issued by DSHS in October 2015. In the BHOs' responses, each organization describes how it will fully support the integration of the mental health and SUD systems of care, outlining how it will partner with its BHAs to ensure that capacity and functional systems are in place to meet the multiple needs of current and future enrollees. Each response describes the BHO's administrative processes, workforce development, policies and procedures, data integration and reporting, and clinical practices in order to develop core integrated capabilities.

As a result of the new contract requirements relating to the integration of SUD treatment services, as well as the SUD provider preparedness review regarding the integration, the BHOs identified a number of necessary tasks. These included an increased level of technical assistance for the SUD providers facing new and significantly greater contract requirements; additional oversight and monitoring required by BHO staff due to the increased number of provider network agencies; the need for increased chemical dependency knowledge among staff at the BHOs; and an increase in data management due to the number and type of providers under the new system. As a result of these additional tasks, the BHOs recognized the need to hire new staff, with some BHOs as much as doubling their staff.

Technical assistance provided by the BHOs included working with the SUD providers to create policies and procedures covering federal, State, and contract requirements; developing quality management, utilization management, and compliance and program integrity programs; and either implementing new informational and data system technologies or updating and revising systems that the SUD providers already had in place. Additionally, the BHOs also needed to develop, update, and revise their own policies and procedures and various programs. Most of the BHOs already had policies and procedures in place and only needed to update and revise their current policies. Great Rivers BHO, as a result of being a new entity and not previously an RSN, had to develop and implement new internal and external policies, procedures, and programs, including a quality management program, a utilization management program, and a compliance and program integrity plan.

Most of the SUD providers needed extensive education from the BHOs, specifically on managed care, new payment structures under managed care, clinical documentation requirements, the Service Encounter Reporting Instructions (SERI) and the data dictionary, authorization requirements, and the requirements of the grievance and appeal system. They also needed training on program integrity, as well as fraud, waste, and abuse.

Additional BHO staff was necessary to provide the required oversight and monitoring of the newly contracted providers. Pre-delegation agreements, excluded provider checks, onsite assessments, and ongoing program monitoring and auditing of the SUD providers needed to be completed or put into place. Because many of the BHOs' existing staff had little to no knowledge regarding SUD treatment programs, the BHOs recruited and hired staff with the credentials and experience in SUD treatment. Many of the BHOs provided training to their clinical staff on the American Society of Addiction Medicine (ASAM) guidelines. The guidelines are used to enhance the use of multidimensional assessments to develop patient-centered service plans and to guide clinicians, counselors, and care managers in making objective decisions about patient admissions, continuity of care, and transfer/discharge for various levels of care for addictive, substance-related, and co-occurring conditions.

With the increase in program data requirements and management, most BHOs also increased staffing in their information technology departments. Staff instructed the SUD providers on the use of the Behavioral Health Data Consolidation (BHDC) data dictionary and the Service Encounter Reporting Instructions (SERI). The data dictionary contains reporting requirements for the BHOs to meet the DBHR's State and federal reporting requirements and explains each of the required fields for the transactions that are submitted directly to DBHR. The SERI explains the requirements for encounter submissions by the BHO to the State's ProviderOne reporting system.

Some BHOs identified challenges in transitioning the SUD providers into the BHO structure. Challenges included the lack of information provided by the State to the SUD providers, specifically regarding information about managed care, the grievance system, and compliance and program integrity. Another challenge was obtaining timely and correct information on the data dictionary from the State so as to adequately train the SUD providers on the specifics of data submission and encounter requirements. An ongoing problem for all BHOs' provider agencies is the continued need to recruit and hire qualified clinicians in order to provide timely, quality healthcare services to the growing numbers of eligible Medicaid enrollees.

At the time of the reviews, most BHOs were in various stages in the process of transitioning and integrating mental health and substance use disorder treatment services. Qualis Health reviewed all aspects of the implementation of the transition plan. Most of the transitions plans were well planned and strategically designed. Many BHOs' timelines had been met and tasks had been completed. Qualis Health interviewed and performed onsite walkthroughs at two SUD provider agencies for each BHO to assess the SUD providers' status in the BHO integration. The providers were interviewed to evaluate their knowledge of policies and procedures related to enrollee rights, the grievance system, and program integrity, as well as the status of their implementation of those policies and procedures. The interviews confirmed that most BHOs were meeting their due diligence in providing the appropriate information and training to the BHAs.

The following section summarizes the cumulative results of the interviews and onsite walkthroughs with the SUD providers, providing strengths and opportunities for improvement.

SUD Walkthrough Results

Table B-2 on the following page summarizes the results of the SUD walkthroughs. The scoring key appears below.

Scoring Key

Fully Met (pass) ●	Partially Met (pass) ◉	Not Met ○	Not Applicable ●

Table B-2: Summary of SUD Walkthrough Results

	Optum Pierce	North Sound	King County	Thurston-Mason	Spokane	Greater Columbia	Great Rivers	North Central	Salish
Employee Conduct									
Employees and visitors wear ID badges.	◉	◉	◉	◉	◉	○	◉	●	◉
Workstation Use									
Workstations and computer monitors are positioned to prevent unauthorized persons from viewing ePHI.	●	●	◉	◉	●	●	●	●	●
Employees protect user IDs and passwords and don't share them.	●	●	●	◉	●	◉	●	●	●
Employees don't share workstations while logged in.	●	●	●	●	●	●	●	●	●
User IDs and passwords are not posted on or near workstations.	●	●	●	●	●	●	●	●	●
Documents with PHI are face down or concealed, especially in public areas and when employees leave their workstations.	●	●	●	●	●	●	●	●	●
When documents with PHI are not in use, they are stored or filed so as to avoid observation or access by unauthorized persons.	●	●	●	●	◉	●	◉	●	●
Unattended computers are returned to the logon screen (automatically or by user) or have password-enabled screensavers when not in use.	●	◉	◉	●	●	◉	●	●	●
Laptops, PDAs, and other portable equipment are physically secured with a lock that does not have a key present or nearby.	●	●	●	●	●	●	●	●	●
PHI on printers, photocopiers, or fax machines is always attended by employees.	●	●	●	●	●	●	●	●	●
Backups of ePHI are secured in a safe area (i.e, offsite and not in or near workstations).	●	◉	●	●	●	●	●	●	●
Access Controls									
Doors with access-control mechanisms, such as locks or swipe-card	●	●	●	◉	●	●	●	●	●

systems, are closed.									
Access to the server room is restricted to authorized personnel.	◉	●	●	●	●	○	●	●	●
Access to fax machines and printers is limited to authorized staff.	●	●	●	●	●	●	●	●	●
Office doors, filing cabinets, and desks are closed and locked when unoccupied.	●	●	●	●	●	●	◉	●	●
After hours, office doors, filing cabinets, and desks are locked, and/or building is alarmed properly.	●	●	●	●	●	●	●	●	●
Environmental Controls									
Smoke detectors and fire extinguishers are accessible and operational.	●	●	●	●	●	●	●	●	●
Computer equipment is plugged into surge protectors and, where appropriate, uninterruptible power supplies.	●	●	●	●	●	●	●	●	●
Server equipment is away from sprinklers and other water supplies.	○	◉	●	○	●	●	●	◉	●
Enrollee Rights and Grievances									
Enrollee rights are posted in an area visible to enrollees	●	●	●	●	◉	◉	●	◉	●
Enrollee rights are written in easily understood language.	●	●	●	●	●	◉	◉	●	●
Enrollee rights are posted in prevalent languages.	◉	○	●	◉	●	◉	◉	●	●
Enrollee rights include language on how to obtain interpreter services.	●	●	●	●	●	○	●	●	●
Accommodations are made for hearing/sight impairments.	●	●	●	●	●	●	●	●	●
Grievances are kept separate from the clinical record.	●	●	●	●	●	●	●	●	●
Grievances are kept in a locked cabinet or secured file.	●	●	●	●	●	●	●	●	●
Grievances are accessed only by appropriate designated staff.	●	●	●	●	●	●	●	●	●
ADA Requirements									
ADA access is appropriately marked.	◉	◉	◉	●	◉	●	●	◉	◉
Accessible Entrance *People with disabilities should be able to arrive on the site, approach the building, and enter the building as freely as everyone else. At least one path of travel should be safe and accessible for everyone,*	◉	◉	◉	●	◉	●	◉	◉	◉

including people with disabilities.									
Access to Goods and Services *Ideally, the layout of the building should allow people with disabilities to obtain goods or services without special assistance. Where it is not possible to provide full accessibility, assistance or alternative services should be available upon request.*	◉	◉	◉	●	◉	●	●	◉	●
Usability of Restrooms *When restrooms are open to the public, they should be accessible to people with disabilities.*	◉	◉	◉	●	◉	●	●	◉	◉
Rooms and Spaces *Accommodations are made to ensure all clients have access to an appropriate private meeting place for services. Are there spaces for wheelchair seating distributed throughout some meeting rooms, and are doorways wide enough for wheelchairs to get through?*	◉	●	◉	●	◉	●	●	◉	●
Additional Access *When amenities such as public telephones and drinking fountains are provided to the general public, they should be accessible to people with disabilities.*	●	●	◉	●	◉	●	●	◉	●
Medication Monitoring									
Medication Security *Medication security procedures must both ensure that drugs are secure and allow appropriate access by authorized personnel.*	◉	●	●	●	●	●	●	●	●
Medication Administration *There are policies and procedures covering who is authorized to administer medications, and that the policies are followed.*	●	●	●	●	●	●	●	●	●
Seclusion and Restraint									
What is the facility's policy about seclusion and restraint?	◉	◉	◉	●	◉	◉	◉	◉	◉
Does the facility engage in seclusion and restraint?	●	●	●	●	●	●	●	●	●
Miscellaneous Environment of Care									
DBHR license is in a conspicuous place.	●	●	●	●	●	●	●	●	●
There is adequate private space for personal consultation.	●	●	●	●	●	●	●	●	●

Reception is separate from therapy areas.	●	●	●	●	●	●	●	●	●
Any poisonous external chemicals or caustic materials are kept in separate, secure, locked storage.	●	●	◉	◉	●	●	●	●	◉
There is an outpatient evacuation plan and maps of evacuation routes.	●	●	◉	●	●	●	●	●	●

Strengths/Opportunities for Improvement

Employee Conduct

Opportunity for Improvement
Most SUD providers did not require visitors to either sign a visitors log or wear visitor badges. Because enrollees also do not wear identification, this makes it difficult to distinguish outside guests from enrollees/residents. For the inpatient facilities, allowing outside access to the facility without proper identification could pose a potential risk to the clients, guests, and staff.

- DBHR should ensure the BHOs are following up with the SUD providers to require visitors to either sign a visitors log or wear visitor badges.

Workstation Use

Strengths

- In the HIPAA Administrative Simplification Security Rule, Workstation Use is the second Physical Safeguard Standard. The standard requires that the contracted provider ensure appropriate workstation uses, how such uses are to be performed, and in what physical environment access to workstations that process electronic protected health information (ePHI) is permitted. All SUD providers demonstrated they had policies and procedures in place to ensure staff do not share workstations while logged on, and had controls to ensure against the display of passwords on or near workstations; PHI on printers, photocopiers, or fax machines was always attended by staff.
- All SUD providers ensured that workstations were physically secured. Workstations include, but are not limited to, desktop computers, laptop computers, tablet computers, and personal data assistants (PDAs) that transmit, receive, or store ePHI.

Opportunities for Improvement
The HIPAA Privacy Regulations require that appropriate administrative, technical, and physical safeguards are in place to protect the privacy of protected health information. Workstations and computer monitors should be positioned to prevent unauthorized persons from viewing ePHI. Some of the SUD providers did not demonstrate adherence to this rule.

Some SUD providers indicated they do not have mechanisms in place to ensure unattended computers are returned to the logon screen (automatically or by user) or have password-enabled screensavers when not in use. Not having these processes in place presents increase risk with regard to ePHI.

During the walkthroughs with several SUD provider agencies, reviewers observed lapses with regard to securely storing documents containing PHI when those documents were not in use. Filing cabinets and rooms where clinical records are stored were unlocked and easily accessible. The providers should ensure that when documents containing PHI are not in use, they are stored or filed so as to avoid observation or access by unauthorized persons.

- DBHR should ensure the BHOs are monitoring the SUD providers for compliance with HIPAA Privacy Regulations, record keeping procedures, and computer privacy procedures.

Access Controls

Strengths

- Most SUD providers ensured doors with access-control mechanisms, such as locks or swipe-card systems, were closed at all times. These controls should be in place to monitor access, identify users requesting access, record access attempts, and grant or deny access to a specific area.
- Most of the SUD providers' protocols were in place to ensure office doors, filing cabinets, and desks were closed and locked when unoccupied, demonstrating that their actions aligned with their HIPAA/security policies.
- All SUD providers indicated that, after hours, office doors, filing cabinets, and desks were locked and/or the building was alarmed properly.

Opportunity for Improvement

Some SUD providers did not have mechanisms in place to restrict access to their server rooms. These providers need to restrict server room access to authorized personnel to increase security. Moreover, it is recommended that additional security measures be implemented, such as a log that includes the name and signature of the individual who accessed the server room, date and time in/out, and the purpose for accessing the server room.

- DBHR should ensure the BHOs are requiring the BHAs to implement mechanisms to safeguard and restrict access to the server rooms.

Environmental Controls

Strengths

- All SUD providers had both smoke detectors and fire extinguishers accessible and operational. Smoke alarms and fire extinguishers are the first lines of defense in the event of a fire in a building. The location of most of the extinguishers was made conspicuous by marking the location with a sign. Most fire extinguishers were installed on hangers or brackets and were readily available.
- All computer equipment observed at the SUD provider agencies was protected from power surges through the use of surge protectors and, where appropriate, uninterruptible power supplies.

Opportunity for Improvement

Several SUD providers did not have their server equipment stored away from sprinklers and/or other water supplies. Taking steps to protect data centers against fire, smoke, heat, and water damage helps to safeguard the entire organization. Using water-based sprinkler systems can cause irreparable damage to the equipment in the server rooms. These providers should consider alternative fire suppression methods such as waterless systems.

- DBHR should ensure the BHOs are requiring the BHAs to take steps to prevent environmental damage to the server equipment.

Enrollee Rights and Grievances

Strength

- All SUD providers acknowledged the grievance record retention requirements, including following all policies outlined by the BHO, storing grievances separately from the clinical records, locking grievances in a secure file cabinet or electronic file, and granting access only to authorized designated staff.

Opportunities for Improvement
Several SUD providers did not have enrollee rights posted in an area visible to enrollees. Furthermore, many providers had outdated rights and needed to update their rights to include the State's most recent version.

Many SUD providers did not have enrollee rights posted in prevalent languages other than English or have them readily accessible upon request. Providers need to make all written information, including enrollee rights, available in the prevalent, non-English languages spoken in their service area.

- DBHR needs to ensure the BHOs have the most recent version of the enrollee rights in order for the BHOs to distribute the rights to the SUD providers. BHAs are required to post enrollee rights in the prevalent languages, and all written information, including enrollee rights, should be available in the prevalent, non-English languages spoken in their service area.

ADA Requirements

Opportunity for Improvement

- Most SUD providers struggled to meet ADA accessibility requirements, including ensuring ADA access is appropriately marked, having an accessible entrance, access to goods and services not being hindered, ease of access and use of restrooms, and rooms and spaces used by the enrollees having appropriate spacing requirements to allow for wheelchair access and other accommodations. Individuals with disabilities should be able to arrive at the provider agency, approach the building, and enter the building as freely as everyone else. Moreover, the layout of the building should allow individuals with disabilities to obtain goods or services without special assistance. Where it is not possible to provide full accessibility, assistance or alternative services should be available upon request.

Seclusion and Restraint

Strength

- All SUD providers stated they did not use seclusion and restraint. The providers indicated they had been provided with training in "hands-off" de-escalation techniques, such as Right Response or CPI.

Opportunity for Improvement
Most SUD providers acknowledged that although they did not engage in seclusion and restraint, they did not have a facility policy and procedure in place. SUD providers should make every effort to structure safe environments and provide a behavioral framework, such as the use of positive behavior interventions and supports. In order to reduce the risk involved with seclusion and restraint, all SUD providers should have their own policy and procedure in place as well as a mechanism to monitor the adherence to the policy. SUD providers should include in their policy the impact of seclusion and restraint and emphasize the commitment to enrollee safety and dignity.

- DBHR should ensure the BHOS are requiring the SUD providers to have a well-written policy and procedure on seclusion and restraint.

Miscellaneous Environment of Care

Strengths

- At all of the SUD provider facilities, the provider's DBHR license was displayed in a conspicuous place, making it easy for anyone to view the certification date and services the facility was licensed to provide; there was adequate private space for personal consultation; and the reception areas and lobbies were separate from therapy areas.
- Most SUD providers had prominently posted evacuation plans and maps of evacuation routes that clearly identified locations of exits and assembly points in the event of an emergency.

Opportunity for Improvement

Several SUD providers did not have proper controls in place to ensure all poisonous external chemicals or caustic materials were kept in separate, secure, and locked storage. Proper storage and handling can reduce or eliminate associated risks at these facilities. Proper storage information can usually be obtained from the Material Safety Data Sheet (MSDS), label, or other chemical reference material.

- DBHR needs to encourage the BHOs to make certain the BHAs have proper controls in place to ensure all poisonous external chemicals or caustic materials are kept in separate, secure, and locked storage.

SUD Provider Interview Results

Qualis Health interviewed two SUD providers for each BHO, for a total number of 18 providers. Each BHO's score is indicative of the number of providers who demonstrated their readiness during the interview.

Scoring Key

Two providers demonstrated knowledge/preparedness ●	One provider demonstrated knowledge/preparedness ◉	Neither provider demonstrated knowledge/preparedness ○

Table B-3: Summary of SUD Provider Interview Results

Protocol Section	CFR Citation	Optum Pierce	North Sound	King County	Thurston-Mason	Spokane	Greater Columbia	Great Rivers	North Central	Salish
Enrollee Rights										
Enrollee Rights	438.100 (a)	●	●	●	●	●	●	●	●	●
Information Requirements	438.100 (b) 438.10 (a)–(d)	●	●	●	●	●	●	●	●	●
Information Requirements—Specific	438.100 (b) 438.10 (f)	●	●	●	●	●	●	●	●	●
Information Requirements—General	438.100 (b) 438.10 (g)(1),(3)	●	●	●	●	●	●	●	●	●
Respect and Dignity	438.100 (b)(2)(ii)	●	◉	●	●	●	●	●	●	●
Alternative Treatment Options	438.100 (b)(2)(iii)	●	●	●	●	●	●	●	●	●
Seclusion and Restraint	438.100 (b)(iv)	◉	○	●	●	●	●	●	●	◉
Federal and State Laws	438.100(d)	●	●	●	●	●	●	●	●	●
Grievance System										
Grievance Systems	438.228 (a),(b)	●	●	●	●	●	●	●	●	●
Notice of Action	438.404 (a)	●	◉	●	●	●	●	●	◉	●
Content of Notice	438.404 (b)	●	●	●	●	●	●	●	●	●
Timing of Notice	438.404 (c)	●	◉	●	●	●	●	●	◉	●
Handling of Grievances and Appeals	438.406	●	◉	●	●	●	●	●	●	●
Resolution and Notification—Timeframes	438.408 (a)–(c)	●	◉	●	●	●	●	●	●	●
Expedited Resolution of Appeals	438.410	●	●	●	●	●	●	●	●	●
Grievances and Appeals—Information Requirements	438.414	●	◉	●	●	●	●	●	●	●
Recordkeeping and Reporting	438.416	●	◉	●	●	●	●	◉	◉	◉
Continuation of Benefits	438.420	●	◉	●	●	●	●	●	◉	●
Effectuation of Reversed Appeal Resolutions	438.424	●	◉	●	●	●	●	◉	○	●
Certifications and Program Integrity										

Provider Eligibility	438.600	●	◉	●	●	●	●	●	◉	●
Data Certification	438.602 438.604	●	○	●	○	◉	●	●	●	●
Source, Content and Timing of Certification	438.606	●	○	●	●	●	●	◉	○	●
Program Integrity Requirements	438.608 (a),(b)	●	◉	●	◉	●	◉	●	◉	●
Specific Requirements - Compliance Programs	438.608 (b)	●	◉	◉	◉	◉	◉	◉	○	◉
Required Provider Agreement – Record Retention	431.107	●	◉	●	◉	●	●	●	◉	●
Excluded Entities	455.100	●	●	●	●	●	●	●	●	●
Disclosure of Ownership	455.102 455.104	●	●	●	◉	●	●	●	●	●
Cooperation with Fraud Control Units	455.21	●	○	●	●	●	●	●	●	●
Suspension of Payments	455.23	◉	○	●	●	●	●	◉	◉	●
Civil Money Penalties and Assessments	1003.102	●	●	●	●	●	●	●	●	●

Strengths/Opportunities for Improvement

Enrollee Rights

Enrollee Rights

Strengths

- All SUD providers were able to give details on how/when enrollees are informed of their rights, the languages the rights are offered in, and where the rights are posted at their facility.
- All SUD providers were able to explain how the BHO informs providers about enrollee rights and responsibilities, the trainings the BHO has conducted on enrollee rights, and how the BHO monitors compliance of providers regarding enrollee rights.

Information Requirements

Strengths

- All SUD providers were able to describe how the provider organization assists enrollees in understanding enrollee materials supplied by the BHO.
- All SUD providers were able to specify the information providers routinely provide to all Medicaid enrollees on enrollee rights, the process for disseminating the information to new and existing enrollees, and the frequency with which this information is distributed.

Information Requirements—Specific

Strengths

- All SUD providers were able to define the process for enrollees to access crisis services and how the BHO monitors crisis service access.

- All SUD providers were able to articulate the various ways in which enrollees are informed of how to obtain benefits from out-of-network providers, including second opinions.

Information Requirements—General

Strengths

- Most of the SUD providers were aware of the mechanisms the BHOs use to inform enrollees of their rights regarding grievance, appeal, and fair hearing procedures.
- Most of the SUD providers were aware that the BHOs do not provide incentive plans for the utilization of services.

Respect and Dignity

Strengths

- Most of the SUD providers were able to communicate the mechanisms they have in place to ensure enrollees are treated with respect, dignity, and consideration of privacy, including staff trainings involving site leadership, ongoing staff meetings that reinforce this right, and posting of the rights in various locations at the provider agencies.
- Most of the SUD providers are aware the BHOs monitor the providers regarding compliance with ensuring enrollees are treated with respect, dignity, and consideration of privacy through annual administrative reviews, staff interviews during the BHO onsite visits, and monitoring of grievance reports.
- All SUD providers were able to define the safeguards they have in place to ensure protection of personal information from unauthorized disclosure, including the use of encryption methods for emails and faxes, properly secured/locked filing cabinets, and precautions set up within their electronic health records.

Alternative Treatment Options

Strength

- All SUD providers were able to describe how they inform enrollees about available and alternative treatment options including giving the enrollees a choice of practitioners and SUD providers in conjunction with ensuring enrollee participation in individual service plans.

Seclusion and Restraint

Strengths

- All SUD providers conveyed they do not employ seclusion and restraint but instead use alternative behavior modification approaches or call 911 if a situation escalates.
- All SUD providers explained that the BHOs monitor provider compliance regarding the use of seclusion and restraint through review of the providers' policies and procedures during annual administrative reviews, performing clinical record reviews, and monitoring quarterly grievance reports.

Opportunity for Improvement

Several of the SUD providers were not aware of the need for a policy and procedure against the use of seclusion and restraint as a means of coercion, discipline, convenience, or retaliation, or acknowledged the lack of such a policy. Furthermore, some providers indicated they had not conducted or attended a

formal training regarding enrollees' right to be free from any form of seclusion or restraint. The BHOs need to ensure all of their contracted providers have a policy and procedure in place against the use of seclusion and restraint. Moreover, the BHOs need to make certain all staff at the contracted provider agencies have received adequate de-escalation training during the BHOs' monitoring of compliance of the enrollee's right to be free from seclusion and restraint.

- DBHR should ensure the BHOS are requiring the SUD providers to have a well-written policy and procedure on seclusion and restraint.

Federal and State Laws

Strength
All SUD providers were able to outline the other federal and State laws they must post and be in compliance with, including but not limited to the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

Grievance System

Grievance Systems

Strength
All SUD providers were able to explain how collaboration occurs between the BHO and the providers in regard to logging, reporting, and resolving grievances. The providers also indicated that most of the BHOs provided additional technical assistance and trainings on the grievance system before and during the transition from an RSN to a BHO.

Notice of Action

Strength

- Most of the SUD providers described the process the BHO uses to coordinate with the providers if a notice of action (NOA) is returned.

Opportunity for Improvement
Some SUD providers were unsure what a notice of action was or who initiated the notice of action. BHOs should continue to make available training for their providers regarding notices of action.

- DBHR should ensure the BHOs are continuing to educate the BHAs on the grievance system.

Content of Notice

Strength

- Most SUD providers were able to delineate how the BHO monitors the providers for compliance with requirements for notices of action. All providers indicated that there has never been a corrective action issued by the BHO to the SUD providers in regard to NOAs.

Timing of Notice

Strength

- Most SUD providers were able to articulate the steps they would follow if the provider determined the misuse of a client ID card. These steps included notifying DSHS, the BHO, the Medicaid Fraud Control Unit (MFCU), and the provider's site leadership.

Opportunity for Improvement
Some of the SUD providers were unclear about the timelines for standard authorization decisions and/or expedited authorization decisions. Some of the providers were unaware that expedited authorization decisions occurred. BHOs should continue to work with their contracted providers to ensure they are cognizant of the differing authorization decisions and the required timeframes.

- DBHR should ensure the BHOs are continuing to educate the BHAs on the grievance system.

Handling of Grievances and Appeals

Strengths

- Most SUD providers were able to articulate how the provider would assist enrollees in completing forms and taking other procedural steps necessary to file a grievance or appeal including connecting the enrollee with the Ombuds or whomever the enrollee requested to assist in the process.
- Most SUD providers were able to explain the process for acknowledging a grievance that was received both orally and in writing. Additionally, the providers were aware of the acknowledgement letter that must be sent and the five-day timeframe for doing so.
- All SUD providers explained how the BHO monitors compliance with the grievance system through provider grievance reporting to the BHO, Ombuds reports, and annual administrative reviews.

Resolution and Notification—Timeframes

Strength

- Most SUD providers were able to explain their process for resolving a grievance including working with the enrollee one on one to ensure a satisfactory resolution is reached. The providers were able to articulate how the BHOs monitor for compliance on grievance resolution through quarterly grievance reporting, annual administrative reviews, enrollee satisfaction surveys, and Ombuds reporting.

Expedited Resolution of Appeals

Strength

- Most of the interviewed SUD providers were able to describe how they would assist an enrollee with requesting an expedited resolution if the circumstance arose.

Grievances and Appeals—Information Requirements

Strengths

- Most SUD providers were able to outline the delegation agreements between the provider and the BHO regarding the grievance system. The SUD providers were able to describe how the BHO disseminates information to the provider related to grievance, appeal, and fair hearing procedures through the use of emails, phone calls, and trainings.

Recordkeeping and Reporting

Strength

- Most of the SUD providers were able to explain their processes for maintaining records of grievances including the length of time the records are kept and ensuring grievances are maintained separately from the clinical record

Opportunity for Improvement

Some SUD providers were unaware of record retention requirements, including keeping records for a minimum of six years and separate from the enrollee clinical record. The BHOs should continue to work with their providers to ensure they are in compliance with the recordkeeping and recording policies regarding grievances.

- DBHR should ensure the BHOs are requiring the BHAs to have a policy and procedure in place for the proper storage and retention of all records.

Continuation of Benefits

Strength

- Most of the SUD providers indicated they would continue providing services to enrollees during the State fair hearing process.

Opportunity for Improvement

Some of the interviewed SUD providers were unclear about the enrollee's right to continue receiving services from the provider during the State fair hearing process. The BHOs should continue to provide training to its providers to ensure the providers understand the circumstances in which the provider must continue to provide services upon the filing of an appeal or request for a State fair hearing.

- DBHR should ensure the BHOs are continuing to educate the BHAs on the grievance system.

Effectuation of Reversed Appeal Resolutions

Strength

- Most SUD providers were able to articulate the mechanisms the BHO has in place regarding payment to the provider for services rendered to an enrollee while an appeal was pending if the State fair hearing officer reversed a decision to deny authorization of services.

Opportunity for Improvement

Some SUD providers were unaware of any BHO payment mechanisms in place during a pending appeal, as they had never experienced this situation. The BHOs should ensure providers understand the policies and procedures in place regarding payment to the provider for services rendered to an enrollee while an appeal is pending if the State fair hearing officer reverses a decision to deny authorization of services.

- DBHR should ensure the BHOs are continuing to educate the BHAs on the grievance system.

Certifications and Program Integrity

Provider Eligibility

Strength

- Most SUD providers were aware of the requirement to coordinate with the BHO in regards to conducting and submitting a monthly attestation indicating the provider had completed the excluded provider (OIG) check to determine if provider staff, including administrative staff, custodial staff, volunteers and subcontractors are eligible to participate in federal healthcare programs.

Opportunity for Improvement
The BHOs should continue to work with their providers to ensure they are able to meet the regulatory and contractual standards inclusive of providing the BHO with an attestation on a monthly basis to ensure the BHO can fulfill its requirement to report its monitoring of excluded providers to the State.

- See the overall opportunity at the end of this section.

Data Certification

Strength

- Most SUD providers were able to illustrate the process for ensuring encounter data had integrity checks prior to submitting the data to the BHO. Many providers described their use of daily, weekly and monthly reports to guarantee accuracy of the data before it was certified and attested to the BHO for completeness and truthfulness.

Opportunity for Improvement
The BHOs should continue to work with their providers to make certain processes are in place before encounter data is submitted, certified, and attested to for accuracy, completeness, and truthfulness.

- See the overall opportunity at the end of this section.

Source, Content and Timing of Certification

Strength

- Most SUD providers were aware that encounter data must be certified and include an attestation before the data is submitted to the BHO.

Opportunity for Improvement
Some of the interviewed SUD providers were not knowledgeable about the certification process that occurred at their agency. The BHOs should continue to work with providers to ensure the providers have policies and procedures in place regarding the certification of data and are familiar with these processes.

- See the overall opportunity at the end of this section.

Program Integrity Requirements

Strength

- Many SUD providers were able to describe the steps to take in the event of a suspected case of fraud, waste, or abuse. Furthermore, they were able to explain some of the compliance training received from the BHO regarding these processes. Many SUD providers indicated they have program integrity policies and procedures in place that are designed to guard against fraud and abuse.

Opportunity for Improvement

The BHOs need to ensure their providers have administrative and management arrangements or procedures designed to guard against fraud and abuse. At minimum, the BHO should provide an annual compliance training to ensure providers understand the necessary steps that must be taken in the event of a suspected case of fraud, waste, or abuse. Many of the interviewed SUD providers indicated they have not conducted an annual risk assessment to identify their top three vulnerabilities nor have they created an action plan to mitigate these organizational risks. The BHOs should continue to work with their providers to ensure annual risk assessments are performed and action plans are created.

- See the overall opportunity at the end of this section.

Specific Requirements—Compliance Programs

Strengths

- Many SUD providers indicated they have a Code of Ethics and Standards of Conduct and were able to articulate what the Code of Ethics encompassed.
- Some SUD providers were able to describe their written compliance plan, including how it addressed the seven essential elements.

Opportunity for Improvement

The BHOs need to make certain all of their providers have a Code of Ethics and Standards of Conduct. The providers need to also include staff attestation documentation on the Code of Ethics and Standards of Conduct.

- The BHOs should continue to work with their providers to develop a written compliance plan that addresses the seven essential elements of an effective compliance program.

Required Provider Agreement—Record Retention

Strength

- Most SUD providers were able to articulate their policies and procedures regarding record retention, including but not limited to credentialing and re-credentialing, incident reporting, requests for services, authorizations, clinical records, complaints, grievances, appeals, referrals for fraud, waste and abuse, and outcomes of fraud, waste and abuse investigations.

Opportunity for Improvement

Several of the SUD providers were either unaware of the various record retention policies or were unable to describe the timeframe requirement for record retention.

- The BHOs should continue to provide training on the requirements for record retention and monitor the providers to ensure they are in compliance with the keeping of all records.

Excluded Entities

Strength

- All SUD providers were able to describe the process for reviewing the list of excluded individuals/entities (LEIE) on the Office of the Inspector General (OIG) website to ensure the providers' employees are not on the excluded provider list.

Disclosure of Ownership

Strength

- Most of the interviewed SUD providers were able to communicate how the BHO monitors them to ensure there is no direct ownership or control interest that exceeds five percent. This monitoring includes the providers submitting an attestation substantiating whether or not the provider has direct ownership or control interests exceeding five percent.

Cooperation with Fraud Control Units

Strength

- Most SUD providers were able to describe how the provider ensures all suspected case of fraud, waste, and/or abuse are appropriately reported to the BHO, DSHS, and MFCU. Most of the providers stated they have fraud hotline numbers posted conspicuously in their buildings and provide staff training on reporting fraud, waste, and/or abuse and have mechanisms in place to ensure enrollees, staff, and any volunteers are protected from retaliation if fraud, waste, and/or abuse are reported.

Suspension of Payments

Strength

- Many SUD providers were familiar with how the BHO monitors the provider for suspension of payments in cases of fraud, including the frequency, such as during annual administrative reviews. Some SUD providers indicated they would submit a report to the BHO indicating suspension of payments in case of fraud.

Opportunity for Improvement

The BHOs should continue to educate their providers on the BHOs' policies and procedures to monitor for suspension of payments in cases of fraud inclusive of record retention requirements to maintain all materials documenting the lifecycle of a payment suspension that was imposed in whole or part for a minimum of five years from the date of suspension issuance.

- See the overall opportunity at the end of this section.

Civil Money Penalties and Assessments

Met Criteria

Overall Opportunity for Improvement—Certifications and Program Integrity

- DBHR should work with the BHOs to ensure that the BHAs understand compliance and program integrity and have the required policies, procedures, and programs in place.

Compliance Review

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

Methodology

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

- performing desk audits on documentation submitted by each BHO, including the BHO's transition plan and timelines for converting from an RSN to a BHO
- conducting telephone interviews with two of each BHO's contracted mental health agencies and two of its substance use disorder (SUD) treatment providers
- conducting onsite walkthroughs of two SUD treatment providers
- reviewing up to ten each of grievances, appeals and notices of actions, State fair hearing cases, and cases of suspected fraud, waste and abuse
- conducting onsite interviews with BHO staff on standards related to enrollee rights, the grievance system, and certifications and program integrity; and performance improvement projects

Scoring

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

Fully Met means all documentation listed under a regulatory provision, or component thereof, is present and BHO staff provided responses to reviewers that were consistent with each other's responses and with the documentation.
Partially Met means all documentation listed under a regulatory provision, or component thereof, is present, but BHO staff were unable to consistently articulate evidence of compliance, or BHO staff could describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.
Not Met means no documentation is present and BHO staff had little to no knowledge of processes or issues that comply with regulatory provisions, or no documentation is present and BHO staff had little to no knowledge of processes or issues that comply with key components of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

Scoring Key

Fully Met (pass) ●	Partially Met (pass) ◉	Not Met ○

Summary of Compliance Results

Table B-4 summarizes the results of the 2016 compliance review. The following sections offer greater detail on overall and individual BHO performance in each of the review areas.

Table B-4: Results of BHO Compliance Review

BHO	Enrollee Rights and Protections	Grievance System	Certifications and Program Integrity
Optum Pierce	●	◉	◉
North Sound	◉	◉	◉
King County	●	◉	◉
Thurston-Mason	◉	◉	◉
Spokane	◉	◉	◉
Greater Columbia	◉	◉	◉
Great Rivers	◉	●	◉
North Central	◉	●	◉
Salish	◉	◉	◉

Enrollee Rights and Protections

Table B-5 indicates the elements for which BHOs received a recommendation requiring a corrective action plan.

Table B-5: Enrollee Rights Summary of CAPs

Protocol Section	CFR Citation	Number of BHOs with CAPs
Enrollee Rights	438.100 (a)	3
Information Requirements	438.100 (b) 438.10 (a)–(d)	2
Information Requirements—Specific	438.100 (b) 438.10 (f)	4
Information Requirements—General	438.100 (b) 438.10 (g)(1),(3)	2
Respect and Dignity	438.100 (b)(2)(ii)	1
Alternative Treatment Options	438.100 (b)(2)(iii)	0
Advance Directives	438.100 (b)(iv)	2
Seclusion and Restraint	438.100 (b)(iv)	3
Federal and State Laws	438.100(d)	0

Enrollee Rights

Strengths: Access

- Several BHOs have enrollee/member handbooks that include not only enrollee rights, but also

information on obtaining services, available treatment options and provider directories.
- Most BHOs include on their websites enrollee/member handbooks and enrollee rights in the prominent languages for each BHO's service region.

Strength: Quality
- Some BHOs have provided community education through the use of Ombuds services to educate enrollees on enrollee rights, availability of services and obtaining authorization for services.

Strengths: Quality
- Most BHOs ensure the BHAs are providing the enrollees with a copy of their rights at intake and annually thereafter. Most BHOs monitor compliance with enrollee rights through agency administrative reviews, chart reviews, Quality Review Team (QRT) surveys, and tracking and reviewing of enrollee grievances.
- Several BHOs have conducted weekly and monthly workgroups with both the mental health and SUD treatment providers to review, revise and rewrite each BHO's policies to ensure the policies are inclusive of both the mental health and SUD treatment providers.
- OPBHO has reassigned a staff member whose main responsibility is to monitor the mental health and SUD treatment providers at least annually for compliance with the CFRs, DBHR contract language and the WACs. The monitoring includes working directly with the agency care managers, speaking with enrollees in the reception areas, sitting and observing interactions and practices in the reception areas, and working closely with the Ombuds

Recommendation: Quality
Several of the BHOs lack evidence that they have performed annual administrative reviews onsite at the BHAs to monitor and ensure the BHAs are in compliance with standards regarding enrollee rights.
- DBHR needs to ensure the BHOs are performing annual administrative onsite reviews of their contracted BHAs to make certain the BHAs are in compliance with standards regarding enrollee rights.

Information Requirements

Strengths: Access
- Most BHOs' websites notify enrollees of language services provided free of charge to individuals whose primary language is not English, including interpreters and written information in other languages.
- OPBHO's consumer solutions/affairs committee reviews and approves all enrollee materials to ensure they are written in easily understood language.

Strengths: Quality
- GRBHO has a well-written customer services policy and procedure, which describes the hours of GRBHO's customer service lines, the duties of the customer service staff, and procedures for assisting enrollees who may need help with interpreter services or understanding their benefits and services. GCBHO's customer service coordinators are available to assist enrollees with any questions regarding their understanding of the requirements and benefits of the services available to them.
- NCBHO's PowerPoint on customer service training outlines a process for BHO staff to assist enrollees with understanding their benefits, as well as a procedure for handling requests for interpreter services.

- KCBHO's website notifies clients that written information is available in alternative formats, such as audiotape, Braille or large print, and may be accessed upon request. Audio versions of the KCBHO brochure and client rights are available on compact disk (CD) from KCBHO Client Assistance Services and on KCBHO's website.
- SBHO ensures enrollees are provided with information in alternative non-English formats by including in its BHAs' contracts that the BHAs provide information through audio or video recordings in the enrollee's primary language, have an interpreter read the materials in the enrollee's primary language, or provide materials in an alternative format that is acceptable to the enrollee. If one of these methods is used, it must be documented in the enrollee's clinical record.

Recommendation: Access
Several of the BHOs do not collect and track the use of interpreter services either at the BHO or at the BHAs in order to analyze unmet enrollee needs.

- DBHR needs to make sure the BHOs have a process in place to collect and track the use of interpreter services in order to analyze unmet enrollee needs.

Information Requirements—Specific

Strengths: Access

- Most BHOs have a mechanism and process in place to inform enrollees on how to obtain out-of-network services and how to file an appeal if out-of-network services are denied.
- All BHOs allow freedom of choice among the contracted BHAs in each BHO's service network area.
- Most BHOs clearly inform enrollees on the availability of crisis services to all individuals, the steps to take in the event of a crisis, and how to access 24-hour crisis services.

Strengths: Quality

- Prior to the BHO transition, most RSNs sent enrollees a well-written and informative communication informing them of what to expect once the RSN became a BHO.
- Most BHOs' leadership teams have been hosting regular community forums in order to inform the community about the BHO and provide a space for answering any questions from the community regarding the BHO's transition from an RSN.
- GCBHO has a well-written integrated crisis system policy with clearly designed standards for the provision of crisis services, the oversight of the crisis system, and the expected outcomes of the provisions of crisis care.
- GCBHO incorporates the monitoring of the efficiencies and effectiveness of the crisis system, including the use of post-stabilization services, into the BHO's quality management improvement process.

Recommendation: Access
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 BHO's service area. Several BHOs do not collect this information from their provider agencies to distribute to enrollees upon request.

- DBHR needs to ensure that all BHOs 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 BHO's service area.

Information Requirements—General

Strengths: Quality

- All BHOs have several methods by which to inform enrollees of the grievance, appeal and fair hearing processes, including through the BHOs' enrollee rights and member handbooks/brochures, on their websites, and through the Ombuds brochures.
- Most BHOs inform enrollees of how the BHO, the BHA or the Ombuds can assist with the grievance process, including the filing of grievances and appeals.

Recommendation: Access

All BHOs stated they do not participate in physician incentive plans, but several BHOs lack a policy and procedure on ensuring the BHO and its BHAs are not providing incentive plans for the utilization of services.

- DBHR needs to make certain the BHOs have both a policy and procedure for ensuring that neither the BHO nor the BHAs are providing incentive plans for utilization of services.

Respect and Dignity

Strengths: Quality

- All BHOs require their staff and contractors to sign an oath of confidentiality, store written information with patient health information in locked cabinets in a secure location, use passwords to protect electronic information, obtain information releases, and have mechanisms in place to report breaches of confidentiality.
- Most of the BHOs monitor contracted BHAs with regard to respect, dignity and consideration of privacy through administrative reviews, clinical record reviews, enrollee satisfaction surveys, and grievance reporting and by reviewing the Ombuds' reports.
- OPBHO has many safeguards and policies that provide for the protection of its enrollees' health information. All written enrollee information is kept in locked cabinets in a separate room accessible only to specific designated staff using a card swipe. The rooms are monitored by video cameras.
- NSBHO and OPBHO stated that the enrollee's right to be treated with regard to respect, dignity and consideration of privacy is the core basis of each BHO's center of care. As part of each BHO's internal quality control, the staff is trained at hire and is continuously assessed for compliance to ensure the enrollee's right to be treated with respect, dignity and consideration of privacy is maintained.
- TMBHO staff members routinely visit the provider agencies' lobbies, where they can monitor the treatment of enrollees with regard to respect, dignity and consideration of privacy.

Alternate Treatment Options

Strength: Access

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

Strength: Quality

- Most BHOs monitor their contracted BHAs' compliance with these policies through annual provider directory requests, annual administrative reviews, grievance tracking reports and clinical record reviews.

Advance Directives

Strengths: Quality

- All BHOs have policies and procedures in place that require contracted BHAs to inform enrollees, at the time of intake, of their rights regarding mental health advance directives and medical advance directives.
- Most BHOs require their BHAs to include a signed attestation in the enrollee's clinical record that the enrollee received and understands the information regarding advance directives and that the enrollee has either chosen or not chosen to execute one or both types of advance directive.
- Most BHOs inform enrollees whom they should contact with any complaints concerning BHA non-compliance with advance directives.
- GRBHO requires its BHAs to provide training on advance directives during orientation for new staff and annually for all staff. The BHO requires the training to include definitions, State laws, educational materials for individuals, and role requirements and prohibitions in relation to implementation of the directives. It also requires the BHAs to emphasize the purpose of an advance directive in enhancing an incapacitated individual's control over their treatment.

Recommendation: Quality
Several BHOs are not monitoring their contracted BHAs to confirm enrollees are given information on their rights regarding both medical and mental health advance directives and/or how and where to file complaints concerning non-compliance with advance directives.

- DBHR needs to ensure that all BHOs are informing and documenting in the enrollee's chart that the enrollee was given information on both medical and mental health advance directives as well as how and where to file complaints concerning non-compliance with advance directives.

Seclusion and Restraint

Strengths: Quality

- Most BHOs reported that they do not employ seclusion and restraint and have policies and procedures in place to ensure the efficacy of this policy. BHOs require their contracted BHAs to use no-force behavior management techniques as preventative measures, using evidence-based practices.
- Most BHOs monitor their contracted BHAs' compliance with this policy through annual administrative reviews, annual provider chart reviews, grievance reporting, Ombuds reports, enrollee satisfaction surveys and quarterly Provider Performance Reports.
- SBHO outlines 12 standards in its policy regarding seclusion and restraint that must be followed if seclusion and restraint becomes necessary in an evaluation and treatment (E&T) facility. These standards include "The dignity, privacy, and safety of individuals who are restrained or secluded should be preserved to the greatest extent possible, at all times, during the use of these interventions."

Recommendation: Quality
Several BHOs did not understand the importance of monitoring and requiring all contracted BHAs to have policies and procedures in place on the use of seclusion and restraint. Enrollees have the right to be free

from seclusion and restraint at all provider facilities.

- DBHR needs to clarify its expectation for the BHOs to monitor the use of seclusion and restraint and behavioral de-escalation processes through annual administrative reviews, annual provider chart reviews, grievance reporting, Ombuds reports, enrollee satisfaction surveys and quarterly Provider Performance Reports. The BHOs need to require all BHAs to have policies and procedures in place on the use of seclusion and restraint.

Federal and State Laws

Strengths: Quality

- All BHOs require and monitor contracted BHAs for complying with other federal and State laws, such as the Civil Rights Act, Age Discrimination Act, Rehabilitation Act, Americans with Disabilities Act and Health Insurance Portability and Accountability Act.
- As part of ensuring compliance with these laws, many BHOs have provided training to their staff and the staff of their contracted BHAs.
- OPBHO's new staff is required to attend a six-month training that includes education on all these applicable State and federal rules and regulations.

Grievance System

Table B-6 indicates the elements for which BHOs received a recommendation requiring a corrective action plan.

Table B-6: Grievance System Summary of CAPs

Protocol Section	CFR Citation	Number of BHOs with CAPs
Grievance Systems	438.228 (a),(b)	2
Notice of Action	438.404 (a)	2
Content of Notice	438.404 (b)	4
Timing of Notice	438.404 (c)	0
Handling of Grievances and Appeals	438.406	0
Resolution and Notification—Timeframes	438.408 (a)–(c)	0
Resolution and Notification—Format of Notice	438.408 (d)	0
State Fair Hearings	438.408 (f)	0
Expedited Resolution of Appeals	438.410	0
Grievances and Appeals—Information Requirements	438.414	1
Recordkeeping and Reporting	438.416	2
Continuation of Benefits	438.420	0
Effectuation of Reversed Appeal Resolutions	438.424	0

Grievance Systems

Strength: Access

- All BHOs have policies and procedures in place to inform enrollees of their right to access the grievance and appeal process and the State's fair hearing system. The policies specify how to file both oral and written grievances and appeals and the timeframes for filing. The policies and procedures are culturally, linguistically and age appropriate and include provisions for enrollee assistance.

Strengths: Quality

- Many of the BHOs have their own brochures informing enrollees and/or their delegated advocates of the enrollee's right to file a grievance and appeal and to a State fair hearing.
- Some BHOs have brochures informing enrollees that assistance with the grievance process will be provided if needed and that if the enrollee or their advocate is not already receiving assistance from the Ombuds, Ombuds services will be offered.
- Some BHOs have provided extensive training to their contracted BHAs on the grievance system.

- SCBHO requires all BHAs to log all grievances and to forward the logs quarterly to the BHO. The BHO then analyzes all grievances for trends and quality improvement opportunities and submits the logs to DBHR per contract requirements.
- NSBHO's philosophy is that grievance reporting is a good process for quality improvement, and for improving processes both at the BHO and at the contracted BHAs. During the interviews with two of NSBHO's contracted mental health agencies, both agencies stated that the BHO had a robust internal and external grievance system in place. The agencies also stated that the BHO has created an atmosphere among clinicians in which grievances are not perceived as a negative reflection on the BHAs but rather promote welcome feedback on the accessibility, timeliness and quality of services.
- NCBHO provided extensive training to its contracted BHAs to ensure that providers log all grievances they receive into the BHO's Avatar database. NCBHO monitors the database to ensure that timelines for responding to grievances are met.

Recommendation: Quality
Many of the BHOs continue to have challenges in capturing and logging all grievances, which impacts their ability to identify opportunities to improve the care and services provided to enrollees and to generate reports for making informed management decisions.

- DBHR needs to continue to work with the BHOs to develop and implement reliable procedures for capturing all grievances in order to analyze and integrate the information to improve the care and services provided to enrollees and to generate reports for making informed management decisions.

Notice of Action

Strengths: Quality

- Most of the BHOs have systems in place for determining the prevalent non-English languages spoken by their enrollees.
- OPBHO's Advisory Committee reviews all enrollee materials, including the notice of action (NOA), for content and readability.
- NSBHO can provide NOAs in English, Somali, Laotian, Cambodian, Chinese, Korean, Spanish, Vietnamese and Russian.

Content of Notice

Strengths: Quality

- Most BHOs' NOAs contain the required elements, including an explanation of the reasons for the action, information regarding what the enrollee can do if they do not agree with the decision, the enrollee's right to file an appeal, the enrollee's right to request a fair hearing, an explanation of the circumstances in which an enrollee can request an expedited appeal, the right to interpreter services at no cost to the enrollee, and the enrollee's right to have benefits continue pending the resolution of an appeal.

Recommendation: Access
Many of the BHOs did not include in their NOAs the clarification that interpreter services are available at no cost to the enrollee.

- DBHR needs to ensure that all BHOs are informing enrollees that interpreter services are provided at no cost to the enrollee.

Timing of Notice

Strengths: Timeliness

- Many of the BHOs stated they receive few if any requests for expedited authorizations as they authorize requests for services within 24 to 48 hours.
- To ensure timely decisions are maintained with the increase of the enrollee population, OPBHO hired five additional clinical staff to work 12-hour shifts from 7am to 7pm, and three staff to work 12-hour shifts overnight.
- OPBHO sends all NOAs by certified mail and tracks the NOAs in its database. If an NOA is not delivered to an enrollee, the BHO will notify the BHA so that the agency can notify the enrollee through a different mechanism.

Handling of Grievances and Appeals

Strengths: Quality

- All BHOs' grievance policies include language indicating that staff making decisions on grievances and appeals are mental health and chemical dependency professionals with the appropriate clinical experience to make decisions involving medical necessity, expedited resolution or clinical issues.
- Many of the BHOs have customer service staff available to assist enrollees with any questions or concerns they may have regarding any aspect of the grievance and appeal process, including the completion and filing of grievance and appeal forms.

Resolution and Notification—Timeframes

Strengths: Timeliness

- Many of the BHOs respond to enrollee grievances and appeals within 24 hours.
- NCBHO uses its *Grievance Monitoring Report* and annual administrative reviews to monitor the disposition of grievances and resolution of appeals to ensure compliance with timeliness requirements.

Resolution and Notification—Format of Notice

Strength: Quality

- TMBHO's responses to grievances are thoughtful and thorough and include solutions or resolutions to enrollees' grievances.

State Fair Hearings

Strength: Quality

- Most BHOs have several methods by which to inform enrollees of their right to a State fair hearing, including informing enrollees at the time of enrollment and including the information on the BHOs' websites.

Expedited Resolution of Appeals

Strength: Timeliness

- All BHOs have policies and procedures in place for grievances, standard appeals and expedited appeals. The policies specify that expedited appeals are to be resolved within three working days of receipt of the appeal, unless the enrollee requests an extension or the BHO demonstrates that the extension is in the enrollee's interest.

Grievances and Appeals—Information Requirements

Strengths: Quality

- SBHO requires its BHAs to have policies and procedures on the grievance system. The BHO monitors for compliance with these policies through annual provider and subcontractor administrative reviews, trainings provided by the BHO, and review of grievance tracking reports, including the review of unresolved enrollee grievances, appeals and/or fair hearings.
- GRBHO has created a comprehensive provider monitoring tool that includes auditing numerous items related to grievance system compliance.

Recordkeeping and Reporting

Strength: Quality

- Many of the BHOs require their BHAs to follow the individual BHO's policies on recordkeeping, which require:
  - grievances to be stored separately from the clinical records
  - grievances to be locked in a secure file cabinet or electronic file
  - access to the grievances to be granted only to specific designated staff
  - grievances to be kept for a minimum of six years

Recommendation: Quality

Several BHOs do not require or monitor their BHAs to ensure the BHAs have policies and procedures in place for the proper recordkeeping of grievance and appeals.

- DBHR needs to work with all BHOs to require and monitor their contracted BHAs to ensure the BHAs have policies and procedures in place for proper recordkeeping of grievances and appeals.

Continuation of Benefits

Strength: Access

- All the BHOs have policies that outline the enrollee's right to have benefits continue pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services. These rights are included in each of the BHO's NOA letters mailed to enrollees.

Effectuation of Reversed Appeal Resolutions

Strength: Quality

- All the BHOs met this CFR citation.

Certifications and Program Integrity

Table B-7 indicates the elements for which BHOs received a recommendation requiring a corrective action plan.

Table B-7: Certifications and Program Integrity Summary of CAPs

Protocol Section	CFR Citation	Number of BHOs with CAPs
Provider Eligibility	438.600	5
Data Certification	438.602	3
Source, Content and Timing of Certification	438.606	3
Program Integrity Requirements	438.608 (a),(b)	8
Compliance Programs	438.608 (b)	7
Record Retention	431.107	7
Excluded Entities	455.100	3
Disclosure of Ownership	455.102	2
Cooperation with Fraud Control Units	455.21	2
Suspension of Payments	455.23	2
Civil Money Penalties and Assessments	1003.102	6

Provider Eligibility

Strength: Quality

- Many of the BHOs monitor, on a yearly basis, a sample of their BHAs' personnel files, credentialing policies and procedures, and employee training records.

Recommendation: Quality
Although all BHOs have policies and procedures in place indicating and ensuring that staff are not listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation, as required by federal or State laws, or found to have a conviction or sanction related to healthcare as listed in the Social Security Act, Title 11, many of the BHOs' policies do not include the BHOs' and the BHAs' intention to report to DSHS within ten business days any excluded individuals or entities discovered in the screening process.

- DBHR needs to confirm all BHOs have policies and procedures in place that include the intention of the BHOs and BHAs to report to DSHS within ten business days any excluded individuals and entities discovered in the screening process.

Data Certification

Opportunities for Improvement: Quality
Many of the BHAs stated they were unfamiliar with the Service Encounter Reporting Instructions (SERI).

- DBHR should continue to provide education and support to the BHOs and the BHAs on proper clinical documentation and the SERI manual.

The results of the encounter data validation Qualis Health performed revealed opportunities for the BHOs to correct errors prior to certifying the data they submitted to the State.

- DBHR should work with the BHOs to improve their accuracy in data checks to ensure that encounters submitted to the State are accurate, complete and truthful prior to submitting the data.

Source, Content and Timing of Certification

Strengths: Timeliness

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

Opportunity for Improvement: Quality

Many of the BHOs do not keep a log of attestations and data transaction submissions.

- DBHR should encourage the BHOs to create a log of attestation and data transaction submissions and keep this on file for documentation and validation purposes.

Program Integrity Requirements

Strengths: Quality

- Many of the BHOs have provided training to all BHO and BHA staff on all aspects of compliance, including fraud and abuse.
- NSBHO ensures annual compliance training through a formal annual training, monthly ten-minute video sessions, and reporting discussions at committee meetings on education and opportunities offered by the BHO. These training opportunities are required for all BHO staff, the board of directors and the BHO's delegated entities.
- Many of the BHOs have well-written compliance programs that contain the following: introduction; standards of conduct policies and procedures; identification of the compliance officer and committee; and details on how the BHO is conducting effective training and education, monitoring and auditing, reporting and investigation, response and prevention, enforcement and discipline, and assessment of effectiveness.
- GRBHO has an anti-retaliation and whistleblower protection policy and procedure that includes definitions, those to whom the policy applies, the process for registering and receiving a complaint regarding retaliation, directions on how enrollees can utilize Ombuds services to assist in the filing of a complaint, an explanation of protections, and a listing of possible sanctions for those involved in retaliatory behavior.

Recommendations: Quality

Although several BHOs conducted risk assessments, identified the top potential areas of risk and implemented action plans to mitigate the risks, many of the BHOs did not.

- DBHR needs to ensure that all BHOs are performing annual risk assessments and sharing the results with the BHO's executive team, governing board and appropriate committees. The leadership discussions need to include developing action plans to regularly monitor risks and

vulnerable areas, and seek interventions where appropriate to mitigate risks. Additionally, DBHR needs to ensure the BHOs include the results of the annual risk assessment in the annual BHO program evaluation.

Most of the BHOs lacked both evidence of receiving any reported cases of suspected fraud, waste and abuse and evidence they were recording and logging any of cases of suspected fraud, waste and abuse. Additionally, most of the BHOs lacked evidence that the formal logs were reviewed by the compliance committee and incorporated into the committee's meeting agenda as a standing agenda item.

- DBHR needs to ensure BHOs continually educate and maintain effective lines of communication with their staff and the staff at the BHAs on what should be reported to the BHO regarding suspected cases of fraud, waste or abuse as well as any other compliance issues that may be identified. Additionally, DBHR must make certain all suspected reports of fraud, waste and abuse are recorded in a formal log to be reviewed by the BHO's compliance committee and incorporated into the committee's meeting agenda as a standing agenda item.

Compliance Programs

Strengths: Quality

- GRBHO holds monthly Ethics and Compliance Committee meetings with an agenda and meeting minutes. The committee is responsible for overseeing multiple activities, including review of policies and procedures; staff training; internal and external compliance monitoring; and review of ethical issues, reports of suspected fraud and abuse, and changes in federal and State rules and regulations that impact operations or could result in additional risk to the BHO.
- NCBHO has appropriately selected a designated compliance officer and a compliance committee that are accountable to the governing body/senior management. NCBHO's compliance officer is certified in healthcare compliance.
- SBHO's contracted providers indicated the BHO's compliance officer has demonstrated through training and ongoing communication that there are open lines of communication between the compliance officer and the staff at the delegated entities.

Opportunity for Improvement: Quality

Many of the BHOs' compliance officers have not been certified in compliance and have had no formal training in compliance and program integrity.

- DBHR should consider requiring that all BHO compliance officers have formal compliance and program integrity training and/or be certified in compliance.

Recommendations: Quality

Many of the BHOs lacked written compliance programs containing the seven essential elements of a compliance program, and current WAC and BHO contract language.

- DBHR needs to ensure the BHOs update their formal compliance programs to contain current BHO contract language, WAC language, and the seven elements: implementing policies and procedures, designating a compliance officer, conducting effective training and education, developing effective lines of communication, conducting internal monitoring and auditing, enforcing standards through well publicized guidelines, responding promptly to detected problems, and undertaking corrective action.

Some of the BHOs lacked evidence that they were annually monitoring their BHAs to ensure the BHAs have effective compliance programs for providing guidance, enforcing internal controls, and mitigating

risks related to healthcare compliance.

- DBHR needs to make certain the BHOs annually monitor their BHAs to ensure each has an effective compliance program in order to provide guidance, enforce internal controls, and mitigate risks related to healthcare compliance.

Many BHOs are not requiring annual compliance training for fraud, waste and abuse for their board of directors, BHO staff and BHA staff. Furthermore, many of the BHOs are not maintaining attestations of attendance that include the training date, who attended the training, and evidence of the effectiveness of the training.

- DBHR needs to ensure the BHOs are conducting annual compliance training for fraud, waste, and abuse, for their board of directors, BHO staff and BHA staff and make certain the BHOs are retaining attestations of attendance for these annual compliance trainings.

Many BHOs do not have a chartered compliance committee that meets monthly or at least quarterly to focus on developing and managing an organization-wide compliance program and to cover the wide array of compliance topics that touch every aspect of the BHO, including but not limited to training and education, monitoring and auditing, reporting and investigation, response and prevention, risk assessment and mitigation, enforcement and discipline, and assessment of effectiveness.

- DBHR needs to require BHOs to have a formal chartered compliance committee, and make certain the committee meets monthly or at least on a quarterly basis. The committee should maintain committee meeting minutes that document the BHO's focus on developing and managing an organization-wide compliance program.

Record Retention

Strength: Quality

- OPBHO includes in its contracts with the BHAs the following language on record retention: "Contractor shall ensure that it has internal policies and procedures that include the requirement to retain all books, records, documents and other material relevant to this Contract for a period of not less than six (6) years after the termination hereof in compliance with Medicaid records retention standards."

Recommendation: Quality

Many BHOs lacked a policy and procedure requiring the BHO and the BHAs to retain for six years all records disclosing the extent of services the provider furnishes to enrollees, including but not limited to records pertaining to credentialing and recredentialing; incident reporting; requests for services; authorizations; clinical records; complaints; grievances; appeals; referrals for fraud, waste and abuse; and outcomes of fraud, waste and abuse. The policy needs to include a mechanism to ensure the BHO monitors for compliance with the policy.

- DBHR needs to make certain BHOs have policies and procedures on retaining for six years all records disclosing the extent of services the provider furnishes to enrollees, including but not limited to records pertaining to credentialing and recredentialing; incident reporting; requests for services; authorizations; clinical records; complaints; grievances; appeals; referrals for fraud, waste and abuse; and outcomes of fraud, waste and abuse. The policy needs to include mechanisms for ensuring BHO and BHA compliance with the policy.

Excluded Entities

Strengths: Quality

- Most of the BHOs run the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) database monthly against the HR database for all staff, board members, agency owners and vendors for exclusion from participation in federal programs.
- KCBHO's program integrity policy describes how the BHO monitors for exclusion of entities owned or controlled by a sanctioned person and how it will deny or terminate provider participation if full disclosure is not made or conviction occurs.
- Because GCBHO does not delegate to its BHAs the monitoring for individuals excluded from participation in Medicare or any of the State healthcare programs, the BHO demonstrated it has mechanisms in place for tracking individuals and entities on a monthly basis and keeps a tracking log for monitoring and reporting purposes.

Disclosure of Ownership

Strength: Quality

- Both OPBHO and NSBHO check the disclosure of ownership upon contract execution, as well as upon request, when a contract is renewed or extended.

Recommendation: Quality
Some BHOs lacked a mechanism to monitor their BHAs for disclosure of ownership or controlling interest in the organization with five percent or more interest.

- DBHR needs to make sure BHOs have updated administrative monitoring tools to include monitoring their BHAs for disclosure of ownership or controlling interest in the organization with five percent or more interest.

Cooperation of Fraud Control Units

Strength: Quality

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

Suspension of Payments

Strength: Quality

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

Recommendation: Quality
Some BHOs have not developed or updated their policies and procedures to reflect the monitoring and suspension of payments in cases of fraud.

- DBHR needs to ensure BHOs have developed and implemented current policies and procedures specific to monitoring vendors, providers or subcontractors for suspension of payments in cases of fraud.

Civil Money Penalties and Assessments

Strength: Quality

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

Recommendation: Quality

Most BHOs lacked a policy and procedure to monitor vendors, providers or subcontractors for civil money penalties and assessments.

- DBHR needs to ensure that all BHOs develop policies and procedures to monitor their vendors, providers and subcontractors for civil money penalties and assessments.

Performance Improvement Project Validation

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

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

Methodology

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

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

Scoring

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

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

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

Summary of PIP Validation Results

In 2016, each BHO was required to complete a clinical PIP and a non-clinical PIP (one of which was required to focus on children), as well as a substance use disorder-focused PIP (required as of the BHO contract start date: April 1, 2016). Clinical PIPs topics utilize outcome indicators to measure changes in behavioral health status or functional status such as prevention and care of acute and chronic conditions for high-risk, high-volume, or high-need enrollees. Non-clinical PIPs focus on member satisfaction or process of care areas and may address coordination or continuity of care, access to care, and availability of services, as well as enrollee appeals, grievances, and satisfaction.

Qualis Health's review of the BHOs' PIPs revealed many areas of strength as well as some opportunities for improvement throughout the state. Themes within the BHOs' chosen topics included care coordination, increasing enrollee engagement in services, and improved identification of enrollees' level of care. Many PIPs were still in the early phases of study, particularly for the SUD-focused PIPs, for which sufficient data were not yet available to conduct thorough analysis of the study topics. In those cases, Qualis Health was unable to assess for success related to real or sustained improvement. Table B-8 indicates the BHOs' PIP topics and validation results.

Table B-8: Summary of BHO PIP Validation Results

BHO	Study Topic		Validation Result
Greater Columbia	Clinical/Children's PIP	Promoting Medication Adherence in Youth	N/A
	Non-clinical PIP	Increasing Timeliness of Provider-Submitted Authorization Requests through Identification of Systemic Barriers	N/A
	SUD PIP	Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs	N/A
Great Rivers	Clinical PIP	TBD	N/A
	Non-clinical PIP	TBD	N/A
	SUD PIP	TBD	N/A
King County	Clinical PIP	Effectiveness of the Transitional Support Program	Partially Met
	Non-clinical/ Children's PIP	Improved Coordination with Primary Care for Children and Youth	Partially Met
	SUD PIP	TBD	N/A
North Central	Clinical/Children's PIP	Adopting the Washington State Children's System Principles and Core Practice Model to Improve the	Fully Met

		Penetration Rate of Child and Family Team Participation for Medicaid Children Ages 0–20	
	Non-clinical PIP	Crisis Intervention Follow-up: Does the Implementation of a Standardized Discharge Protocol Increase the Percentage of Medicaid Enrollees Receiving a Crisis Service Who Receive Clinically Indicated Follow-up Services	Fully Met
	SUD PIP	TBD	N/A
North Sound	Clinical/ Children's PIP	Change in LOCUS\CALOCUS Level for Youth with an EPSDT Referral	Partially Met
	Non-clinical PIP	Improving timeliness of Services using the Open Access Model	Partially Met
	SUD PIP	Increasing Substance Use disorder Penetration Rates.	Partially Met
Optum Pierce	Clinical PIP	Care Coordination between BHO and Medical Providers in Pierce County	N/A
	Non-clinical/Children's PIP	Unplanned Discharges from the Optum Pierce BHO WISe Program	N/A
	SUD PIP	Use of the GAIN-SS Tool to Improve Referrals within the Behavioral Health Organization Network in Pierce County	N/A
Salish	Clinical PIP	Tobacco Use Cessation	Fully Met
	Non-clinical/Children's PIP	Improving Identification of Intensive Needs Children and Youth	Fully Met
	SUD PIP	Improving Implementation of the Grievance System among SUD Providers	N/A
Spokane	Clinical PIP	Reduction in Spokane County Hospital Readmissions for Individuals Discharged from State Hospitals As a Result of Enhanced Case Management	Partially Met
	Non-clinical/Children's PIP	Increase in Access to Treatment for Children Residing in Rural, Underserved Areas As a Result of School-Based Outpatient Services	Partially Met
	SUD PIP	SUD Continuity of Care	N/A
Thurston-Mason	Clinical/Children's	High-fidelity Wraparound	Fully Met

	PIP		
	Non-clinical PIP	Implementing LOCUS to Increase Service Episodes for Adult Medicaid Clients	Fully Met
	SUD PIP	SUD Residential Access	N/A

Greater Columbia (GCBHO)

Clinical/Children's: Promoting Medication Adherence in Youth (Not Applicable)
GCBHO selected this PIP study topic in order to increase medication compliance among Medicaid-enrolled youth. GCBHO chose this topic after it identified non-adherence to psychotropic medication as an issue based on data received from a questionnaire that was used in a previous PIP. This PIP is still in its early stages and further research must be conducted to understand the reasons why youth are not complying with their prescribed medication. Once GCBHO has an understanding of the causes and barriers related to this issue it can choose an intervention to address this issue and then formulate its study question.

Non-Clinical: Increasing Timeliness of Provider-Submitted Authorization Requests through Identification of Systemic Barriers (Not Applicable)
For its non-clinical PIP, GCBHO selected its topic based on data that revealed, among its BHAs, that there were significant differences in the average lengths of time between an enrollee's request for service and the BHA's submission of the request for authorization to the BHO. While GCBHO has the data to show that there is an apparent issue related to some BHAs' ability to submit requests for service in a timely manner, the reasons for the delays are not clear. GCBHO plans to explore the possible root causes for the lags in submission, and, based on its findings, the BHO will develop interventions to increase the timeliness of authorization requests among its BHAs.

SUD: Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs (Not Applicable)
GCBHO is in the early stages of formulating its SUD PIP. The BHO plans to create an intervention to increase engagement in detox programs and decrease recidivism rates. GCBHO needs to conduct further research to gain an understanding of the reasons enrollees leave detox prematurely. Once the BHO fully understands the reasons individuals fail to complete detox programs, it can create an intervention to address the causes.

Great Rivers (GRBHO)

At the time of the 2016 external quality review, GRBHO had been operating as a BHO for only five months. GRBHO was the only truly new entity in the BHO system, having been created from two different Regional Support Networks: Grays Harbor RSN and Timberlands RSN. The BHO has no historical data for the region it covers, and at the time of the review, GRBHO was still in the initial stages of collecting data from its BHAs. The BHO did not have enough information to formulate potential PIP topics, so the BHO instead submitted a PIP task timeline for the years 2016 and 2017.

King County (KCBHO)

Clinical: Effectiveness of the Transitional Support Program (Partially Met)
KCBHO successfully completed its clinical PIP on reducing psychiatric hospitalizations of Medicaid enrollees through its Transitional Support Program (TSP). TSP uses a consultative model that assists hospital staff with assessment, discharge planning, and care coordination of involuntarily detained enrollees. Two indicators were used in the PIP: annual average length of hospitalization and annual number of hospitalizations for an individual enrolled in TSP. Analysis of the data found statistically significant improvement in both indicators and a clinically meaningful decrease in both the number of psychiatric hospitalizations and lengths of stay in the study population. Hospitalization admissions declined by more than one-half and lengths of stay were reduced by more than two-thirds. KCBHO did not communicate its study in the form of a question, but created statements regarding potential outcomes of the intervention. When writing a PIP study question, it should be clear, concise, measurable and in the form of a question.

Non-clinical/Children's: Improved Coordination with Primary Care for Children and Youth (Partially Met)
This PIP is in its third year and is intended to focus on reducing psychiatrically related emergency department (ED) visits among youth through care coordination between the BHO and Molina Apple Health. Although Qualis Health issued corrective action plans last year for this PIP, none have been addressed and KCBHO has still not clearly stated its interventions or the criteria it plans to use to determine the interventions. KCBHO needs to begin data collection and reporting and analyzing the needs for youth dually enrolled in the BHO and Molina. KCBHO initiated this PIP in 2013; if the work of this PIP cannot begin soon, KCBHO needs to formulate a new PIP for which it can begin collecting data within six months of initiation.

SUD: Topic to be Determined (Not Applicable)
KCBHO is exploring two possible SUD PIP topics. One potential topic is implementing a naloxone program in community settings where at-risk populations frequent. The other topic is creating an intensive protocol to support, rather than ban, enrollees who violate drug treatment program rules. KCBHO has chosen to focus on opiate use for this PIP due to the severity of the issue of opiate use within King County. If the BHO chooses to pursue the naloxone PIP, it will need to ensure there is a clear correlation between the intervention and any reduction in opiate use. If the BHO opts to implement the PIP regarding the creation of a protocol to assist in the reduction of enrollees being banned from SUD programs, it needs to set clear guidelines regarding behaviors that will and will not result in an individual being banned. The BHO should also consider working with a manageable number of SUD programs at the onset of this PIP and, if successful, possibly expand the PIP to more programs.

North Central (NCBHO)

Clinical/Children's: Adopting the Washington State Children's System Principles and Core Practice Model to Improve the Penetration Rate of Child and Family Team Participation for Medicaid Children Ages 0–20 (Fully Met)
NCBHO's clinical/children's PIP focused on increasing the percentage of unduplicated Medicaid-enrolled youth who received a validated child and family service planning and coordination service. In an effort to reach its goal, NCBHO provided clinicians with training on practice guidelines and service coding. This PIP began in 2013. Results of data analysis showed that for the first re-measurement period there was not a statistically significant improvement; however, there was a slight improvement in number of youth

seeking services. For the second and final re-measurement, statistically significant improvement was achieved. NCBHO intends to continue the work of this PIP, through a combined implementation of practice guidelines and the new level of care policy, in an effort to achieve further progress in increasing child and family service planning and coordination of service team meetings.

Non-clinical: Crisis Intervention Follow-up: Does the Implementation of a Standardized Discharge Protocol Increase the Percentage of Medicaid Enrollees Receiving a Crisis Service Who Receive Clinically Indicated Follow-up Services? (Fully Met)
NCBHO initiated its non-clinical PIP in January 2014. The intent of the PIP was to implement a standardized discharge protocol for enrollees receiving crisis services in order to increase the number of enrollees who received clinically indicated follow-up services. The baseline and two re-measurement periods for this PIP have been completed. Analysis of the data has found that improvement was statistically significant.

SUD: Topic to be Determined (N/A)
At the time of the external quality review, NCBHO was working to clarify its SUD PIP topic. As the BHO moves forward honing its study topic, it should avoid concentrating on areas that are contract requirements or core performance measures. NCBHO should continue to look at SUD data to identify trends, needs, gaps, and barriers in order to select a PIP that is truly an area in need of improvement.

North Sound (NSBHO)

Clinical/Children's: **Change in LOCUS\CALOCUS Level for Youth with an EPSDT Referral (Partially Met)**
NSBHO's clinical children's PIP is still in its initial planning stage; the specific indicator, intervention, and study question have not been fully formulated. The BHO is interested in focusing its PIP on increasing care coordination of youth with EPSDT referrals in order to increase their level of functioning as evidenced by a change in the Child and Adolescent Level of Care Utilization System (CALOCUS)/Level of Care Utilization System (LOCUS) score. The BHO needs to conduct a thorough analysis of enrollees' needs, care, and services to confirm that this is an area that needs improvement.

Non-clinical: Improving Timeliness of Services Using the Open Access Model (Partially Met)
NSBHO has chosen to focus its non-clinical PP around the implementation of the Open Access model throughout its region. The initial aim of the PIP was to utilize Open Access to decrease enrollees' wait time between requests for service and intake assessments. NSBHO has not provided a thorough analysis related to enrollee requests for services and intakes to ensure that this is an area that needs improvement. NSBHO is in the process of reformulating this study topic in order to ensure the study topic is appropriate, and that the study question and the intervention are clearly defined

SUD: Increasing Substance Use Disorder Penetration Rates (Partially Met)

NSBHO had initially planned to focus its SUD PIP on increasing penetration rates within the region; however, this study topic closely mirrors a state performance measure and cannot be used for a PIP. NSBHO needs to collect more data and conduct additional research to fully ascertain which SUD issues need to be addressed.

Optum Pierce (OPBHO)

Clinical: Care Coordination between BHO and Medical Providers in Pierce County (N/A)
OPBHO's care coordination PIP is still in its nascent stages. OPBHO has expressed interest in targeting enrollees with diabetes, but has not obtained data to verify that this is a specific segment of the population in need of improved care coordination. OPBHO plans to conduct further research to understand which enrollees are not being referred to PCPs. OPBHO should be cautious about how this PIP is approached, as PCP care coordination for enrollees with identified medical needs is a contract requirement, and the PIP will need to encompass more than what is required by the State.

Non-clinical/Children's: Unplanned Discharges from the Optum Pierce BHO WISe Program (N/A)
OPBHO's non-clinical PIP regarding the unplanned discharges from the WISe program is still under development. Given the information OPBHO has found related to WISe program discharges and agreement from stakeholders, the pursuit of this PIP topic is well suited. When further defining the design of the PIP, OPBHO should consider several factors, including but not limited to the specific issue that will be addressed, ease of implementation of the intervention, burden and acceptability of the PIP by BHA staff who will be assisting with implementation, and data availability.

SUD: Use of the GAIN-SS Tool to Improve Referrals within the Behavioral Health Organization Network in Pierce County (N/A)
OPBHO has laid out a strong foundation for this SUD PIP. The topic of looking into the incongruity of clinicians' diagnoses and GAIN-SS scores has the potential to impact healthcare integration within the BHO. OPBHO's initial plan of looking at this issue across both the SUD and mental health systems may not be realistic at this time. Attempting to conduct a PIP with too many interventions with varying providers can be difficult to implement and track. OPBHO should consider first concentrating on the mental health system, as data are already easily available. Once data are consistently available for SUD services, OPBHO can decide if pursuing another phase of the PIP is feasible.

Salish (SBHO)

Clinical: Tobacco Use Cessation (Fully met)
SBHO has created a three-phase PIP to improve tobacco use cessation among Medicaid enrollees. The goal of the first phase is to improve assessment of tobacco use and documentation of that information in the electronic medical record (EMR). The second phase of the PIP goes beyond the assessment intervention and includes additional steps consistent with the Public Health Service clinical practice guideline for "treating Tobacco Use and Dependence" (2008 as recommended by the U.S. Preventative Services Task Force.) The third phase will consist of measuring tobacco use outcomes before and after the intervention with the goal of decreasing tobacco use among enrollees. The first phase of this PIP was completed in February 2016. The PIP demonstrated sustained improvement through its baseline and two re-measurement periods. The intervention for phase two was initiated in March 2016 and the measurement periods are expected to be completed by March 2018.

Non-clinical/Children's: Improving Identification of Intensive-Needs Children and Youth (Fully Met)
This non-clinical PIP sought to create a consistent process to identify the high-risk, high-cost, high-needs Medicaid-enrolled youth within the SBHO region. The intervention for this PIP included a policy change and training of clinicians regarding the identification of high-risk/high-need children and youth. SBHO found that the baseline and first re-measurement comparison demonstrated a decline in performance; however, improvement was found in the remaining measurement periods once an adjustment was made to expand the inclusion criteria of the indicator. The final measurement period for this study will be

completed on December 31, 2016, and data will be analyzed in the first quarter of 2017. Ongoing tracking of the intervention has demonstrated evidence of sustained improvement.

SUD: Improving Implementation of the Grievance System among SUD Providers (N/A)
SBHO is in the early stages of formulating its SUD PIP. The BHO has selected an SUD topic based on data showing there is a clear issue regarding the lack of grievances filed by SUD enrollees. For its intervention, SBHO intends to provide training, supportive materials, and technical assistance to providers. The BHO is considering two possible indicators: an increase in the number of grievances filed among enrollees and improvement in staff knowledge regarding grievances. As this PIP moves forward and the BHO works to finalize its study question or questions, all elements of the PIP study design should be taken into consideration to ensure all aspects of the PIP are realistic and obtainable.

Spokane (SCBHO)

Clinical: Reduction in Spokane County Hospital Readmissions for Individuals Discharged from State Hospitals As a Result of Enhanced Case Management (Partially Met)
SCRBHO chose to implement a clinical PIP by utilizing enhanced care management (ECM) as a means to promote stabilization and wellness for individuals discharged from the state hospital. The indicator for this PIP was a decrease in the percentage of hospital readmission rates within 30 days of discharge. The original dates to collect baseline data were January through June 2012, with two re-measurement periods: January through June 2013 and January through June 2014. A third re-measurement period was added from January 2015 through June 2015. Only nominal updates were documented in the 2015 PIP submission, and while there was sustained improvement for all measurement periods, SCRBHO did not provide explanation for its rationale in extending the PIP an additional year. SCRBHO has retired this PIP. SCRBHO is encouraged to implement significantly shorter PIPs. Once sustained improvement is achieved, the PIP should be retired or evolved to another phase. All steps, analysis, and explanations should be clearly documented so that any work completed on a PIP is apparent to reviewers.

Non-clinical/Children's: Increase in Access to Treatment for Children Residing in Rural, Underserved Areas As a Result of School-Based Outpatient Services (Partially Met)
SCRBHO has completed its non-clinical/children's PIP. The goal of the PIP was to target children and youth in rural ZIP codes by providing school-based outpatient services in order to improve their health and functional status. Analysis of the data between measurement periods showed statistically significant improvement. Minimal updates were made to the 2016 PIP submission. Changes to the data analysis plan were noted in the 2015 and 2016 submissions; neither submission contained an explanation of how the new analysis plan was appropriate to the study question and data types. In the future, SCRBHO is encouraged to begin the new PIP study topic selection process as soon as the previous PIP has been retired, rather than a full year after the PIP has ended.

SUD: SUD Continuity of Care (N/A)
SCRBHO has proposed an SUD PIP that would implement a change in its system of care in order to ensure seamless transitions from one level of care to another. In order to facilitate this process, SCRBHO will allow concurrent open episodes with both inpatient and outpatient care. The intent is to improve communication, coordination, discharge planning, and "warm handoffs" between providers. The goal is to create seamless transitions and continuity of care to improve engagement and retention and reduce recidivism. SCRBHO is in the early stages of creating its SUD PIP. The BHO needs to consider all the elements of PIP study design and implementation as it moves forward in its PIP formulation to ensure all aspects are realistic and executable.

Thurston-Mason (TMBHO)

Clinical/Children's: High-fidelity Wraparound (Fully Met)
TMBHO initiated this clinical/children's PIP in 2011. The purpose of the study was to evaluate if the utilization of High-Fidelity Wraparound supports improve Medicaid-enrolled children and youth's emotional and behavioral functioning as measured by the Strengths and Difficulties Questionnaire (SDQ), Total Difficulties Scale, and the Child and Adolescent Needs and Strengths (CANS) scores. TMBHO has shown sustained improvement through repeated measurements over comparable periods of time. TMBHO intended to measure CANS scores until the end of 2016, but given the clear success of the intervention, it does not appear necessary to continue this PIP in its current form. Using the work that the BHO and behavioral health agencies have already accomplished with WISe, the BHO should consider evolving this PIP and formulating a new study question with a new intervention.

Non-Clinical: Implementing LOCUS to Increase Service Episodes for Adult Medicaid Clients (Fully Met)
TMBHO's non-clinical PIP focuses on whether implementing the use of the LOCUS to determine the level of care needed for an individual will help to increase the number of Medicaid service hours and therefore lead to more successful outcomes for its enrollees. TMBHO initiated this PIP in 2012. The baseline and re-measurement periods have been completed, and analysis of the data has found no improvement in service hours for Medicaid-enrolled adults. TMBHO is considering several potential next steps if it chooses to continue focusing on this study topic. The BHO may work with the BHAs to add other services such as groups or in-home visits, add peers or other types of services, implement evidence-based practices, or create some type of adult wraparound program to better serve enrollees.

SUD: SUD Residential Access (N/A)
TMBHO is in the initial stages of formulating its SUD PIP. The preliminary data collected by TMBHO appear to show that within Thurston and Mason counties there is variance between the number of individuals referred for inpatient treatment and those who were admitted to residential treatment. Once TMBHO is able to collect and analyze baseline data and there is some understanding of the issues related to accessibility, an intervention can be implemented and a full study question can be created.

Strengths

- Over the course of 2016, DBHR has implemented a PIP review and approval process that includes communication with the EQR team and clear feedback to the BHOs regarding study topic submissions.
- The majority of PIPs that had reached the point of data analysis received overall scores of fully met, with high confidence in reported results.
- Many BHOs incorporated evidence-based or promising practices into the framework of the PIPs.
- Several BHOs were able to assess their projects' effectiveness and make adjustments to improve outcomes.
- PIPs demonstrated an overall commitment to providing quality and comprehensive care to enrollees.
- Most BHOs were receptive and responsive to feedback and technical assistance regarding the formulation and implementation of PIPs.

Recommendations

The requirement for BHOs to implement a third PIP focusing on SUD services is new for 2016. All of the BHOs faced challenges regarding SUD data collection. Without complete and accurate data, the BHOs found it difficult to fully understand the needs of enrollees related to substance use disorder and what gaps might exist in the SUD program. The formulation of a PIP needs to include the collection and analysis of internal and external data related to the study topic. Without this data, the BHOs are unable to analyze the data and identify a study topic.

- DBHR needs to develop procedures to ensure the BHOs are able to receive reliable SUD treatment service data.

Several BHOs chose PIP study topics that were State performance measures and contract requirements.

- DBHR needs to clearly communicate to the BHOs that State performance measures and contract requirements are separate obligations and cannot be used as PIP study topics.

Some BHOs struggled with choosing new PIP topics.

- DBHR needs to ensure that when selecting a PIP study topic, the BHOs:
    - ensure there are data to support the focus of the PIP as an area that truly needs improvement
    - do not attempt to create a PIP around a program or process that does not show evidence of needing improvement. PIPs are meant to improve the care and treatment of enrollees in areas that are in need of advancement, not highlight programs or processes that are successful.
    - fully and clearly define the intended intervention(s)

Several BHOs' PIPs were in place for extended measurement periods with only minimal explanation or updates to the PIP submission.

- DBHR needs to ensure that the BHOs' PIP measurement periods are clearly stated and appropriate in length. Data need to be reviewed at least on a quarterly basis to ensure the PIP is moving in a successful direction. Any changes in the study periods need to be clearly documented with thorough and valid explanations of deviations from the initial plan.

Many of the BHOs have staff who are unfamiliar or unsure of the PIP process. Many of these staff need continued technical assistance with understanding the CMS protocol for conducting performance improvement projects.

- DBHR and the EQRO need to continue to provide technical assistance to the BHOs and their staff on the CMS protocol and PIP study design.

Encounter Data Validation

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

Methodology

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

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

Qualis Health performed three activities supporting a complete encounter data validation for the State's BHOs: a review of the procedures and results of each BHO's internal EDV required under the BHOs' contract with the State; state-level validation of all encounter data received by the State from each BHO during the review period; and an independent validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of each BHO's internal EDV.

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

Qualis Health obtained and reviewed each BHO's encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2015. The BHOs' encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates and fields selected for validation were reviewed for conformance with DBHR contract requirements. The BHOs' encounter and/or enrollee sampling procedures were reviewed to ensure conformance with accepted statistical methods for random selection.

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

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

Qualis Health Encounter Data Validation
Qualis Health's encounter data validation process consists of electronic data checks—state-level validation of all encounter data received by the State from each BHO during the review period; and a clinical record review—independent validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of each BHO's internal EDV.

Electronic Data Checks
Qualis Health analyzed encounter data submitted by each BHO to the State to determine the general magnitude of missing encounter data, types of potentially missing encounter data, overall data quality issues and any issues with the processes the BHO has in compiling encounter data and submitting the data files to the State. Specific tasks included:

- a review of standard edit checks performed by the State on encounter data received by the BHO and how Washington's Medicaid Management Information System (MMIS) treats data that fail an edit check
- a basic integrity check on the encounter data files to determine whether expected data exist, whether the encounter data element values fit within expectations, and whether the data are of sufficient quality to proceed with more complex analysis
- application of consistency checks, including verification that critical fields contain values in the correct format and that the values are consistent across fields
- inspection of data fields for general validity
- analysis and interpretation of data on submitted fields, the volume and consistency of encounter data and utilization rates, in aggregate and by time dimensions, including service date and encounter processing data, provider type, service type and diagnostic codes

Onsite Clinical Record Review
Qualis Health performed clinical record reviews onsite at provider agencies under contract with each BHO. The process included the following:

- selecting a statistically valid sample of encounters from the file provided by the State
- loading data from the encounter sample into an auditing tool (MS Access database) to record the scores for each encounter data field
- providing the BHO with a list of the enrollees whose clinical charts were selected for review for coordination with contracted provider agencies pursuant to the onsite review

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

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

Scoring Key

Fully Met (pass) ●	Partially Met (pass) ◉	Not Met ○

Summary of EDV Review

The results of the BHOs' EDV are presented below. Because Qualis Health's 2016 EDV reviewed encounter data from 2015, and the internal EDVs were conducted prior to the BHO transition, results for Great Rivers BHO, a new entity, are reflected in the performance summaries for Grays Harbor and Timberlands RSNs. Table B-9 displays the cumulative results for EDV scoring elements across the RSNs/BHOs.

Table B-9: Summary Results of External Review of Encounter Data Validation Procedures

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

Table B-10: Summary Results of Qualis Health Encounter Data Validation

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

BHO EDV Procedures

Results of the review of the RSNs'/BHOs' EDV report summaries submitted to the State indicated numerous issues, including the following:

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

BHO Sampling Procedures

Overall, the RSNs/BHOs described protocols that would be appropriate and adequate for validating providers' encounter data. The sampling procedures appear to result in random oversamples; however, three of the ten RSNs/BHOs met criteria for this area and three of the ten only partially met this area. The

primary reason for the partially met scores was lack of documentation explaining the RSNs'/BHOs' sampling procedures.

- Seven of the RSNs/BHOs submitted inadequate documentation describing the sampling procedure and methodology to ensure a fully met score.
- Eight RSNs/BHOs used their own data to compare to the clinical records. Two RSNs/BHOs used the State data from ProviderOne.

Data Entry Tools

The data entry tools developed by the RSNs/BHOs that submitted them appeared to be appropriate for the reviews, with the exception of a few RSNs/BHOs that were missing contract-required elements.

- Four of the ten RSNs/BHOs used MS Access databases to record and document the results of the encounter reviews.
- Six RSNs/BHOs used Excel spreadsheets.
- One RSN/BHO used a combination paper and MS Access database, using the paper tool onsite and later completing data entry with the tool.
- Two RSNs'/BHOs' tools did not contain all the required contract elements for review.

Methodology

- Five of the 10 RSNs/BHOs adequately described their EDV methodology. Of the three that did not meet this standard, two had not included all the required elements required for the encounter review. Two of the three also did not conduct analysis on the results or include a discussion of the analysis of the review.
- All but two RSNs/BHOs reported information about the staff who conducted the encounter reviews, some of which included their positions at the RSN/BHO, their credentials, and/or their attendance records for prior EQRO EDV training.
- Staff who conducted the reviews included IS managers, operations managers, quality managers, and contract monitors.
- Of the 10 RSNs/BHOs, only five documented a process for, or mentioned, inter-rater reliability.

Qualis Health EDV

Qualis Health's Electronic Data Checks

- Qualis Health analyzed the required demographic data submitted to the State by the RSNs/BHOs and found that most had submitted 100 percent of the required demographic data.
- For two data elements, preferred language and sexual orientation, the response "unknown, patient refused" was unusually high for many RSNs/BHOs.

Onsite Clinical Record Review

Qualis Health reviewed both demographic and encounter data for slightly more than 411 encounters in approximately 100 unique client clinical records for each of the RSNs/BHOs. The demographic data included the enrollee's last name, first name, Social Security Number, date of birth, race/ethnicity, Hispanic origin, gender, language, and sexual orientation. Results for demographic validations varied between RSNs/BHOs. As it is not required in the BHOs' contract for EDV with the State, not all RSNs/BHOs reviewed demographic data. The RSNs/BHOs typically reached the 95 percent match rate on first name, last name, gender, and date of birth. The most common elements that did not reach 95 percent were race/ethnicity, Hispanic origin, preferred language, Social Security Number and sexual orientation.

For each of the encounters, the following data fields were reviewed: procedure code, service date, service minutes, service location, agency, provider type, and whether the service code agreed with the treatment described. The field for service code agrees with treatment described received the highest rate of mismatches within the Qualis Health review, with all 10 of the BHOs not meeting the 95 percent standard. Three RSNs/BHOs reached 95 percent in all areas except service code agrees with treatment described. Six RSNs/BHOs did not meet the 95 percent standard in location and procedure code, with one RSN/BHO receiving a no match for almost 100 percent for location. Four RSNs/BHOs did not meet standard for provider type, five RSNs/BHOs did not meet standard for duration, but only two RSNs/BHOs did not meet the 95 percent standard for author identified.

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

There were also a variety of issues related to encounters found within the clinical onsite review. Examples of errors included:

Coding errors
- submitting improper durations for the code utilized
- submitting codes that did not meet SERI, WAC, or contract requirements
- submitting improper codes for an individual in a 24/7 facility
- submitting the incorrect codes for the services provided
- submitting an encounter for services that were rendered by a community member
- submitting only one location code
- submitting multiple services that are not allowed to be submitted together (example: high-intensity codes with individual modality codes)
- not documenting location on the progress note
- submitting codes without a modifier or with the incorrect modifier

Documentation concerns
- submitting encounters without clinical documentation, supporting documentation, and/or evidence of medical necessity
- submitting encounters without the required elements
- submitting the same documentation for multiple different services

Provider type errors
- submitting the incorrect provider type for the staff that provided the service
- submitting codes with a provider type not allowable per the SERI (example: provider type 5 submitted as 96372)
- Not signing credentials on progress notes

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

- submitting excessive durations for reported services (such as 8+hours for one service)

Submitting services that are not eligible for submission to the State

- submitting nursing assessment codes at the same time as evaluation and management codes
- submitting services prior to an intake assessment
- submitting duplicate encounters for the same service
- submitting two services at the same time with two clinicians, such as attending a medical appointment with the client at the same clinic with both the prescriber and the clinician encountering
- submitting mental health services in a residential setting to account for bed days/room and board, when no service was documented and/or rendered
- submitting services without supporting documentation
- submitting encounters for no-shows, no-contacts, or enrollees not at home
- submitting encounters for internal consultations and staffing
- submitting encounters for administrative tasks: listening to and leaving voicemails, reading and sending e-mails, texting, faxing, writing letters, calling in prescriptions, rescheduling appointments, making reminder calls
- submitting encounters for social events, with no therapeutic intervention documented, including researching plane tickets, helping with homework, art group, bingo group, exercise group, computer skills group, transportation, touring the YMCA, playing various sports games and going to Best Buy. Additional activities also included filling out phone applications, moving a client's belongings to storage, attending court, waiting while the client attends therapy appointment, grocery and other shopping, employment support, recycling group, touring schools, ice skating, picnics, housing meetings, learning how to budget, yoga group, watching movies, observing the client sleeping, listening to music, reading the newspaper, gardening, and taking out the trash.

Opportunities for Improvement

Because there is no standardized format for the BHOs to submit their yearly EDV reports to DBHR, many of the reports were missing crucial information, such as adequate descriptions of the methodology, sampling procedures, data analysis results, and summary of findings that would determine whether or not items met criteria for adequacy.

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

DBHR does not have a process in place to identify and monitor encounters for accuracy, timeliness, and truthfulness and, when issues arise, to report and resolve the issues with the BHOs.

- DBHR should develop a process for monitoring encounters for accuracy, timeliness, and truthfulness and actively work with the BHOs when issues are identified.

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

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

Recommendations

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

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

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

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

Many BHOs are submitting coding errors to ProviderOne. The State reported that ProviderOne does not contain any edits to reject any codes and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to have processes in place in which ProviderOne create edits to reject encounters that are submitted incorrectly to the State.

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

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

Wraparound with Intensive Services (WISe) Focused Study

As part of its external quality review activities for 2016, Qualis Health conducted the 2016 EQRO Focused Study: Quality Service Review (QSR) of Children's Wraparound with Intensive Services (WISe) Implementation, a program of the Washington State Department of Social and Health Services Behavioral Health Administration (BHA). The study is designed to assess the success of Behavioral Health Organizations (BHOs) in implementing the WISe program. Qualis Health also conducted encounter data validation (EDV) on selected encounters for the WISe population.

WISe EDV

Encounter data validation is a process used to validate encounter data submitted by BHOs to the State. Encounter data are electronic records of the services provided to WISe enrollees by providers under contract with a BHO. Encounter data are used by BHOs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the BHOs for the WISe program.

As part of the WISe Focused Study, Qualis Health performed an EDV for statewide WISe services across BHOs. The methodology was the same as for the overall EDV, discussed in the previous chapter.

Qualis Health staff reviewed encounter documentation included in the clinical record to validate data submitted to the State and to confirm the findings of the analysis of State-level data. Upon completion of the clinical record reviews, Qualis Health calculated error rates for each encounter field.

Summary of EDV Review

Table B-11 shows the results of Qualis Health's review of demographic data for statewide WISe encounters. Table B-12 shows the results for encounter data.

Table B-11: EDV Results for Statewide WISe Demographic Data

Field	Match	No Match—Erroneous	No Match—Unsubstantiated
Last Name	98.69%	1.31%	0.00%
First Name	98.69%	1.31%	0.00%
SSN	27.45%	1.31%	71.24%
Date of Birth	98.69%	0.65%	0.65%
Gender	97.39%	0.65%	1.96%
Hispanic Origin	79.74%	11.11%	9.15%
Race/Ethnicity	90.20%	4.58%	5.23%
Preferred Language	83.66%	11.11%	5.23%
Sexual Orientation	52.29%	12.42%	35.29%

Table B-12: EDV Results for Statewide WISe Encounter Data

Field	Match	No Match—Erroneous	No Match—Unsubstantiated
Procedure Code	76.06%	23.04%	0.89%
Date of Service	99.11%	0.22%	0.67%
Place of Service	70.02%	25.73%	4.25%
Provider Type	90.6%	6.94%	2.46%
Units of Service	94.63%	4.47%	0.89%
Clinical Note Matches Procedure	58.61%	40.04%	1.34%
Author Identified	99.33%	0.67%	0.0%

Qualis Health reviewed both demographic and encounter data for slightly more than 411 encounters in approximately 100 unique client clinical records throughout the state of Washington for the WISe enrollees. The demographic data included the enrollee's last name, first name, Social Security Number, date of birth, gender, whether they are of Hispanic origin, race/ethnicity, preferred language, and sexual orientation. The state typically reached the 95 percent match rate on first name, last name, gender, and date of birth. The most common elements that did not reach 95 percent were race/ethnicity, Hispanic origin, preferred language, Social Security Number and sexual orientation.

For each of the encounters, the following data fields were reviewed: procedure code, service date, service minutes, service location, agency, provider type, and whether the service code agreed with the treatment described. The field for service code agrees with treatment described received the highest rate of mismatch within the Qualis Health review with not meeting the 95 percent standard as it only received a 58.6% match rate. Other elements that did not meet the 95% match rate were place of service (70.0% match), procedure code (76.1% match), and provider type (90.6% match).

There were also a variety of issues related to encounters found within the clinical onsite review. Examples of errors included:

Coding errors

- submitting codes that did not meet SERI, WAC, or contract requirements
- submitting improper codes for while an individual is in a 24/7 facility
- submitting the incorrect codes for the services provided
- missing WISe encounters due to staff submitting codes without required U8 modifier because of lack of WISe training

Documentation concerns

- submitting encounters without clinical documentation, supporting documentation, and/or evidence of medical necessity
- submitting encounters without the required elements

Provider type errors

- submitting the incorrect provider type for the staff who provided the service
- not signing credentials on progress notes

Duration errors

- submitting services that are incorrectly bundled

- submitting excessive durations for reported services

Submitting services that are not eligible for submission to the State

- submitting two services at the same time with two clinicians, such as attending a medical appointment with the client at the same clinic with both the prescriber and the clinician encountering
- submitting services without supporting documentation
- submitting encounters for no-shows, no-contacts, or enrollees not at home
- submitting encounters for internal consultations and staffing
- submitting encounters for administrative tasks
- submitting encounters for transportation, helping with homework, and other events with no documented therapeutic intervention and medical necessity

Recommendations

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

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

Many BHOs are submitting coding errors to ProviderOne. The State reported that ProviderOne does not contain any edits to reject any codes and therefore accepts all codes whether they are submitted correctly or not.

- DBHR needs to have processes in place in which ProviderOne create edits to reject encounters that are submitted incorrectly to the State.
- DBHR needs to have a process in place in which ProviderOne flags encounters that are excessive in duration

While onsite, providers reported that there was a lack of WISe training throughout the state; therefore WISe services were not always submitted with the U8 modifier.

- DBHR needs to create regular WISe trainings offered throughout the state to ensure all WISe services are able to be captured.

WISe Quality Service Review (QSR)

The WISe Quality Service Review (QSR) was designed to assess the quality of the interaction between the behavioral health provider's WISe teams and the youth and families in setting goals for and achieving wellness. Specifically, the review was intended to help identify practices associated with high-quality, effective care coordination and behavioral health treatment. DBHR selected the three provider agencies as well as the WISe clinical records at each of those agencies for review. The review followed the directions outlined in the *Washington State Quality Service Review Manual for the Data Collection and Rating Protocol.*

The review utilized three primary data sources to identify effective practices:

- Child and Adolescent Needs and Strengths (CANS) assessments
- File review data on day-to-day treatment and care coordination practices
- Multi-level stakeholder interview data on individual and organizational supports for effective care

CANS data are captured electronically in the Behavioral Health Assessment System (BHAS) electronic record system. Protocols for attaching these data were included in the above-referenced manual. The clinical record review consisted of obtaining data by careful rating of individual encounter notes in a child or youth's file, using the first six months of progress notes provided by the treating mental health practitioner, and all notes provided by the care coordinator and the psychiatrist or other psychotropic medication provider. The use of the six-month timeframe for review of the mental health practitioner's notes was designed to parallel the timeframe of the data analysis used to generate estimates of treatment effects at participating sites. Multi-level stakeholder data were obtained through surveys and discussion group facilitation with the administrators and WISe staff at each of the three agencies. The following content describes impressions resulting from each component of the record review.

Behavioral Health Assessment System (BHAS) Treatment Review Inventory

This section of the review applied the CANS, Reassessments/Assessment Updates, and Discharge Assessments to assess whether or not youth met the WISe algorithm to enter WISe services, the timeliness of referrals, and the timeliness of the full assessment following the CANS screening. Each item below was defined as follows:

Item 1. **Use of Standardized, Science-Based Access Determination Protocol**
This item assessed whether or not the individual met the WISe algorithm to enter WISe services. The majority of the individuals reviewed met the algorithm; however, some individuals in the WISe program did not meet the WISe algorithm.

Item 2. Timely Access Determination
This item assessed how many days passed between the date the provider was contacted by the referral source and the date the CANS assessment was completed. The date the assessment was completed varied by provider as there were reported concerns with entering in data and dates auto filling to the data entry date. If there was a lag in time between assessment completion date and the date of the data entry, then the assessment completion date would reportedly autofill to the date of the data entry.

Item 3. Timely Start to, and Completion of, Assessment

This item assessed how many days lapsed between the CANS screening and the full CANS assessment. Providers experienced the same date concerns as with item 2.

The information in the BHAS report was intended for scoring the BHAS treatment review inventory; however, providers reported complications related to entering the data, resulting in misreported dates. This complication skewed the timelines under review and rendered other sections of the review less representative of what actually occurred in each individual case. WISe providers reported not using the reports in the BHAS system because of lack of accuracy in the reports, specifically resulting from the inability to change invalid or incorrect information, such as dates. If the BHAS system allowed changes and corrections, it would benefit providers as well as the State's efforts to monitor the effectiveness of the WISe program.

Therapy Collaborative Process Data

For this portion of the review applied two quality measures for therapist notes. The first quality measure, using the Therapist Treatment Practices Summary, assessed the treatment planning and selection process during the first 60 days of therapy.

The second quality measure, using the Therapist Treatment Quality Elements form, was a review of all face-to-face treatment-related encounters during the first six months of treatment to better understand what treatment practices were used.

The following describes the components included in the Therapy Collaborative Process.

Therapist Treatment Practices Summary

These items assessed the first 60 days of progress notes completed by the treating mental health practitioner.

Item 1. Clear Correspondence between Primary Diagnosis and CANS Ratings

For the majority of charts reviewed, there was a logical correspondence between the primary diagnosis and the CANS rating. When clinicians did not complete the CANS with the individual, however, this was not always the case. A number of charts indicated that care coordinators completed the CANS assessment. This may have contributed to the discrepancies in the CANS ratings. Staff completing the CANS need to be continuously trained on how to administer the CANS and should be refreshed regularly on diagnostic criteria. When the assessment is performed correctly, there should be logical correspondence between the primary diagnosis and the CANS rating.

Item 2. Clear Correspondence Between Standardized (CANS) Ratings and Therapy Treatment Priorities

The review revealed a number of concerns relating to the correspondence between the CANS ratings and the therapy treatment priorities. The majority of treatment plans did not address all elements identified in the CANS, nor did most treatment plans contain goals and objectives specific to treatment-related items. Many clinical records did not include treatment plans at all, and documentation of therapy services did not always evidence clinical interventions supporting treatment priorities. In many cases, the comprehensive care plan was considered the treatment plan. Additionally, the comprehensive care plans were frequently created by care coordinators, most of whom did not have adequate credentials to create the treatment plan for the mental health practitioner. The majority of these comprehensive care plans did not contain therapeutic elements.

In order to be a good quality metric, the CANS should be completed by the therapist/mental health professional, and treatment plans should be created by the treating mental health professional and address all of the needs identified in the CANS.

Item 3. Goals Include both Strength Development and Need Amelioration
All of the information required to assess this item should have been obtainable from the Initial Treatment Plan and the Initial CANS assessment. However, these sources did not always provide the required information. Many charts did not contain a strength development goal, were not written in measureable terms, and did not address a behavioral emotional need identified with the CANS rating. Creating effective treatment plans was identified as an opportunity for improvement for all WISe provider sites. To improve the effectiveness of this item as a quality metric, the State should provide treatment plan training for clinicians.

Item 4. Caregiver and Youth Understand Treatments and their Relationship to Goals
The intent of this item was to capture whether or not the therapist's documentation included evidence of conversations with family/youth about the major psychiatric syndromes identified as needing treatment, associated risk behaviors or functional impairment, and how treatment will address these symptoms and impairments. Documentation of the provided services should demonstrate the extent to which the therapist created a climate in which the youth and family understood how the assessment's findings lead to treatment, and how the suggested treatment(s) could help them reach the health and well-being goals important to the youth. Evidence of this item should highlight how the interaction occurred, and how it facilitated the asking and answering of questions about needs and treatment, ultimately leading to a shared understanding of how to move forward. The majority of documentation reviewed did not indicate this interaction occurred between the therapist and the youth/caregiver. Many charts included generic statements without specific details pertaining to the individual, or documentation of conversions with another WISe team member, such as the care coordinator.

This review area could serve as a good measure of quality if the State provides training on how documentation in service notes should support quality services, which includes the extent to which the therapist created a climate in which the youth and family understood how the assessment's findings lead to treatment, and how the suggested treatment(s) could help the family reach the health and well-being goals important to the youth.

Therapist Treatment Quality Elements

The Therapist Treatment Quality Elements form is a session-by-session review of all treatment-related encounters. Case management and scheduling activities are explicitly excluded. Reviewed elements included the encounter date, total hours of face-to-face contact with the youth or caregiver during a given session, whether or not the session was a Child and Family Team meeting, and whether the focus of the session was the same as for the previous session.

Each structural element, youth practice element, and caregiver practice element was scored using a 0–3 scale. Zero indicated there was no evidence that this element occurred within the documentation of the service. One indicated that the term was used within the documentation but that there was no evidence of action or interaction occurring. Two indicated the action was described within the documentation of the service, and three indicated that there was clear interaction described within the documentation. The review included whether or not the clinical chart included documentation of the following structural

elements: psychoeducation, use of an evidence-based practice, new skills training, skill review or adaptation, new skill use, skill generalization, homework assignment, enlisting of treatment supporters, or transition or maintenance planning.

Each therapy note was also specifically reviewed on whether or not the documentation indicated progress specific to a goal or behavior, whether success was clearly celebrated, and whether the youth was present in the session. If the youth was present in the session, youth practice elements were reviewed for being present in the encounter and included identifying triggers, functional analysis of behavior, cognitive restructuring, communication skill training/practice, evoking greater commitment to change, evoking greater desire to change, positive activity scheduling, reflective listening, relapse prevention planning, relaxation training, structured problem solving, self-verbalization, and other practices.

The last therapy element scored on the 0–3 scale indicated whether or not the caregiver was present. If the caregiver was present, the following caregiver practice elements were identified for whether or not they were included in the encounter: using clear commands, differential reinforcement, identifying triggers, increasing monitoring, limiting exposure, praising desired behaviors, providing clear rewards, role psychoeducation, reducing conflict, time out/privilege loss, other clearly identifiable practice element (intervention) used.

Last, each documented therapy service encounter was reviewed to identify whether any contextual treatment supporters were enlisted during the service. This list included coach, child welfare worker, educator, employer, faith community representative, extended family, peer partner, parent partner, physician/ psychiatrist, probation officer, substance use counselor, and/or other supporters. The option to check “none other enlisted” was also present.

Overall Therapist Treatment Quality Element

An overall theme resulting from the review of therapist treatment quality elements was a lack of quality documentation to support the provided treatment. This is not unique to the WISe program and has been an issue identified statewide. Documentation often tends to lack evidence of clinical interventions and key elements to support the service being provided. Much of the documentation reviewed consisted of a narrative of the individual’s dialogue and did not contain any information about what service the clinician provided, the individual’s response to the intervention, an assessment of the individual, whether or not there was homework, and whether there was any progress toward the identified goals. Training on how to document encounterable services using the quality elements would increase the likelihood that the therapist treatment practice elements would improve this item as a quality measure.

Care Coordination Collaborative Process Data

For this section of the review, two quality items were assessed to understand the care coordinators’ collaborative process and how well this process reflects a collaborative empowerment for the child/youth and her/his family: The Care Coordinator Practice Summary and the Care Coordination Quality Elements.

Care Coordinator Practice Summary

The primary source of documentation reviewed in the care coordinator practice summary was the set of case notes leading up to formal Child and Family Team meetings until the date of the review or discharge from the WISe program. Other documents relevant to these initial weeks of engagement were also reviewed in order to understand how the initial collaboration resulted in the initial stabilization of any crises and the development of a set of shared goals. Following are the items included in this section.

Item 1. Timely Contact from (Action on) Referral
The intent of this item was to identify whether the care coordinator contacted the individual within 24 hours of the CANS screener completion date. The CANS screener completion date was obtained from the BHAS report, and the date of first contact was identified from progress notes.

Item 2. Evidence of Rapid Outreach/Engagement
This item was assessed to capture the care coordinator's efforts at engaging multiple key persons involved with the individual within seven days or fewer in order to build rapport and begin identifying goals. This item was rated on the 0–3 scale. Zero indicated that there were attempts and discussions with at least two key persons within seven days. One indicated that there were attempts and discussion with only one key person. Two indicated that attempts were made but the care coordinator was unable to reach and discuss with at least one key person within seven days. Three indicated there was a single or no attempt and that no discussion occurred with anyone.

Although this item partly reflected how well care coordinators were attempting to reach out to and engage with potential treatment supporters, the full score was dependent upon whether the other party returned the contact or actively engaged. Therefore, if a care coordinator was active in attempting to contact individuals but did not receive a response within seven days, the care coordinator's efforts would not be fully credited.

Item 3. Evidence of Effective Outreach (Choice of Time and Place, Attendance Barriers Identified and Addressed)
This item reviewed for evidence that the care coordinator contacted the youth/caregiver to discuss any concerns and barriers that could interfere with rapidly obtaining WISe services and that the care coordinator also met with the youth/caregiver face to face. This item was also rated on a 0–3 scale. Zero indicated that supports were offered and accepted and that there were three face-to-face meetings with the care coordinator within 30 days of the two face-to-face meetings with the care coordinator within 30 days of the completion of the screener. Two indicated that limited supports were offered and/or only one meeting occurred within the first 30 days of the completion of the screener. Three indicated no meetings occurred within the first 30 days.

Given the multiple factors affecting scoring, this section was difficult to accurately score. For example, three face-to-face meetings may have occurred, but documentation may not have indicated that barriers were discussed and supports were offered and accepted. Documentation did not always indicate specific barriers or whether there was interaction between the care coordinator and the youth/caregiver in identifying needed supports. Separating these items in the review might assist in determining whether face-to-face meetings are occurring and whether barriers and supports are being offered.

Item 4. Psychoeducation on Service Process Provided (Timelines, Expected Duration, Team Approach, Caregiver and Youth Direction of Treatment)
This item was intended to review whether or not the care coordinator was engaging the youth/caregivers in a discussion about WISe services within the first two meetings. This item was scored on a 0–3 scale based on the evidence within progress notes. Zero indicated that WISe services were described, literature provided, questions evoked and answered and that the youth/caregivers made an informed choice about proceeding with the service. One indicated that a discussion of the content of WISe services had taken place, but that some indication was present that this did not happen immediately. Two indicated a limited discussion had taken place or that either the caregiver or youth still had questions about WISe. Three indicated that no discussion of WISe services had occurred, or that the coordinator

was reluctant to provide important details about WISe services. Individual charts indicated that on occasion, care coordinators either failed to document the interaction or provided generic documentation indicating WISe discussion had occurred but that was not unique to the individual. Documentation typically did not include any questions or responses from the individual or caregiver, suggesting the choice to proceed with services was implied. Providing training to care coordinators about how to document services so that all provided services and interactions are captured within the clinical record would improve this item as a quality measure.

Item 5. Strengths Discovery Included in Initial Assessment

This item was intended to validate that all family members' strengths and culture were discussed and integrated into the formulation of the child's support needs and strengths in the CANS. This item was scored with the 0–3 rating using progress notes. Zero indicated that all family members' strengths and culture were discussed and integrated into the formulation of the child's support needs and strengths in the CANS. One indicated that the child and at least one primary caregiver's strengths and culture were discussed and integrated. Two indicated that only the child's strengths and culture were discussed and integrated into the assessment. Three indicated that no discussion or integration of strengths and culture occurred.

This item essentially requires the reviewer to assess two separate elements and score them as one. Many charts contained strengths and cultural elements for the youth but did not contain documentation indicating that there was discussion about the strengths or cultural element or that they were incorporated into the initial CANS assessment. Scoring the two elements separately would allow the reviewer to award credit to the coordinator for having the conversation with the youth, caregiver, and/or family about strengths and/or culture and also give credit for documentation stating that the strength and cultural element were incorporated into the assessment.

Item 6. Caregiver/Youth Reviewed Initial CANS Assessment, Feedback Incorporated into Final Version

This item reviewed whether or not the family reviewed the final CANS assessment, gave feedback about the assessment, and whether changes were incorporated into the final version. This item was scored on a 0–3 scale. Zero indicated evidence of iterative review and feedback integration throughout the assessment process. One indicated evidence of one review and feedback integration cycle. Two indicated evidence that a review occurred, but that incorporation of suggested changes was incomplete or did not occur. Three indicated no documented evidence was ever formally reviewed with the caregiver/ youth.

This item also revealed issues regarding documentation of services. Reviewed charts typically did not contain documentation supporting that the assessment was formally reviewed or that any feedback was received and incorporated. Again, training coordinators to accurately document the services provided would improve this item as a quality measure.

Item 7. Clear Correspondence Between Standardized (CANS) Ratings and Cross-System Care Plan Goals

For this item, the reviewer looked for evidence relating to three items. Item one was whether or not risk behavior items that were rated a "3" on the CANS were addressed in the treatment plan and the crisis plan. Item two was whether or not appropriate treatment providers were enlisted based on the CANS behavioral/emotional needs. Item three reviewed whether or not stakeholders had input in the treatment plan.

Reviewers located these items easily within the documentation and were sound indicators of quality given the purpose of the WISe program is to incorporate a multitude of stakeholders into the treatment of the youth and family.

Item 8. Goals Include both Strength Development and Need Amelioration
For this item, the reviewer again looked for evidence relating to three items. Item one was whether there were five treatment goals or fewer. Item two was whether or not there was at least one strength-based goal. Item three was whether or not all goals were defined in measurable terms.

These items have the potential to reflect quality services; however, training on appropriate and functional treatment planning needs to occur. The review indicated that treatment planning, including cross system care planning, indicated a need and an opportunity for improvement within this area.

Item 9. **Caregiver/Youth's Language Reflected in Cross-System Care Plan Goals**
This item was intended to ensure that the cross-system care plan was written in lay language and not in technical/professional language. This item was scored on the 0–3 scale. Zero indicated that all goals were written in lay language and described in terms offered by the family. One indicated that one goal reflected. Two indicated that two or more goals used technical/professional language. Three indicated that the goals were written entirely using technical/professional language.

This item is a good indicator of quality and should be reviewed. How well a treatment plan functions depends upon whether or not the youth, caregiver and/or family can understand the goals and the roadmap toward recovery.

Item 10. Timely Initial Cross-System Care (Treatment) Plan (As Evidenced by Caregiver and Youth Sign-off Date)
This item gauges the extent to which the cross-system care plan is completed in a timely fashion as evidenced by the caregiver and youth signature. This item is a sound indicator of quality and should be continued to be reviewed.

Item 11. Immediate Safety Needs Addressed
This item reviewed whether a crisis plan was completed within the first 45 days of initial contact and if there is supporting documentation that a copy was given to the caregiver and/or youth. This item should continue to be reviewed to ensure quality of services with this high-risk population.

Care Coordination Quality Elements

The ratings in this section are designed to give a clear sense of the content and outcomes of Child and Family Team meetings. The focus is on the processes of goal identification, identifying support for completing the tasks associated with goal completion, and the extent to which the task completion actually occurs. Several items were rated.

Item 1. Indicate total hours of face-to-face contact with child / youth or caregiver recorded in progress notes since last Child and Family Team meeting. Include time spent in this Child and Family Team meeting. Exclude all other activities, including travel, call, and documentation time.
The intent of this item is to search for evidence of the quantity of face-to-face time spent in direct interaction with the youth and/or caregivers. This item should be continued to be reviewed for quality and utilization.

Item 2. Content of the Meeting
This item rated whether the progress note indicated evidence of the use of one or more of the following elements: addressing a crisis, establishing goals, coordinating supports, celebrating success, and transition planning. The presence of one or more of these terms in the progress note was scored with the same scale as the therapy notes using a 0–3 scale. Zero indicated no evidence. One indicated the element/term was used. Two indicated the action was described, and three indicated collaboration was described.

These elements are crucial in determining the quality of the Child and Family Team meetings and also rely upon adequate quality documentation of the meetings. In some WISe programs reviewed, documentation stated "see cross-system care plan" for the documentation of the service without describing interactions, celebrations, planning, completion of goals, and other important aspects of the meeting. If training and guidance about the documentation of this service was given, this would be a stronger element to review for quality.

Item 3. Same Goals As Last Meeting?
This item prompted the reviewer to indicate whether or not the same goals were present as in the previous meeting. This element should continue to be reviewed as a quality element as goals on the plan should be completed and new ones created if needed.

Item 4a. Reviewed Last Child and Family Team Meeting's Goals?
This item prompted the reviewer to indicate whether there was evidence that the last Child and Family Team meeting's goals had been reviewed. This item should continue to be reviewed as a quality element as all goals from the prior meeting should be followed up on and documented. This element does rely upon documentation within the chart to indicate that this activity occurred. As indicated in other sections of this review, documentation training would strengthen and more accurately describe the services provided.

Item 4b. Reviewed Last Meeting's Tasks?
This item prompted the reviewer to indicate whether there was evidence that the last meeting's tasks were reviewed. This item should continue to be reviewed as a quality element as all tasks from the prior meeting should be followed up on and documented. This element does rely upon documentation within the chart to indicate that this activity occurred. As indicated in other sections of this review, documentation training would strengthen and more accurately describe the services provided.

Item 5. Follow-through
This item indicates whether or not the reviewer found evidence that all team members followed through and completed their tasks. There were three options in scoring this item: everyone completed their task, people in one context did not follow through with their tasks, and people in more than one context did not follow through with their tasks. This item builds upon item 4b in reviewing the tasks. This item should continue to be reviewed as a quality element as all tasks from the prior meeting should be followed up on and documented, and the barriers to completing those tasks should be identified. This element does rely upon documentation within the chart to indicate that this activity occurred. As indicated in other sections of this review, documentation training would strengthen and more accurately describe the services provided.

Item 6. **If Someone Did Not Follow Through on Their Tasks, in What Contexts Were They Supposed to Have Provided Support?**

This item only applies if everyone did not complete their tasks. Three contexts were provided: home, school, and community. This item should continue to be reviewed for quality as this would assist in identifying in which context of the child's life follow-through did not occur.

Item 7. **Settings Actively Needing Support**
This item featured four settings: home, school, community, and other. This item should continue to be reviewed for quality as this information would assist in identifying trends and potential contexts to engage and enlist as treatment supports, although the context community encompasses a large variety and could be difficult to narrow down. More options may be beneficial to understanding settings.

Item 8. **Attendees**
This item prompted the reviewer to note who attended the Child and Family Team meeting. The list of potential treatment supports and professionals included youth, caregiver, care coordinator, therapist, child welfare worker, coach, educator, employer, extended family, faith community representative, parent partner, peer partner, physician/psychiatrist, probation officer, substance use counselor, and other. This item should continue to be reviewed with every Child and Family Team meeting to ensure consistency of the attendees supporting the treatment.

Item 9. Attendees Enlisted to Help Youth Meet Goals
This item reviews the same attendee list in Item 8 in order to indicate who was enlisted to help the youth meet their goals by assigning a task to that individual. This item should continue to be reviewed as a quality element.

Item 10. Has a Crisis Occurred Since the Last Child and Family Team Meeting?
For this item, the reviewer looked for evidence within the documentation in the progress notes of whether a crisis occurred in between any Child and Family Team meetings. This element depends upon accurate documentation and a solid definition of what constitutes a crisis. This element allows a reviewer to indicate at the next Child and Family Team meeting and whether or not the crisis was addressed. This element should continue to be included as a quality review element.

Following a review of all the Child and Family Team meetings the review continued look for evidence of more practice summary elements.

Item 12. Service Duration
This item prompted the reviewer to indicate whether or not the individual had been in services for more than 12 months.

Item 13. Completed Transition Plan
This item was intended to review for evidence that a transition plan was discussed and completed with all formal service providers, natural supports, family and the youth prior to completion of the WISe program. This item was rated on a 0–3 scale. Zero indicated that a plan was completed and reflected input from formal service providers, natural supports, family and youth. One indicated that a plan was completed with input from family and youth or formal service providers, but not both. Two indicated that a plan was present but did not appear to be individualized to the family's current supports and needs. Three indicated that there was no plan in the file. This item is crucial for the success of individuals served and should continue to be reviewed as a quality element.

Item 14. **Updated Crisis Plan**

The intent of reviewing this element is to ensure that prior to completion of the WISe program the individual's crisis plan was updated. This item should continue to be reviewed as a quality element.

Item 15. Service Transition
This intent of this element is to look for evidence that the youth was discharged or exited from WISe services. It is unclear how this element indicates quality and appears to be a marker for the next review item.

Item 16. **Post-transition Follow-up and Supports Monitoring**
For this item, the reviewer looks for evidence of whether or not the care coordinator checked in with the client after discharge and the extent of this follow-up. The item was rated on a 0–3 scale, with zero indicating evidence of both post-care follow-up and maintenance of the youth's treatment gains, and three indicating no post-care follow-up and evidence of the youth's symptoms and/or functioning worsening. It is unclear how a score of three would occur and how the coordinator would gather the information that the youth was worsening without post-care follow-up at a minimal level. The scale may need to be reviewed for accuracy. Evidence that this service occurred will depend upon the quality of documentation within the progress notes. As indicated in other areas, this is an identified area for opportunities for improvement to better indicate the quality of services provided.

Psychiatric Intervention: Necessity Questionnaire

This review element was designed to identify whether or not there is clear evidence within the chart for psychiatric services as indicated on the CANS assessment. The following items were assessed.

Item 1. Is the child/youth taking psychotropic medication upon entering WISe Services?

Item 2. If yes, for which condition(s) does the initial assessment indicate that the child/youth is currently taking a psychiatric medication? The choices included psychotic symptoms, mood disorders, anxiety, ADHD, or other mental health concern.

Item 3. What is the CANS initial assessment rating for this item?

Item 4. Determination of need for psychiatric evaluation based on the scores that are a two or a three on psychosis, attention impulse, mood disturbance, and anxiety items on the CANS.

Item 5. Provision of psychiatric evaluation and access to psychotropic medication indicated by an assessment and prescription within 30 days of CANS assessment, if needed.

All of these elements should continue to be reviewed as quality elements, as it is important to be able to access appropriate resources when they are clinically indicated and available.

Psychiatrist Intervention: Quality Elements

The following items were reviewed to provide a sense of the extent to which psychiatric services were experienced as collaborative and effective. If the youth was on medication while in WISe services, the reviewer was to find evidence, if possible, of all the medications the individual was taking and what the medication was addressing. Items reviewed included:

Item 1a. Need/syndrome being addressed

Item 1b. Is medication a first-line treatment for this condition?

Item 2a. Credential for providing psychotropic medication (board-certified ARNPs or MDs)

Item 2b. If not board-eligible in psychiatry, dates of monthly consultation with psychiatrist

Item 3. Name and purpose of medication understood by client and caregiver

Item 4. Treatment side effects understood by client/caregiver

Item 5. Dosage, frequency, method of administration documented and understood by client/caregiver

Item 6a. Documentation of whether laboratory monitoring is required

Item 6b. If required, schedule of monitoring listed

Item 7. Reviewed for effects, positive, negative, or side effects at least every three months

Item 8. Documentation of reasons provided to caregiver and youth for stopping/changing medications

Item 9. Child taking multiple prescription medications simultaneously to address behavioral/emotional needs

As for other review elements, this element depends upon quality documentation of the prescribing clinician. Many prescribers documented that there was a review of effects, positive and negative, or side effects, every three months, with the review being unique to the individual. Documentation of reasons for stopping and starting medications was also individualized. However, other types of documentation consisted of generic statements found in all progress notes from that prescriber. This element should be continued to be reviewed, as many youth are prescribed a concerning amount of medications for a variety of reasons; these should be reviewed for appropriateness.

Provider Interviews

As part of the WISe review process, all WISe staff at the three provider agencies chosen for the clinical record reviews were invited to participate in an interview. The Qualis Health reviewers requested that all the WISe staff be present to answer questions, including the administrators. Questions covered the BHAS, CANS, and start-up processes. Reviewers requested that the WISe staff come to consensus on each answer and rate their answer. Throughout this process, there was evidence that the staff were answering the questions by rationalizing the scoring criteria to agree with their answers in order to obtain high scores. For example, if the criteria for obtaining a high score depended on using the BHAS reports and the site didn't use the BHAS reports but used internal reports, Staff would state that they fully met this element. This continued at all three agencies, even with clarifications and prompts. From the reviewer perspective, this process did not appear to capture the elements intended.

WISe staff indicated that because the questions primarily pertained to BHAS, CANS, and the startup processes, the interview process did not capture and highlight the quality of work and services their teams were providing to the WISe population.

Overall Impressions

Several themes emerged as a result of the WISe reviews that appeared to be affecting the quality of services reviewed. One of these themes was the quality of documentation and the lack of accurate reporting of the services and interaction provided. Because documentation lacked clinical interventions and key elements, evidence of the quality work these WISe teams were providing was difficult to find. More training on documentation standards would benefit the WISe programs and make quality elements more evident.

The second theme was treatment planning. There was evidence of confusion regarding what constitutes a treatment plan and who can create one. Some WISe sites stated that their cross-system care plan was the treatment plan, but these plans were not always created by a mental health professional and/or did not contain therapeutic interventions and goals. Additionally, the treatment plans did not always contain strength-based goals or measureable objectives. Training on creating a functional treatment plan would help make correlations between CANS and provided services evident.

A third theme was the appearance of a missing element within the review. Although peer and parent partners play a crucial role within the WISe program, they were not a part of this review. It would benefit a quality review to examine all aspects of the program for the quality services they provide to youth and their families.

Information Systems Capabilities Assessment Follow-up

The ISCA evaluates the ability of information systems to accurately and reliably produce performance measure data, encounter data, and reports to assist with management of the care provided to enrollees. The 2016 EQR consisted of a follow-up of recommendations and opportunities for improvement issued to each BHO (formerly RSN) as a result of the 2015 ISCA. Table B-13 displays the recommendations to DBHR resulting from this review and the State's responses to those recommendations.

Table B-13: Review of DBHR Responses to 2015 EQR ISCA Recommendations

Prior-Year Recommendations	DBHR Response	EQRO Response
Section A: Information Systems (This section assessed the RSN's information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.)		
DBHR needs to develop, adopt and implement a quality strategy that the RSNs understand and support.	The State has appointed a new DBHR Quality Administrator. This person's primary focus regarding the EQR activities for 2016 will be the development of the shared DBHR/HCA Quality Strategy.	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.
Section B: Hardware Systems (This section assessed the RSN's hardware systems and network infrastructure.)		
DBHR needs to explore ways to facilitate training and recruitment of mental health clinicians to meet Medicaid enrollees' access needs.	DBHR is currently participating in the SAMHSA multi-state workgroup focusing on workforce training and development for mental health and SUD.	The EQRO considers this response appropriate.
Section C: Information Security (This section assessed the security of the RSN's information systems.)		
DBHR needs to provide clear direction and technical assistance for the RSNs as they implement the Children's Mental Health System Principles.	DBHR has included implementation of the Children's Mental Health Principles as a core component within the WISe training.	The EQRO considers this action responsive.
DBHR needs to continue to update the WISe manual and program expectations.	In FY 2015, the manual was updated on a quarterly basis. It will continue to be updated on an annual basis using an inclusive stakeholder process.	The EQRO considers this response appropriate.
DBHR needs to work with RSNs to • develop strategies to strengthen participation of allied partners in implementing the WISe program • continue community	• DBHR has contracted with the Workforce Collaborative to provide technical assistance to our interagency governance structure, including the engagement of our system partners, youth and families.	The EQRO considers this response appropriate.

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	• DBHR developed WISe information sheets specific to system partners (internal/external) as to their role and involvement in WISe. We have also provided local trainings to system partners in person and via online formats. Community trainings have been provided as new communities begin implementing WISe and as requested. • DBHR asked that WISe capacity be addressed in the BHO Detailed Plan Process. • DBHR has inserted language into the RSN contract and upcoming BHO contracts that set capacity building expectations. In conjunction, the RSN/BHO is required to report quarterly on progress and action steps in meeting the capacity expectations and reporting requirements.	
Section D: Medical Services Data (This section assessed the RSN's ability to capture and report accurate medical services data.)		
DBHR needs to ensure that all RSNs and their contracted providers maintain and observe policies and procedures on the use of seclusion and restraint, as well as de-escalation practices.	DBHR will review BHO policies and procedures on seclusion and restraint. Note: Evaluation and Treatment (E&T) providers are required via licensure and certification to have policies and procedures on seclusion and restraint. DBHR reviews these procedures prior to issuing E&T certifications.	The EQRO considers this action responsive.
DBHR needs to ensure that all RSNs consistently monitor requests at the provider agencies for translation or interpreter services and for written information in alternative formats.	DBHR will ensure that the BHO contracts include language that the BHO monitors requests for translation services.	The EQRO considers this action responsive.
Section E: Enrollment Data (This section assessed the RSN's ability to capture and report accurate Medicaid enrollment data.)		
DBHR needs to require the	DBHR is currently analyzing a	The EQRO considers this action

RSNs to report only units of service, or DSHS needs to modify ProviderOne to accept minutes of service.	data set that has been exported from ProviderOne. DBHR is examining which CPT and CPC codes create significant conversion errors.	responsive and recommends DBHR continue to examine which CPT and CPC codes create significant conversion errors.

Review of Previous-Year EQR Recommendations

Required external quality review activities include a review of the applicable state organization's responses to previously issued EQR recommendations. The table below displays Qualis Health's 2014 and 2015 recommendations to DBHR and the State's responses to those recommendations.

Table B-14: Review of DBHR Responses to 2014–2015 EQR Recommendations

Prior-Year Recommendation	DBHR Response	EQRO Response
Coordination of Care		
DBHR needs to work with the RSNs to ensure the provider agencies are providing coordination of services and documenting the coordination of services in the clinical records.	DBHR will add this requirement to its PIHP contract in the next amendment (7/1/17). DBHR will also work with BHOs at the Quality Leads meetings to ensure this information is disseminated.	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.
Coverage and Authorization of Services		
DBHR needs to ensure that RSNs are able to demonstrate the use of mechanisms for monitoring the inter-rater reliability of clinical staff who make authorization decisions.	DBHR will add this requirement to its PIHP contract in the next amendment (7/1/17).	The EQRO considers this response appropriate. Resolved.
DBHR needs to encourage and work with the RSNs to explore and implement various options for recruiting clinical staff. RSN options might include paying for relocation expenses, advertising in other states and providing for tuition reimbursements.	DBHR has continued to be a part of the SAMHSA multi-state workgroup focusing on recruiting clinical staff.	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.
Subcontractual Relationships		
DBHR needs to ensure all the RSNs are fully identifying the specific nature and conditions of corrective action plans and that the corrective action plans include references to the specific related CFR, WAC or contract citations.	DBHR will send out a guidance memo regarding the importance of including CFR/WAC and/or contract language when writing CAPs.	The EQRO considers this response appropriate. Resolved.
DBHR needs to work with the RSNs to implement procedures and possible incentives/disincentives to the	DBHR will send out a guidance memo regarding BHOs following up with CAPs of their contractors. We cannot ensure BHOs follow	The EQRO considers this response appropriate. Resolved

provider agencies, to ensure that the conditions of corrective action plans are being met.	up with CAPs, but can provide guidance. DBHR does not have a direct contractual relationship with providers. This responsibility has been delegated to the BHOs. DBHR understands that in some areas ensuring follow-through on CAPs could jeopardize network adequacy.	
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.	This has been done. Significant changes have been made to grievance monitoring at the DBHR level. All grievance policies and procedures have been reviewed by DBHR and many have been revised. As a result, reporting of grievances has also increased. Ln addition, all BHOs will be participating in a Grievance Learning Collaborative starting in January 2017 as part of DBHR's commitment to continuous quality improvement.	Resolved.
Practice Guidelines		
DBHR needs to ensure the RSNs' practice guidelines are meeting the needs of the enrollee populations, that the RSNs are implementing the appropriate practice guidelines in the care and treatment of enrollees and that the RSNs have a process in place whereby the practice guidelines are used to help make decisions regarding utilization management, enrollee education opportunities and coverage of services.	DBHR plans to add this item to our contract monitoring matrix as a high priority for contract monitoring in early 2017.	The EQRO considers this action appropriate. Resolved.
QAPI		
DBHR needs to ensure RSNs develop appropriate policies and procedures and level of care criteria for identifying, monitoring and detecting underutilization and overutilization of services. In addition, DBHR needs to ensure RSN current levels of care	Although the contract does not require levels of care, DBHR does require in the BHO contract that BHOs look at under and over utilization. DBHR will add this item to the DBHR quality improvement committee to focus on in 2017.	The EQRO considers these actions appropriate. Resolved.

systems support an expected service level intensity within each level of care	In addition, DBHR will do a policy and procedure review and have the BHO quality leads discuss in 2017. Utilization management is required by contract in sections 6.12.2. and 9.3. DBHR will ask the BHOs for their utilization management plans in order to review their methodologies for determining over- and under-utilization, and how they operationalize utilization management.	
DBHR needs to ensure the RSNs are reviewing, updating and approving policies and procedures at least yearly to be certain the policies and procedures are in accordance with current best practices, terminology and references to contract language, WACs and CFRs.	RSNs were required to submit updated policies and procedures to DBHR for review when responding to the Detailed Plan in an effort become BHOs. In addition, DBHR issues regular reminders at the quality leads meetings that policies and procedures need to be completed and updated regularly.	The EQRO considers this response appropriate. Resolved.
To be in compliance with the CFR, the State must develop, implement and distribute to the RSNs a quality plan.	DHBR continues to try to get feedback from the Health Care Authority because this is a joint quality strategy plan, and the Health Care Authority is the State Medicaid Authority.	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.
DBHR needs to continue to work with the RSNs to develop and implement reliable procedures for capturing all grievances and appeals, transfers and requests to change providers in order to analyze and integrate the information and use it to generate reports for making informed management decisions.	Please see prior section regarding the work and changes that DBHR has implemented. The grievance reports have been revamped, as have the instructions for completing the reports. Multiple conference calls discussing the intricacies of reporting grievances and appeals have been held, during which time BHO staff have been able to ask specific questions. Starting in 2017, this dialogue will continue as DBHR initiates the Grievance Learning	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.

	Collaborative.	
DBHR needs to ensure that all RSNs are evaluating the quality and appropriateness of care and services furnished to enrollees through the use of performance and quality benchmarks with valid, objective measures to assess their performance against those benchmarks.	DBHR interprets this section of CFR to include the required core performance measures, which includes Performance Improvement Projects (PIPs) and State-assigned Performance Measures. DBHR has been working to establish a more effective way to work with the BHOs to review study topics for new PIPs, of which there were several in 2016 due to the new contract requirement of an additional SUD PIP. DBHR has also been working with multiple stakeholders in the past two years to develop State-assigned performance measures that evaluate the quality and appropriateness of care and services furnished to enrollees. DBHR expects the baseline data to be ready shortly, and once that is received, DBHR will set benchmarks. The BHOs will then have objective measures to assess their performance against the benchmarks.	The EQRO considers this response appropriate. Resolved.
DBHR needs to work with the RSNs to ensure the RSNs' work plans are informative and summarize both ongoing activities as well as short-term activities and include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year.	The deliverable for QAPI work plans was removed from the BHO contracts. Does it need to be added back in? DBHR does work with the BHOs to ensure that they work to address EQR findings, and provide technical assistance in developing and completing corrective action plans. DBHR also receives and reviews roll-up reports of grievances from each BHO.	To ensure the BHOs' work plans are informative and summarize both ongoing activities as well as short-term activities and include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances and recommendations for the coming year, Qualis Health recommends DBHR include the work plans as a deliverable in the BHOs' contracts.
Performance Improvement Project Validation		

DBHR needs to • Develop a clear and systematic approach for approving PIPs that includes due dates for RSN submission, as well as DBHR's dates of review and approval of PIPs. • Ensure all DBHR reviewers have a full understanding of the EQRO PIP protocol so that only true performance improvement projects are approved. Create a communication plan for RSNs regarding timeline submission dates and the status of PIP submissions.	The PIP forms have been changed, making them easier to understand and complete. In addition, a PIP cover sheet was developed to help keep better track of each BHO's current PIPs. The PIP review process has also changed. A new study topic review form was developed, so BHOs submit this form to DBHR and Qualis Health, who perform a joint review of each new PIP to either approve the new PIP or provide ongoing technical assistance. A few of the BHOs have relied heavily this year on this process. Since only new PIPs were required to be submitted, this has simplified the process greatly.	The EQRO considers this response appropriate. Resolved.
Encounter Data Validation		
In order to improve the reliability of encounter data submitted to the State, DBHR needs to work with the RSNs to standardize data collection and analytical procedures for encounter data validation.	Qualis Health has provided technical assistance and DBHR has supported this endeavor.	The EQRO considers this response appropriate. Resolved.
DBHR needs to provide guidance to the RSNs as to how to bundle services correctly, review the numerous errors in encounter submission that were found in the clinical chart review, and revise the SERI to further clarify proper coding for clinicians and ensure the RSNs know and understand the content of the State contract and the SERI. DBHR may consider providing further training on both the contract and SERI to the RSNs.	DBHR needs more clarification as to the specific services being bundled, because only three state plan services are bundled in SERI.	Qualis Health will work with DBHR in clarifying the specific services being bundled.
DBHR needs to work with ProviderOne to create an	DBHR can check with P1 and review at the next joint data	The EQRO considers this response appropriate and

algorithm to reject encounters that are submitted incorrectly to the State.	workgroup. DBHR believes that P1 rejects retired codes. DBHR does not have the authority to fix P1.	recommends continued implementation of this recommendation.
DBHR needs to create expectations or protocols for RSNs on how to address errors identified in encounters.	DBHR will ask a member of the IT team to look into this in early 2017.	The EQRO considers this response appropriate and recommends continued implementation of this recommendation.

Appendix

Appendix A: MCO Profiles

Amerigroup Washington (AMG)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	64.7%	
Adults' access (45-64 yrs)	75.8%	▼
Adults' access (total)	68.8%	▼
Children's access (12-24 mths)	95.9%	▲
Children's access (25 mths-6 yrs)	80.9%	▼
Children's access (7-11 yrs)	86.9%	
Children's access (12-19 yrs)	87.3%	

Maternal health visits

Timeliness of prenatal care	67.1%	
Frequency of prenatal care	42.6%	▲
Postpartum care	56.7%	

Well-child visits

0-15 months, 6+ visits	68.4%	▲
3-6 yrs, annual visit	61.9%	
12-21 yrs, semi-annual visit	39.7%	

Preventive Care

Women's health screenings

Breast cancer screening	43.9%	▼
Cervical cancer screening	45.8%	▼
Chlamydia screening	56.6%	▲

Weight assessment and counseling

Children's BMI percentile assessment	45.8%	▲
Children's nutritional counseling	51.6%	▼
Children's physical activity counseling	47.0%	▼
Adult BMI precentile assessment	84.9%	

Children's immunizations

Combo 2	67.5%	
Combo 10	37.8%	

Adolescents' immunizations

Adolescent Combo 1	65.0%	▼
HPV vaccination before 13 years	20.2%	▼

Chronic Care Management

Diabetes care

HbA1c testing	86.8%	
Eye examinations	49.0%	▼
Medical attention for nephropathy	86.1%	
Good HbA1c control	41.3%	
Poor HbA1c control *	49.4%	
Bood pressure control	59.4%	
Screening - schizophrenia/bipolar	85.6%	
Monitoring - schizophrenia/bipolar	61.0%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	32.3%	
Asthma med. 12-18 yrs - 75% compliance	72.4%	
COPD medication - bronchodialator	83.3%	
Antidepressant medication - acute	60.5%	▲
Antidepressant medication - continuation	46.4%	▲
ADHD medication follow-up - initial	39.6%	
ADHD medication follow-up - continuing	44.2%	
Medication adherence - schizophrenia	59.8%	▼
Controlling high blood pressure	53.2%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	92.5%	
Antibiotics for acute bronchitis (adults)	37.4%	▲
Children pharyngitis	71.5%	▲
Imaging for lower back pain	71.3%	▼

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

* Lower rate is better performance

Amerigroup Washington (AMG), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Above state rate on well-child visits for children ages 0 to 15 months • Above state rate on both antidepressant medication management measures	• Below state rate on adults' access • Below national rate on all maternal health measures • Below state rate on breast cancer screening and cervical cancer screening

Consumer Experience (Adult CAHPS)

Measure	Score	Quintile
Rating of personal doctor	77.6%	
Rating of specialist	75.6%	
Rating of overall healthcare	70.9%	
Rating of health plan	62.7%	
Getting needed care	75.1%	
Getting care quickly	78.1%	
Customer service	84.1%	

Below the 20th Percentile
20th to 39th Percentile
40th to 59th Percentile
60th to 79th Percentile
At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	95.0%	Grievance System	78.0%
Program Integrity Requirements	93.0%	Performance Improvement Projects	
Coordination and Continuity of Care	94.0%	Provider Selection (Credentialing)	92.0%
Patient Review and Restriction	100.0%	QA/PI Program	100.0%
Coverage and Authorization	95.0%	Sub-contractual Relationships and Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	93.0%	Healthy Options - Health Homes	81.0%

Amerigroup (AMG), a subsidiary of Anthem, utilizes an approach to healthcare that centers on a strong local presence, community-based expertise and relationships, and national resources. In 2015 in Washington, AMG served 141,571 enrollees in 33 counties.

Community Health Plan of Washington (CHPW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	71.8%	
Adults' access (45-64 yrs)	81.5%	▲
Adults' access (total)	75.5%	▲
Children's access (12-24 mths)	74.7%	▼
Children's access (25 mths-6 yrs)	62.3%	▼
Children's access (7-11 yrs)	73.7%	▼
Children's access (12-19 yrs)	75.7%	▼

Maternal health visits

Timeliness of prenatal care	54.5%	▼
Frequency of prenatal care	23.1%	▼
Postpartum care	47.0%	▼

Well-child visits

0-15 months, 6+ visits	42.4%	▼
3-6 yrs, annual visit	62.1%	
12-21 yrs, semi-annual visit	43.8%	

Preventive Care

Women's health screenings

Breast cancer screening	53.3%	
Cervical cancer screening	54.3%	
Chlamydia screening	53.5%	▼

Weight assessment and counseling

Children's BMI percentile assessment	51.8%	▲
Children's nutritional counseling	57.7%	
Children's physical activity counseling	57.7%	▲
Adult BMI precentile assessment	78.7%	▼

Children's immunizations

Combo 2	71.0%	
Combo 10	41.4%	

Adolescents' immunizations

Adolescent Combo 1	76.4%	
HPV vaccination before 13 years	30.2%	

Chronic Care Management

Diabetes care

HbA1c testing	89.0%	
Eye examinations	54.4%	
Medical attention for nephropathy	91.0%	
Good HbA1c control	27.6%	▼
Poor HbA1c control *	64.6%	▲
Bood pressure control	62.4%	
Screening - schizophrenia/bipolar	86.6%	
Monitoring - schizophrenia/bipolar	74.5%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	29.0%	
Asthma med. 12-18 yrs - 75% compliance	75.3%	
COPD medication - bronchodialator	85.5%	
Antidepressant medication - acute	53.1%	
Antidepressant medication - continuation	38.7%	
ADHD medication follow-up - initial	30.5%	▼
ADHD medication follow-up - continuing	46.9%	
Medication adherence - schizophrenia	69.0%	
Controlling high blood pressure	58.9%	▲

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	93.0%	
Antibiotics for acute bronchitis (adults)	32.5%	▲
Children pharyngitis	65.8%	
Imaging for lower back pain	78.0%	

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

* Lower rate is better performance

Community Health Plan of Washington (CHPW), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Statistically above the state rate relating to control of high blood pressure for individuals with hypertension • Statistically above the state rate for adults' access • Significant increases in children's BMI percentile assessment, nutritional counseling, and physical activity counseling	• Among the lowest performance by nationwide plans relating to children's access • Significantly below state rate and national rate for all maternal health measures • Sharp decrease in number of diabetics with HbA1c levels under control from previous year

Consumer Experience (Adult CAHPS)

Measure	Score	Quintile
Rating of personal doctor	80.0%	3
Rating of specialist	70.9%	1
Rating of overall healthcare	65.7%	1
Rating of health plan	69.1%	1
Getting needed care	73.6%	1
Getting care quickly	73.0%	1
Customer service	85.6%	2

1 Below the 20th Percentile
2 20th to 39th Percentile
3 40th to 59th Percentile
4 60th to 79th Percentile
5 At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	85.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	
Coordination and Continuity of Care	86.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Restriction	100.0%	QA/PI Program	87.0%
Coverage and Authorization	76.0%	Sub-contractual Relationships and Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	100.0%	Healthy Options - Health Homes	90.0%

Community Health Plan of Washington (CHPW), headquartered in Seattle, was founded over 20 years ago by Washington community health centers and is the state's only local nonprofit health plan. In 2015, CHPW provided Medicaid services to 294,141 enrollees in 32 counties.

Coordinated Care Washington (CCW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	65.6%	
Adults' access (45-64 yrs)	76.0%	▼
Adults' access (total)	69.4%	
Children's access (12-24 mths)	96.4%	▲
Children's access (25 mths-6 yrs)	86.7%	▲
Children's access (7-11 yrs)	92.0%	▲
Children's access (12-19 yrs)	90.1%	▲

Maternal health visits

Timeliness of prenatal care	70.2%	
Frequency of prenatal care	36.4%	
Postpartum care	55.2%	

Well-child visits

0-15 months, 6+ visits	68.9%	▲
3-6 yrs, annual visit	64.4%	
12-21 yrs, semi-annual visit	38.9%	

Preventive Care

Women's health screenings

Breast cancer screening	48.6%	▼
Cervical cancer screening	48.7%	
Chlamydia screening	55.7%	

Weight assessment and counseling

Children's BMI percentile assessment	21.0%	▼
Children's nutritional counseling	52.4%	▼
Children's physical activity counseling	50.5%	
Adult BMI precentile assessment	86.4%	

Children's immunizations

Combo 2	75.5%	▲
Combo 10	47.1%	▲

Adolescents' immunizations

Adolescent Combo 1	75.2%	
HPV vaccination before 13 years	34.3%	▲

Chronic Care Management

Diabetes care

HbA1c testing	87.0%	
Eye examinations	58.1%	
Medical attention for nephropathy	85.4%	▼
Good HbA1c control	36.9%	
Poor HbA1c control *	54.5%	
Bood pressure control	60.9%	
Screening - schizophrenia/bipolar	83.8%	
Monitoring - schizophrenia/bipolar	66.7%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	31.3%	
Asthma med. 12-18 yrs - 75% compliance	73.9%	
COPD medication - bronchodialator	86.5%	
Antidepressant medication - acute	52.3%	▼
Antidepressant medication - continuation	37.7%	▼
ADHD medication follow-up - initial	33.3%	▼
ADHD medication follow-up - continuing	36.6%	▼
Medication adherence - schizophrenia	65.1%	
Controlling high blood pressure	44.7%	▼

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	91.7%	▼
Antibiotics for acute bronchitis (adults)	26.9%	
Children pharyngitis	46.4%	▼
Imaging for lower back pain	79.3%	

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

* Lower rate is better performance

Coordinated Care Washington (CCW), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Statistically above the state rate for all children's access age groups • Strong performance on childhood immunizations	• Below national rate for all maternal health measures • Below state rate for multiple medication management measures, including antidepressant medication management and ADHD medication management

Consumer Experience (Adult CAHPS)

Measure	Score	Quintile	Measure	Score	Quintile
Rating of personal doctor	80.6%		Getting needed care	78.6%	
Rating of specialist	80.7%		Getting care quickly	79.5%	
Rating of overall healthcare	75.0%		Customer service	80.9%	
Rating of health plan	67.1%				

- Below the 20th Percentile
- 20th to 39th Percentile
- 40th to 59th Percentile
- 60th to 79th Percentile
- At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	91.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	
Coordination and Continuity of Care	83.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Restriction	100.0%	QA/PI Program	100.0%
Coverage and Authorization	76.0%	Sub-contractual Relationships and Delegatior	100.0%
Enrollment and Disenrollment	100.0%	Healthy Information Systems	100.0%
Enrollee Rights	98.0%	Healthy Options - Health Homes	76.0%

Coordinated Care Washington (CCW), a subsidiary of Centene Corporation, works under the core mission that quality healthcare is best delivered locally. CCW provided Medicaid benefits to 181,801 beneficiaries in 26 counties across Washington in 2015.

Molina Healthcare of Washington (MHW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	79.4%	▲
Adults' access (45-64 yrs)	85.4%	
Adults' access (total)	81.3%	▲
Children's access (12-24 mths)	97.5%	
Children's access (25 mths-6 yrs)	88.8%	▲
Children's access (7-11 yrs)	92.8%	▲
Children's access (12-19 yrs)	92.6%	▲

Maternal health visits

Timeliness of prenatal care	75.2%	▲
Frequency of prenatal care	51.7%	▲
Postpartum care	51.3%	

Well-child visits

0-15 months, 6+ visits	62.7%	
3-6 yrs, annual visit	69.7%	▲
12-21 yrs, semi-annual visit	44.4%	

Preventive Care

Women's health screenings

Breast cancer screening	56.7%	▲
Cervical cancer screening	58.7%	▲
Chlamydia screening	54.5%	

Weight assessment and counseling

Children's BMI percentile assessment	50.3%	▲
Children's nutritional counseling	57.6%	
Children's physical activity counseling	53.6%	
Adult BMI precentile assessment	90.1%	▲

Children's immunizations

Combo 2	72.0%	
Combo 10	39.7%	

Adolescents' immunizations

Adolescent Combo 1	74.2%	
HPV vaccination before 13 years	23.5%	▼

Chronic Care Management

Diabetes care

HbA1c testing	89.8%	
Eye examinations	58.5%	
Medical attention for nephropathy	90.5%	
Good HbA1c control	49.0%	▲
Poor HbA1c control *	35.8%	▼
Bood pressure control	68.2%	▲
Screening - schizophrenia/bipolar	85.6%	
Monitoring - schizophrenia/bipolar	66.7%	

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	28.3%	▼
Asthma med. 12-18 yrs - 75% compliance	74.0%	
COPD medication - bronchodialator	85.5%	
Antidepressant medication - acute	52.2%	▼
Antidepressant medication - continuation	37.2%	▼
ADHD medication follow-up - initial	42.6%	▲
ADHD medication follow-up - continuing	49.4%	
Medication adherence - schizophrenia	70.5%	▲
Controlling high blood pressure	56.6%	▲

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	92.8%	
Antibiotics for acute bronchitis (adults)	27.7%	▼
Children pharyngitis	67.9%	▲
Imaging for lower back pain	79.1%	▲

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

* Lower rate is better performance

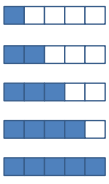
Molina Healthcare of Washington (MHW), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• High rates of good diabetic HbA1c control (and low rates of poor control) compared to state rate • Significantly above state rate for most age groups for both children's access and adults' access	• Significantly below state rate on antidepressant medication management measures • Below national rate on all maternal health measures • Low scores on many CAHPS measures as compared to national benchmarks

Consumer Experience (Adult CAHPS)

Measure	Score	Quintile
Rating of personal doctor	76.7%	
Rating of specialist	75.2%	
Rating of overall healthcare	68.2%	
Rating of health plan	66.6%	
Getting needed care	77.6%	
Getting care quickly	78.4%	
Customer service	80.2%	



Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	93.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	
Coordination and Continuity of Care	83.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Restriction	100.0%	QA/PI Program	100.0%
Coverage and Authorization	86.0%	Sub-contractual Relationships and Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	98.0%	Healthy Options - Health Homes	95.0%

Molina Healthcare of Washington (MHW), established in 1995, offers health plans, medical clinics, and health information management services. In 2015 MHW provided coverage for 566,201 Medicaid enrollees in 37 counties across Washington.

United Healthcare Community Plan (UHC)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	68.3%	▼
Adults' access (45-64 yrs)	79.2%	▼
Adults' access (total)	72.5%	▼
Children's access (12-24 mths)	96.2%	▲
Children's access (25 mths-6 yrs)	87.5%	▲
Children's access (7-11 yrs)	92.5%	▲
Children's access (12-19 yrs)	91.5%	▲

Maternal health visits

Timeliness of prenatal care	67.9%
Frequency of prenatal care	34.5%
Postpartum care	56.7%

Well-child visits

0-15 months, 6+ visits	64.5%
3-6 yrs, annual visit	67.0%
12-21 yrs, semi-annual visit	44.5%

Preventive Care

Women's health screenings

Breast cancer screening	44.7%	▼
Cervical cancer screening	46.2%	▼
Chlamydia screening	55.3%	

Weight assessment and counseling

Children's BMI percentile assessment	38.2%	
Children's nutritional counseling	64.2%	▲
Children's physical activity counseling	51.1%	
Adult BMI precentile assessment	80.8%	▼

Children's immunizations

Combo 2	66.9%
Combo 10	37.5%

Adolescents' immunizations

Adolescent Combo 1	70.4%
HPV vaccination before 13 years	26.5%

Chronic Care Management

Diabetes care

HbA1c testing	86.9%	
Eye examinations	53.8%	
Medical attention for nephropathy	88.1%	
Good HbA1c control	36.3%	
Poor HbA1c control *	52.1%	
Bood pressure control	58.6%	
Screening - schizophrenia/bipolar	85.8%	
Monitoring - schizophrenia/bipolar	78.2%	▲

Other chronic care management

Asthma med. 5-11 yrs - 75% compliance	39.8%	▲
Asthma med. 12-18 yrs - 75% compliance	77.0%	
COPD medication - bronchodialator	83.2%	
Antidepressant medication - acute	56.4%	▲
Antidepressant medication - continuation	41.2%	▲
ADHD medication follow-up - initial	44.8%	▲
ADHD medication follow-up - continuing	57.5%	
Medication adherence - schizophrenia	66.5%	
Controlling high blood pressure	49.4%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	92.3%	▼
Antibiotics for acute bronchitis (adults)	28.9%	
Children pharyngitis	69.7%	
Imaging for lower back pain	74.4%	▼

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

* Lower rate is better performance

United Healthcare Community Plan (UHC), continued

Performance Measure Strengths & Opportunities

Strengths	Opportunities for Improvement
• Statistically higher than state rate on all children's access measures • Significant increase in children's nutritional counseling and physical activity counseling from prior year • Strong performance on multiple medication management measures, notably antidepressant medication management	• Below the state rate for all adults' access measures • Below national rate on all maternal health measures • Below state rate on multiple women's screening measures

Consumer Experience (Adult CAHPS)

Measure	Score	Quintile
Rating of personal doctor	81.1%	
Rating of specialist	76.8%	
Rating of overall healthcare	74.8%	
Rating of health plan	70.3%	
Getting needed care	81.3%	
Getting care quickly	80.7%	
Customer service	84.5%	

Below the 20th Percentile
20th to 39th Percentile
40th to 59th Percentile
60th to 79th Percentile
At or above the 80th Percentile

Regulatory and Contractual Standards

Standards	Score	Standards	Score
Availability of Services	100.0%	Grievance System	93.0%
Program Integrity Requirements	100.0%	Performance Improvement Projects	
Coordination and Continuity of Care	92.0%	Provider Selection (Credentialing)	100.0%
Patient Review and Restriction	100.0%	QA/PI Program	100.0%
Coverage and Authorization	86.0%	Sub-contractual Relationships and Delegation	100.0%
Enrollment and Disenrollment	100.0%	Health Information Systems	100.0%
Enrollee Rights	100.0%	Healthy Options - Health Homes	95.0%

UnitedHealthcare Community Plan (UHC) is a program of UnitedHealth Group, one of the largest health insurers in the United States. In 2015, UHC provided Medicaid coverage to 204,078 enrollees in 31 Washington counties, helping low-income adults and children and people with disabilities get access to personalized healthcare benefits and services.

Appendix B: BHO Profiles

Greater Columbia Behavioral Health Organization (GCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	⦿	**Grievance System**	⦿
Certifications and Program Integrity	⦿		

Strengths	Recommendations
GCBHO's consumer services coordinator has conducted trainings for the BHAs covering the BHO's grievance system, the appeals process, and the state fair hearing process. GCBHO's medical director is very involved in the authorization and appeal process. The medical director reviews all appeals; in his absence, designees with the appropriate clinical expertise handle the appeals. GCBHO's Ombuds and the BHO's customer service coordinator provide training to the BHAs and the community on advance directives.	The BHO has not conducted a formal administrative review of its BHAs, which includes assessing compliance with the grievance system, since 2012. To ensure its BHAs are in compliance with the policies of the grievance system, the BHO needs to reinstate its administrative review at all of its contracted BHAs. GCBHO needs to develop a method for documenting its annual compliance trainings presented to the board of directors, the BHO staff and the BHAs' staff. Documentation should include the date of the trainings, who attended the trainings, and evidence of the effectiveness of the trainings.

Performance Improvement Projects			
Clinical/Children's PIP	**Score**	**Strengths**	**Recommendations**
Promoting Medication Adherence in Youth	N/A	GCBHO has selected a PIP topic based on responses to a questionnaire utilized in its last children's PIP. The study topic of psychotropic medication compliance among youth is consistent with enrollee health risks.	An analysis of causes and barriers related to medication non-compliance should be conducted in order choose an appropriate intervention to successfully address this issue.
Non-Clinical PIP			
Increasing Timeliness of Provider-Submitted Authorization Requests through Identification of Systemic Barriers	N/A	GCBHO's non-clinical PIP was chosen based on area of concern related to provider internal authorization request timeliness. The formulation of this topic is based on data collected by the BHO.	The BHO needs to conduct a root cause analysis to fully understand the reasons why come BHAs are not submitting authorization requests in a timely manner. GCBHO should consider creating tailored interventions for each BHA involved in this PIP.
SUD PIP			
Increasing Engagement in Recovery by Identifying Reasons for Premature Exit from Detox Programs	N/A	This PIP is in its early stages of development. The topic of increasing engagement to decrease recidivism rates is relevant to the care and services delivered by the BHO.	Additional research needs to be conducted so that the BHO can fully understand the reasons individuals fail to complete detox programs.

Greater Columbia Behavioral Health Organization (GCBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	100.0%	N/A	**Hispanic Origin**	87.5%	100.0%
First Name	100.0%	N/A	**Race/Ethnicity**	89.2%	99.5%
SSN	55.0%	N/A	**Preferred Language**	94.2%	95.9%
Date of Birth	98.3%	100.0%	**Sexual Orientation**	68.3%	98.2%
Gender	98.3%	99.8%			
Encounter Data					
Procedure Code	74.9%	99.64%	**Units of Service**	92.2%	98.03%
Date of Service	97.7%	100.0%	**Clinical Note Matches Procedure Code**	75.6%	100.0%
Service Location	0.2%	N/A	**Author Identified**	96.5%	100.0%
Provider Type	94.7%	98.39%			

Strengths	Recommendations
The majority of the BHO's electronic data checks were complete.	When performing its own internal EDV, GCBHO should use the State data submitted to ProviderOne. GCBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. GCBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. GCBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

Information Systems Capabilities Assessment (ISCA) Follow-up
GCRSN met all criteria in the 2015 ISCA.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Handling of Grievances and Appeals	1	1
Excluded Providers	1	1
QA/PI	3	3
EDV	1	1

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

Great Rivers Behavioral Health Organization (GRBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	◉	**Grievance System**	●
Certifications and Program Integrity	◉		

Strengths	Recommendations
The BHO allows enrollees the freedom of choice among the contracted BHAs in the BHO's service area. GRBHO requires its BHAs to track all grievances and submit a monthly report form to the BHO. The grievances are monitored by the BHO's internal grievance committee. GRBHO has customer service representatives available to assist enrollees with any questions or concerns they may have regarding any aspect of the grievance and appeal process, including the completion and filing of forms.	GRBHO needs to develop and implement a policy and procedure on emergency, crisis and post-stabilization care services describing how the BHO will monitor those services. The BHO needs to monitor these services to ensure the enrollee is able to access the 24-hour crisis number.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
To be determined	N/A	N/A	N/A
Non-Clinical PIP			
To be determined	N/A	N/A	N/A
SUD PIP			
To be determined	N/A	N/A	N/A

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

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

Great Rivers Behavioral Health Organization (GRBHO)

Comparison of Qualis Health and BHO EDV Results — Grays Harbor RSN					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	100.0%	N/A	**Hispanic Origin**	95.0%	N/A
First Name	100.0%	N/A	**Race/Ethnicity**	36.7%	N/A
SSN	88.3%	N/A	**Preferred Language**	90.0%	N/A
Date of Birth	98.3%	N/A	**Sexual Orientation**	50.0%	N/A
Gender	98.3%	N/A			
Encounter Data					
Procedure Code	55.2%	98.1%	**Units of Service**	87.3%	97.6%
Date of Service	87.3%	99.1%	**Clinical Note Matches Procedure Code**	77.4%	90.5%
Service Location	86.3%	95.3%	**Author Identified**		
Provider Type	79.7%	89.6%		87.3%	98.1%

Comparison of Qualis Health and BHO EDV Results — Timberlands RSN					
Field	**Qualis Health % Match**	**RSN % Match**	**Field**	**Qualis Health % Match**	**RSN % Match**
Demographics Data					
Last Name	98.3%	N/A	**Hispanic Origin**	95.0%	N/A
First Name	100.0%	N/A	**Race/Ethnicity**	98.3%	N/A
SSN	93.3%	N/A	**Preferred Language**	100.0%	N/A
Date of Birth	100.0%	N/A	**Sexual Orientation**	86.7%	N/A
Gender	100.0%	N/A			
Encounter Data					
Procedure Code	94.8%	99.0%	**Units of Service**	95.3%	100.0%
Date of Service	98.6%	100.0%	**Clinical Note Matches Procedure Code**	73.2%	80.1%
Service Location	96.7%	99.0%	**Author Identified**		
Provider Type	97.2%	100.0%		99.1%	N/A

Strengths	Recommendations
N/A	When performing its own internal EDV, GRBHO should use the State data submitted to ProviderOne. GRBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. GRBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. GRBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

ISCA Follow-up Review

TRSN fully met all criteria for the 2015 ISCA.
GRSN received two recommendations related to Information Security; GRBHO is in the process of addressing those recommendations.

Great Rivers Behavioral Health Organization (GRBHO)

Previous-Year Corrective Action Plans — Grays Harbor RSN		
Section	**Number of CAPs**	**Number Resolved**
Coordination and Continuity of Care	1	1
Coverage and Authorization of Services	1	0
Excluded Providers	1	1
Subcontractual Relationships and Delegation	1	0
Practice Guidelines	1	0
QA/PI	2	0
EDV	1	0
Previous-Year Corrective Action Plans —Timberlands RSN		
Coordination and Continuity of Care	1	0
Coverage and Authorization of Services	1	0
Subcontractual Relationships and Delegation	1	0
QA/PI	1	1
EDV	1	0

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

King County Behavioral Health Organization (KCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	●	**Grievance System**	⦿
Certifications and Program Integrity	⦿		

Strengths	Recommendations
KCBHO requires contracted agencies to keep logs on enrollee requests for translation and interpreter services and submit them to the BHO. If an enrollee requests to obtain treatment from a different BHA, he/she is able to do so, and KCBHO will assist with the transition. As part of the BHO's annual chart review, KCBHO monitors treatment plans to ensure that enrollees are informed of available treatment options and alternatives.	KCBHO needs to work with the BHAs to establish a methodology for recording and logging all grievances received by the BHAs. The BHAs then need to submit all logs quarterly to the BHO. KCBHO should review its website and ensure that the language detailing the requirements relevant to the grievance, appeal and fair hearing processes is easily accessible and informative. KCBHO needs to ensure its policy and procedure related to whistleblower protections, which includes no retaliation, is provided in its new employee orientation and in the annual compliance training program.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Effectiveness of the Transitional Support Program	⦿	KCBHO has completed this PIP and found the implementation of its Transitional Support Program to be successful in decreasing re-hospitalization rates among involuntarily detained individuals.	Due to the success of this PIP, the BHO should consider evolving this PIP to include similar programs, such as peer bridger programs.
Non-Clinical/Children's PIP			
Improved Coordination with Primary Care for Children and Youth	⦿	KCBHO's goal of reducing psychiatrically related emergency department visits among youth is relevant and appropriate.	This PIP was initiated in 2013 and no progress has been achieved in terms of data collection or implementation of an intervention. KCBHO needs to begin the work of this PIP or pursue another topic.
SUD PIP			
Topic to be determined	N/A	Two potential study topics are being considered for the BHO's SUD PIP. Both topics were chosen in an effort to address the county's on-going struggle with opiate abuse.	The BHO needs to finalize its PIP topic and ensure all aspects of its intervention and data collection of realistic.

King County Behavioral Health Organization (KCBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	100.0%	N/A	**Hispanic Origin**	98.3%	N/A
First Name	99.2%	N/A	**Race/Ethnicity**	93.3%	N/A
SSN	88.2%	N/A	**Preferred Language**	0.8%	N/A
Date of Birth	100.0%	N/A	**Sexual Orientation**	79.8%	N/A
Gender	98.3%	N/A			
Encounter Data					
Procedure Code	84.3%	N/A	**Units of Service**	89.5%	N/A
Date of Service	96.0%	N/A	**Clinical Note Matches Procedure Code**	52.5%	N/A
Service Location	76.7%	N/A	**Author Identified**	86.2%	N/A
Provider Type	85.5%	N/A			

Strengths	Recommendations
KCBHO's demographic and encounter data error rates were minimal with the exception of missing language data.	When performing its own internal EDV, KCBHO should use the State data submitted to ProviderOne. KCBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. KCBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. KCBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

Information Systems Capabilities Assessment (ISCA) Follow-up
KCRSN received a recommendation in the 2015 ISCA for Medical Services Data. The recommendation stands.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Information on Grievance Process and Timeframe	1	1
Recordkeeping and Reporting Requirements	1	0
Availability of Services	1	0
Practice Guidelines	1	0
PIP	2	0
EDV	1	1

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

North Central Behavioral Health Organization (NCBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	⦿	**Grievance System**	●
Certifications and Program Integrity	⦿		

Strengths	Recommendations
NCBHO's website clearly informs enrollees about how to recognize when someone is in crisis, how to obtain crisis services, and how to contact crisis services in Chelan and Douglas County as well as Grant County. The website states crisis services are available to all individuals regardless of ability to pay. NCBHO uses its administrative review tool to annually monitor contracted providers' compliance with sharing information on available treatment options and alternatives with enrollees in a manner appropriate to each enrollee's condition.	The BHO needs to initiate a process to ensure it continually reviews the effectiveness of the seven elements of the compliance program. The BHO needs to update all of its policies and procedures to specify that records are to be retained for a minimum of six years.

Performance Improvement Projects			
Clinical/Children's PIP	**Score**	**Strengths**	**Recommendations**
Adopting the Washington State Children's System Principles and Core Practice Model to Improve the Penetration Rate of Child and Family Team Participation for Medicaid Children Ages 0–20	●	NCBHO has completed its PIP and found statistically significant improvement in its goal to improve the rate of youth who received a child and family team service. The BHO plans to continue working on improving this outcome by implementing practice guidelines and a new level of care policy.	As the BHO works to select its next PIP. It should ensure the topic reflects the characteristics of its enrollees in terms of demographics as well as prevalence and potential risks.
Non-Clinical PIP			
Crisis Intervention Follow-up: Does the Implementation of a Standardized Discharge Protocol Increase the Percentage of Medicaid Enrollees Receiving a Crisis Service Who Receive Clinically Indicated Follow-up Services?	●	The selection of this PIP and its intervention was based on enrollee survey data, chart review results and stakeholder input.	For this next non-clinical PIP, the BHO should ensure that it is designed to assess and improve a process or outcome related to the access or quality of the services provided to enrollees.
SUD PIP			
To be determined	N/A	NCBHO is still working to select its SUD topic; its initial topic was similar to a state performance measure.	NCBHO needs to formulate an SUD PIP that does not mirror state performance measures.

North Central Behavioral Health Organization (NCBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	99.2%	87.0%	**Hispanic Origin**	93.3%	N/A
First Name	99.2%	87.0%	**Race/Ethnicity**	95.0%	96.3%
SSN	97.5%	98.2%	**Preferred Language**	95.0%	N/A
Date of Birth	100.0%	100.0%	**Sexual Orientation**	89.2%	N/A
Gender	100.0%	100.0%			
Encounter Data					
Procedure Code	96.1%	99.76%	**Units of Service**	93.8%	99.76%
Date of Service	98.4%	99.76%	**Clinical Note Matches Procedure Code**	64.3%	93.75%
Service Location	96.3%	99.76%	**Author Identified**	98.2%	99.76%
Provider Type	97.9%	99.76%			

Strengths	Recommendations
NCBHO obtained 100 percent completeness on the electronic data checks.	When performing its own internal EDV, NCBHO should use the State data submitted to ProviderOne. NCBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. NCBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. NCBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

Information Systems Capabilities Assessment (ISCA) Follow-up

CDRSN received one recommendation related to Information Security in the 2015 ISCA. The BHO has resolved the issue.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Coordination and Continuity of Care	1	1
Coverage and Authorization of Services	1	1
QA/PI	3	3
EDV	1	0

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

North Sound Behavioral Health Organization (NSBHO)

Compliance with Contractual and Regulatory Standards

Protocol	Score	Protocol	Score
Enrollee Rights and Protections	◉	Grievance System	◉
Certifications and Program Integrity	◉		

Strengths	Recommendations
NSBHO can provide notices of action (NOAs) in English, Somali, Laotian, Cambodian, Chinese, Korean, Spanish, Vietnamese and Russian. NSBHO's policy ensures that the staff making decisions on grievances and appeals are mental health and chemical dependency professionals with appropriate clinical experience to make decisions involving medical necessity, expedited resolution or clinical issues, or a denial based on lack of medical necessity. NSBHO provides oversight during the standard and expedited appeal process to ensure that services are provided as required and timelines for decisions are met.	The BHO needs to update its compliance plan to reflect new BHO contract, WAC and CFR requirements, and to reflect the needs of the new BHO LLC structure. The BHO's executive team needs to meet regularly to monitor risks, develop action plans for vulnerable areas, and seek interventions where appropriate to mitigate risks. Additionally, the team needs to include the results of the annual risk assessment in its annual compliance self-evaluation. NSBHO needs to include language in the NOAs that informs the enrollee that translation services are provided at no cost to the enrollee.

Performance Improvement Projects

Clinical/Children's PIP	Score	Strengths	Recommendations
Change in LOCUS\CALOCUS Level for Youth with an EPSDT Referral	◉	NSBHO's clinical PIP topic is in line with federal and State initiatives related to high-risk/high-need children and youth.	NSBHO needs to conduct further data analysis to ensure that this is an area that needs improvement.
Non-Clinical PIP			
Improving Timeliness of Services Using the Open Access Model Confidence Level	◉	This PIP focuses on improving access and timeliness of care provided to its enrollees.	The BHO needs to ensure all aspects of its intervention are clearly defined.
SUD PIP			
Increasing Substance Use Disorder Penetration Rates	◉	The BHO needs to select a new PIP topic; NSBHO's initial plan of focusing on SUD penetration rates is a state performance measure.	NSBHO needs to formulate an SUD PIP that does not mirror state performance measures. NSBHO needs to use its data and stakeholder input to select another SUD topic.

North Sound Behavioral Health Organization (NSBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	100.0%	98.0%	**Hispanic Origin**	89.9%	N/A
First Name	100.0%	98.0%	**Race/Ethnicity**	91.6%	89.0%
SSN	58.0%	N/A	**Preferred Language**	51.3%	N/A
Date of Birth	100.0%	98.0%	**Sexual Orientation**	83.2%	N/A
Gender	97.5%	N/A			
Encounter Data					
Procedure Code	93.6%	73.4%	**Units of Service**	91.2%	91.7%
Date of Service	97.2%	95.0%	**Clinical Note Matches Procedure Code**	55.3%	73.4%
Service Location	96.0%	90.0%	**Author Identified**	92.4%	80.5%
Provider Type	96.4%	90.7%			

Strengths	Recommendations
Other than Social Security Number (an optional field), all demographic fields were over 99 percent accurate when checked for logical consistency and completeness	When performing its own internal EDV, NSBHO should use the State data submitted to ProviderOne. NSBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. NSBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. NSBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

Information Systems Capabilities Assessment (ISCA) Follow-up

NSRSN received a recommendation in the 2015 ISCA for Information Security. The BHO has resolved this issue.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Information Requirements	1	1
General Information	1	0
Testing of DR/BC Plan	1	1
Data Security Requirements	3	0
Availability of Services	1	1
Coverage and Authorization	1	1
Provider Selection	2	1
QA/PI	1	0
PIP Validation	1	1
EDV	1	0

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

Optum Pierce Behavioral Health Organization (OPBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	●	**Grievance System**	⦿
Certifications and Program Integrity	⦿		

Strengths	Recommendations
OPBHO has conducted weekly workgroups with both the mental health and SUD providers to review, revise and rewrite OPBHO's policies to ensure the policies are inclusive of both the mental health and SUD providers. The executive director of the BHO has been hosting bimonthly community forums in order to inform the community about the BHO and provide a space for answering any questions from the community regarding the BHO's recent transition from an RSN.	OPBHO needs to develop a compliance committee that has a charter, meets on at least a quarterly basis, and follows a formal agenda with reportable meeting minutes, in order to reflect oversight of its compliance program. The BHO needs to develop a policy to monitor vendors, providers and subcontractors for any civil money penalties and assessments.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Care Coordination between OPBHO and Medical Providers in Pierce County	N/A	OPBHO's clinical PIP topic has the potential to create meaningful change for a group of high-need, at-risk enrollees.	OPBHO's care coordination PIP is still in its nascent stages. The BHO plans to conduct further research to understand which enrollees are not being referred to PCPs. The BHO should be cautious about how this PIP is approached, as PCP care coordination for those with medical needs is a contract requirement, and the PIP will need to encompass more than what is required by the State.
Non-Clinical/Children's PIP			
Unplanned Discharges from the Optum Pierce BHO WISe Program	N/A	Given the information OPBHO has found related to WISe program discharges and agreement from stakeholders, the pursuit of this PIP topic is well suited.	When further defining the design of the PIP, OPBHO should consider several factors, including but not limited to the specific issue that will be addressed, ease of implementation of the intervention, burden and acceptability of the PIP by CCS staff, and data availability.
SUD PIP			
Use of the GAIN-SS Tool to Improve Referrals within the BHO Network in Pierce County	N/A	OPBHO has laid out a strong foundation for this SUD PIP. The topic of looking into the incongruity of clinicians' diagnoses and GAIN-SS scores has the potential to impact healthcare integration within the BHO.	OPBHO's initial plan of looking at this issue across both the SUD and mental health systems may not be realistic at this time. It may be simpler and more effective to focus on one system at a time. OPBHO should consider specifically concentrating on the mental health system, as data are already easily available.

Optum Pierce Behavioral Health Organization (OPBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	95.8%	98.3%	**Hispanic Origin**	90.7%	98.1%
First Name	95.8%	98.3%	**Race/Ethnicity**	88.1%	99.0%
SSN	83.9%	94.3%	**Preferred Language**	96.6%	99.6%
Date of Birth	96.6%	99.5%	**Sexual Orientation**	82.2%	98.8%
Gender	93.2%	99.9%			
Encounter Data					
Procedure Code	89.6%	99.5%	**Units of Service**	90.1%	98.8%
Date of Service	94.1%	99.9%	**Clinical Note Matches Procedure Code**	50.9%	99.1%
Service Location	87.6%	99.8%	**Author Identified**	94.6%	99.9%
Provider Type	78.7%	95.1%			

Strengths	Recommendations
Because of the increase in BHAs within OPBHO's network, OPBHO has added an additional staff position for encounter data validation to ensure there is a more robust process for validating the increased number of encounter data submitted.	When performing its own internal EDV, OPBHO should use the State data submitted to ProviderOne. OPBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. OPBHO should train the BHAs on SERI documentation standards.

Information Systems Capabilities Assessment (ISCA) Follow-up
OPRSN fully met all criteria for the 2015 ISCA.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Availability of Services	1	1
QA/PI	1	0
PIP Validation	1	N/A
EDV	2	N/A

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

Salish Behavioral Health Organization (SBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	⦿	**Grievance System**	⦿
Certifications and Program Integrity	⦿		

Strengths	Recommendations
SBHO ensures that all grievance resolutions it offers honor individual voice, choice and rights of or on behalf of the enrollee filing the grievance. The BHO ensures that at all stages of the process, emphasis is placed on the enrollee's requested solution. SBHO monitors its BHAs' compliance with this policy through annual provider directory requests, annual administrative reviews, grievance tracking reports and clinical reviews.	SBHO should update its policies and procedures to indicate it requires its staff and BHA staff to attend annual compliance training. The BHO needs to reevaluate how it assesses BHO risk and ensure its risk-rating categories include high, medium and low. SBHO needs to identify in its risk assessment the organization's top three vulnerabilities. SBHO needs to present its risk assessment results to the Compliance Committee as well as to other leadership staff in order to plan for how the BHO will mitigate its risks.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Tobacco Use Cessation	●	SBHO's clinical PIP is based on a nationally recognized intervention.	SBHO should continue on to the second phase of the PIP where it will implement an intervention focused on tobacco cessation.
Non-Clinical/Children's PIP			
Improving Identification of Intensive-Needs Children and Youth	●	SBHO implemented training and a policy change to improve the identification of high risk/high needs youth.	SBHO should continue to move forward on its next proposed non-clinical/children's PIP to increase the frequency of child and family team meetings.
SUD PIP			
Improving Implementation of the Grievance System among SUD Providers	N/A	The BHO has based its SUD PIP on data that identified a clear issue related to the lack of grievances filed by SUD enrollees.	The study question for this PIP needs to be finalized and all elements of the study design need to be reviewed to ensure they are realistic and obtainable.

Salish Behavioral Health Organization (SBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	100.0%	N/A	**Hispanic Origin**	99.2%	N/A
First Name	100.0%	N/A	**Race/Ethnicity**	97.5%	N/A
SSN	81.5%	N/A	**Preferred Language**	98.3%	N/A
Date of Birth	98.3%	N/A	**Sexual Orientation**	93.3%	N/A
Gender	99.2%	N/A			
Encounter Data					
Procedure Code	97.7%	99.8%	**Units of Service**	97.7%	100.0%
Date of Service	100.0%	100.0%	**Clinical Note Matches Procedure Code**	44.9%	90.3%
Service Location	99.8%	99.8%	**Author Identified**	100.0%	99.2%
Provider Type	97.2%	97.9%			

Strengths	Recommendations
N/A	When performing its own internal EDV, SBHO should use the State data submitted to ProviderOne. SBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. SBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. SBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

Information Systems Capabilities Assessment (ISCA) Follow-up

PRSN received a recommendation for an opportunity for improvement related to Medical Services Data. SBHO has resolved this issue.

Previous-Year Corrective Action Plans

Section	Number of CAPs	Number Resolved
Availability of Services	1	1
Coverage and Authorization of Services	1	1
EDV	1	0

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

Spokane County Regional Behavioral Health Organization (SCRBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	⦿	**Grievance System**	⦿
Certifications and Program Integrity	⦿		

Strengths	Recommendations
Interviews with both mental health and SUD providers indicated that the BHO performs annual administrative reviews to ensure enrollee rights are posted in areas visible to enrollees. Prior to SCRBHO's transition to a BHO, the RSN posted on its website a well-written and informative communication to its enrollees informing them of what to expect once the RSN became a BHO. SCRBHO has provided training on the grievance system to all BHO and BHA staff. The training presentation content is well written and very informative.	The BHO needs to develop and implement a policy and procedure describing the enrollee's right to be treated with respect, dignity and consideration of privacy. The policy should include how the BHO will ensure and monitor that enrollees are being treated with respect, dignity and consideration of privacy by all BHO and BHA staff. SCRBHO needs to include in its NOA that interpreter services are available at no cost to the enrollee. The BHO should create a formal process to track all reports of suspected fraud, waste and abuse, regardless of how the incident is reported to the BHO. Review of the log should be incorporated into the compliance committee meetings as a standing agenda item.

Performance Improvement Projects			
Clinical PIP	**Score**	**Strengths**	**Recommendations**
Reduction in Spokane County Hospital Readmissions for Individuals Discharged from State Hospitals As a Result of Enhanced Case Management	⦿	SCRBHO has completed its PIP and data analysis has shown statistically significant improvement as a result of its intervention.	All steps, analysis and explanations should be clearly documented so that any work completed on a PIP is apparent to reviewers.
Non-Clinical/Children's PIP			
Increase in Access to Treatment for Children Residing in Rural, Underserved Areas As a Result of School-Based Outpatient Services	⦿	SCRBHO chose its study topic through discussion with a variety of stakeholders and through a review of national and local data related to the mental health needs of youth in general as well as those specifically living in rural areas.	SCRBHO is encouraged to begin the new PIP study topic selection process as soon as the previous PIP has been retired, rather than a full year after the PIP has ended.
SUD PIP			
SUD Continuity of Care	N/A	SCRBHO has proposed an SUD PIP intended to improve communication, coordination and discharge planning for its enrollees.	SCRBHO should consider all the elements of PIP study design and implementation as it moves forward in its PIP formulation to ensure all aspects are realistic and executable.

Spokane County Regional Behavioral Health Organization (SCRBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	97.4%	N/A	**Hispanic Origin**	37.9%	N/A
First Name	100%	N/A	**Race/Ethnicity**	50.9%	N/A
SSN	69.0%	N/A	**Preferred Language**	74.1%	N/A
Date of Birth	98.3%	N/A	**Sexual Orientation**	25.0%	N/A
Gender	97.4%	N/A			
Encounter Data					
Procedure Code	93.2%	99.1%	**Units of Service**	97.4%	99.8%
Date of Service	99.3%	99.9%	**Clinical Note Matches Procedure Code**	71.9%	99.5%
Service Location	68.2%	98.3%	**Author Identified**	96.7%	99.3%
Provider Type	79.3%	98.2%			

Strengths	Recommendations
N/A	When performing its own internal EDV, SCRBHO should use the State data submitted to ProviderOne. SCRBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. SCRBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. SCRBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

Information Systems Capabilities Assessment (ISCA) Follow-up

SCRSN received one recommendation for an opportunity for improvement related to Information Security. The BHO has not yet resolved this issue.
SCRSN also received one recommendation for an opportunity for improvement related to Medical Services Data. This issue has been resolved.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Practice Guidelines	1	1
QA/PI	1	1

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

Thurston-Mason Behavioral Health Organization (TMBHO)

Compliance with Contractual and Regulatory Standards			
Protocol	**Score**	**Protocol**	**Score**
Enrollee Rights and Protections	⦿	**Grievance System**	⦿
Certifications and Program Integrity	⦿		

Strengths	Recommendations
TMBHO states that the Ombuds meets regularly with the provider agencies to provide information and answer questions for enrollees on mental health advance directives. The BHO has a system in place to respond to all grievances and appeals within the timeframes required. Qualis Health's review of grievances indicated timeframes are usually within one business day of receipt of a grievance. TMBHO monitors on a yearly basis a sample of its contracted providers' personnel files, credentialing policies and procedures, and employee training records.	TMBHO needs to track the use of interpreter services in order to analyze any unmet language needs of enrollees. TMBHO needs to monitor the BHAs to ensure enrollees are participating in decisions regarding their healthcare, including the right to refuse treatment. TMBHO needs to include in the NOAs that interpreter services are available at no cost to the enrollee.

Performance Improvement Projects			
Clinical/Children's PIP	**Score**	**Strengths**	**Recommendations**
Hi-fidelity Wraparound	●	TMBHO analyzed its data for PIP and identified statistical significance through initial and repeat measurements for the change over time in scores on the SDQ .	This PIP has already shown sustained improvement of the study indicators. Using the work that the BHO and behavioral health agencies have already accomplished with WISe, the BHO should consider evolving this PIP and formulating a new study question with a new intervention.
Non-Clinical PIP			
Implementing LOCUS to Increase Service Episodes for Adult Medicaid Clients	●	TMBHO selected this PIP through a process that involved chart reviews that found Medicaid-enrolled adults received fewer outpatient services than expected, especially in the initial stages of treatment.	Next steps for this study topic should be considered. If this BHO may work with the BHA to add other services such as groups or in-home visits, add peers or other types of services, implement evidence-based practices, or create some type of adult wraparound program to better serve enrollees.
SUD PIP			
SUD Residential Access	N/A	This PIP topic was chosen based on data that shows a variance between the number of individuals referred for inpatient treatment and the number that were actually admitted into treatment.	The BHO needs to word its study question that will create an intervention that will help set the framework for a performance improvement project, not program evaluation.

Thurston-Mason Behavioral Health Organization (TMBHO)

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

Comparison of Qualis Health and BHO EDV Results					
Field	**Qualis Health % Match**	**BHO % Match**	**Field**	**Qualis Health % Match**	**BHO % Match**
Demographics Data					
Last Name	98.3%	N/A	**Hispanic Origin**	89.0%	N/A
First Name	98.3%	N/A	**Race/Ethnicity**	89.0%	N/A
SSN	40.7%	N/A	**Preferred Language**	90.7%	N/A
Date of Birth	100.0%	N/A	**Sexual Orientation**	65.3%	N/A
Gender	97.5%	N/A			
Encounter Data					
Procedure Code	77.7%	95.0%	**Units of Service**	97.0%	96.0%
Date of Service	99.5%	98.0%	**Clinical Note Matches Procedure Code**	64.1%	84.0%
Service Location	74.9%	95.0%	**Author Identified**	99.5%	98.0%
Provider Type	95.9%	96.0%			

Strengths	Recommendations
TMBHO's demographic and encounter data error rates were minimal based on electronic validations.	When performing its own internal EDV, TMBHO should use the State data submitted to ProviderOne. TMBHO should work with its BHAs on documentation standards to ensure that clinical interventions are being well documented. TMBHO should train the BHAs on general clinical documentation standards, and SERI and WAC requirements. TMBHO should train and perform oversight for its BHAs to improve evaluation and management documentation.

Information Systems Capabilities Assessment (ISCA) Follow-up

TMRSN received two recommendations as a result of the 2015 ISCA. One related to Information Security is still in progress; one related to Vendor Data has been resolved.

Previous-Year Corrective Action Plans		
Section	**Number of CAPs**	**Number Resolved**
Respect and Dignity	1	1
Seclusion and Restraint	1	0
Coordination and Continuity of Care	3	3
Coverage and Authorization of Services	1	1
Practice Guidelines	2	0
EDV	1	0

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

Appendix C: Acronyms

ACH	Accountable Community of Health
AHAC	Apple Health Adult Coverage
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
AMG	Amerigroup Washington, Inc.
BC/DR	Business Continuity and Disaster Recovery
BHA	Behavioral Health Agency
BHO	Behavioral Health Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CALOCUS	Child and Adolescent Level of Care Utilization System
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
CCW	Coordinated Care of Washington
CHIP	Children's Health Insurance Program
CHP	Community Health Plan of Washington
CFR	Code of Federal Regulations
CFT	Child and Family Team
CIS	Consumer Information System
CMHA	Community Mental Health Agency
CMS	Centers for Medicare & Medicaid Services
COC	Coordination of Care
CPT	Current Procedural Terminology
DBHR	Division of Behavioral Health and Recovery
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment
ED	Emergency Department
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FIMC	Fully Integrated Managed Care
GHRSN	Grays Harbor Regional Support Network
GRBHO	Great Rivers Behavioral Health Organization
GCBHO	Greater Columbia Behavioral Health Organization
HCA	Health Care Authority
HCPCS	Healthcare Common Procedural Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act
HO	Healthy Options
HOBD	Healthy Options Blind and Disabled
HOFC	Healthy Options Foster Care
IHI	Institute for Healthcare Improvement
ISCA	Information Systems Capability Assessment

KCBHO	King County Behavioral Health Network
LEIE	List of Excluded Individuals and Entities
LOC	Level of Care
LOCUS	Level of Care Utilization System
MCO	Managed Care Organization
MHSIP	Mental Health Statistics Improvement Program
MHW	Molina Healthcare of Washington
MMIS	Medicaid Management Information System
MOSES	Monitoring of Side Effects Scale
MSO	Management Services Organization
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NSBHO	North Sound Behavioral Health Organization
OPBHO	Optum Pierce Behavioral Health Network
OIG	Office of the Inspector General
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider
PDSA	Plan, Do, Study, Act
PIHP	Prepaid Inpatient Health Plan
PBHO	Peninsula Behavioral Health Organization
PIP	Performance Improvement Project
PRISM	Predictive Risk Intelligence System
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QM	Quality Management
QUIC	Quality Improvement Committee
RY	Reporting Year
RSA	Regional Service Area
RSN	Regional Support Network
SAM	System for Award Management
SCRBHO	Spokane County Regional Behavioral Health Organization
SDQ	Strengths and Total Difficulties Questionnaire
SERI	Service Encounter Reporting Instructions
SSA	Social Security Act
SUD	Substance Use Disorder
TSP	Transitional Support Program
UHC	United Healthcare Community Plan
UM	Utilization Management
WAC	Washington Administrative Code
WISe	Wraparound with Intensive Services

Appendix D: PIP Review Procedures

TEAMonitor PIP Review Procedure

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

Part A: Assessing the Study Methodology

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

2: Review the Study Question(s)
a) Was/were the study question(s) stated clearly in writing?

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

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

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

6: Review Data Collection Procedures
a) Did the study design clearly specify the data to be collected?
b) Did the study design clearly specify the sources of the data?

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

7: Assess Improvement Strategies

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

8: Review Data Analysis and Interpretation of Study Results

a) Was an analysis of the findings performed according to the data analysis plan?
b) Were numerical PIP results and findings accurately and clearly presented?
c) Did the analysis identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?

9: Assess Whether Improvement is "Real" Improvement

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

10: Assess Sustained Improvement

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

Part B: Verifying Study Findings (optional)

Were the initial study findings verified upon repeat measurement?

Part C: Evaluate Overall Validity and Reliability of Study Results

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

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

PIP Scoring

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

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

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

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

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

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

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

Qualis Health PIP Review Procedure

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

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

Step 1: Review the Selected Study Topic(s)

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

Step 2: Review the Study Question(s)

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

Step 3: Review the Identified Study Populations

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

Step 4: Review Selected Study Indicator(s)

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

Step 5: Review Sampling Methods

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

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

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

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

Step 6: Review Data Collection Procedures

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

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

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

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

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

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

Step 7: Review Data Analysis and Interpretation of Study Results

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

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

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

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

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

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

Step 8: Assess Improvement Strategies

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

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

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

8.4) Are the interventions culturally and linguistically appropriate?

Step 9: Assess Whether Improvement is "Real" Improvement

9.1) Was the same methodology used for data collection at baseline and repeat measurements?
9.2) Is there a description of the data analysis regarding improvements in process or outcomes of care?
9.3) Is there an evaluation demonstrating that improvement appears to be the result of the intervention? Or an analysis related to why there was not improvement?
9.4) Is there any statistical evidence that any observed improvement is true improvement? Was statistical analysis performed thoroughly and accurately?

Step 10: Assess Sustained Improvement
10.1) Was sustained improvement demonstrated through repeated measurements over comparable periods of time? If improvement was not sustained, was there an explanation? Is there a plan for next steps?

PIP Scoring

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

Fully Met means 100 percent of the required documentation under a protocol step, or component thereof, is present.
Partially Met means at least 50 percent, but not all, of the required documentation under a protocol step, or component thereof, is present.
Not Met means less than 50 percent of the required documentation under a protocol step, or component thereof, is present.
Once Qualis Health assigns a final score to the performance improvement project, an assessment is made to determine the validity and reliability of the reported results for projects that have progressed to at least a first re-measurement of the study indicator. For performance improvement projects that have not progressed to at least a first re-measurement period, the assessment will conclude that "Not enough time has elapsed to assess meaningful change." Because determining potential issues with the validity and reliability of the study design is sometimes a judgment call, Qualis Health reports one of the following levels of confidence in the study findings based on a global assessment of study design, development and implementation:

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

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

"Moderate confidence in reported results" means the study design and data collection and analysis procedures are not of sufficient quality to warrant a higher level of confidence. Study weaknesses

(e.g., threats to internal or external validity, barriers to implementation, questionable study methodology) are identified that may impact the validity and reliability of reported results.

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

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

Appendix E: Regulatory and Contractual Requirements

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

438.206 Availability of Services

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

438.206(c) Furnishing of Services

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

438.608 Program Integrity Requirements (Fraud and Abuse)

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

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

447.46 Timely Claims Payment by MCOs

447.46 Timely claims payment, 9.11

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- Coordination of benefits, 5.13.1

438.208 Primary Care and Coordination

438.208(b) Primary care and coordination of healthcare services

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

438.208(c)(1) Identification, 13.2
438.208(c)(2) Assessment, 14.3
438.208(c)(3) Treatment plans, 14.3
438.208(c)(4) Direct access to specialists, 14.12
438.240(b)(4) Care Coordination Oversight, 14.10

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- Continuity of Care, 14.1
- Transitional Care, 14.5

- Coordination between the contractor and external entities, 14.4
- Skilled nursing facility coordination, 14.6
- Coordination of care for children in foster care and the fostering well-being program, 14.7
- Care coordination with Regional Support Networks (RSNs), 14.8
- Screening tools, 14.11

438.210 Coverage and Authorization of Services

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

438.114 Emergency and Post-stabilization Services

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

Apple Health Contract

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

438.226 Enrollment and Disenrollment

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

438.100 Enrollee Rights

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

Apple Health Contract

- Customer Service, Subsection 6.6

438.228 Grievance Systems

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

438.406(a) Handling of grievances and appeals – General requirements, 13.1.2 and 13.1.5
438.406(b) Handling of grievances and appeals – Special requirements for appeals, 13.1.3 and 13.3.7
438.408(a) Resolution and notification: Grievances and appeals – Basic rule, 11.3 and 11.4.1
438.408(b) and (c) Resolution and notification: Grievances and appeals – specific timeframes and extension of timeframes, 13.2.7 and 13.3.9
438.408(d) and (e) Resolution and notification: Grievances and appeals – Format of notice and content of notice of appeal resolution, 13.2.9 and 13.3.10
438.410 Expedited resolution of appeals, 13.4.3
438.414 Information about the grievance system to providers and subcontractors, 9.4.12
438.416 Recordkeeping and reporting requirements, 13.10
438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending, 9.4.12.3, 13.5.2.2 and 13.8
438.424 Effectuation of reversed appeal resolutions, 13.9

438.240 Performance Improvement Projects (PIP)

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

438.236 Practice Guidelines

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

438.214 Provider Selection (Credentialing)

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

438.240 Quality Assessment and Performance Improvement Program

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

438.230 Sub-contractual Relationships and Delegation

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

438.242 Health Information Systems

438.242 Health information systems – General rule, 7.11
438.242 (b)(1)(2) Basic elements, 7.11
438.242 (b)(3) Basic elements, 7.11

Healthy Options – Health Homes – Section 2703 Affordable Care Act

Apple Health Contract – Health Homes

- Health Care Authority Encounter Data Reporting Guide (Administrative)Health Home Services, Exhibit C 1.28
- AH Contract Exhibit C 3.3 (Administrative) Monthly Reports, Exhibit C, 3.14.1
- Exhibit C, 3.4, 3.5 and 3.7 (Eligibility and Enrollment)
- Exhibit C, 3.8.7 and 3.8.9.2 (Assignment, Engagement and Participation)
- Exhibit C, 3.9 and 3.10 (Assignment, Engagement and Participation)
- Exhibit C, 3.11, 3.12 and 3.13 (Transitional Care Service)
- AH Contract 14.9, Exhibit C, 2.1.6 (Staff)

Appendix F: 2016 Enrollee Quality Report

As a component of its external quality review work for HCA, Qualis Health produced the *2016 Enrollee Quality Report,* designed to provide Apple Health applicants and enrollees with simple, straightforward comparative health plan performance information to assist them in selecting a plan that best meets their needs.

Data sources for this report include the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure sets. The rating method is in alignment with the star rating systems used by other states and reflects the data sources available for the Apple Health population in Washington. For more information on the methodology used to derive this report's star rating system, see the complete *2016 Enrollee Quality Report Methodology.*

2016 Washington Apple Health Plan Report Card

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

KEY: Performance compared to all Apple Health plans — ABOVE AVERAGE ★★★ AVERAGE ★★☆ BELOW AVERAGE ★☆☆

Performance Areas	Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Getting Care	★☆☆	★★☆	★☆☆	★★★	★★☆
Keeping Kids Healthy	★☆☆	★★☆	★★☆	★★☆	★★☆
Keeping Women and Mothers Healthy	★☆☆	★★☆	★☆☆	★★★	★☆☆
Preventing and Managing Illness	★★☆	★☆☆	★☆☆	★★☆	★★☆
Satisfaction with Care	★☆☆	★★☆	★☆☆	★★☆	★★☆
Satisfaction with Plan	★☆☆	★★☆	★★☆	★★☆	★☆☆

These ratings were based on information collected from health plans and surveys of health plan members in 2015 and 2016. The information was reviewed for accuracy by independent auditors. Health plan performance scores were not adjusted for differences in their member populations or service regions.

Performance Area Definitions

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

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

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

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

Satisfaction with Care
- Members report high ratings for:
  - Doctors
  - Specialists
  - Overall healthcare

Satisfaction with Plan
- Members report high ratings for:
  - The plan's customer service
  - The plan overall