2013 External Quality Review Annual Report

Washington State Healthy Options Program
Children's Health Insurance Program
Division of Behavioral Health and Recovery
Washington Medicaid Integration Partnership

December 2013

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

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Acronyms Used in This Report

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

Acronyms for individual RSNs and MCOs are listed on pages 17 and 66, respectively.

Executive Summary

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

This report presents performance results for the 5 managed care organizations (MCOs) and 11 regional support networks (RSNs) that were contracted to provide Medicaid managed care services during 2012–2013. HCA oversees and monitors the MCO contracts, and the Division of Behavioral Health and Recovery (DBHR), within the Aging and Disability Services Administration (ADSA), oversees and monitors the RSNs.

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

State-level strengths

- Four of the five MCOs met or partially met the validation requirements for performance improvement projects (PIPs), notable in that three MCOs had been under contract with HCA for less than a year at the time of the PIP reviews.
- The average rate of emergency room (ER) visits by Washington MCO enrollees fell significantly for the third straight year, and remained significantly below the U.S. Medicaid average.
- DBHR has supported the RSNs' efforts to ensure that mental health treatment adheres to the "golden thread" of therapy. Overall, the RSNs' contracted providers have done a good job of ensuring that
  - mental health assessments establish medical necessity, justify the enrollee's diagnosis, and reflect the enrollee's current life circumstances
  - treatment plans include individualized objectives, interventions, and goals consistent with the issues identified in the assessment
  - progress notes address interventions specified in the treatment plan and the enrollee's progress toward meeting the stated goals
- Children's clinical records reviewed in 2013 almost always indicated that the child had access to unconditional treatment. This approach, based on a "no-fail" policy, teaches children to use more positive behaviors and skills to rebuild relationships with their families and caregivers.
- Of 12 performance improvement projects (PIPs) the RSNs had been conducting for more than a year at the time of review, 11 earned a Fully Met rating.

Recommendations

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

Mental health care delivered by RSNs

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

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

Children's mental health treatment. Many clinical records for children did not document access to other service agencies and systems (e.g., child welfare, juvenile justice, special education)

when the child's assessment indicated such involvement. Mental health providers need to coordinate care with other agencies and systems involved in the child's life.

- ***DBHR needs to work with the RSNs to ensure that mental health clinicians include coordination-of-care objectives in individualized care plans for children, when allied service agencies are involved in the child's care.***

Almost half of the children's treatment plans reviewed did not describe a multidisciplinary team-based approach to treatment.

- ***DBHR needs to work with the RSNs to ensure that children's treatment plans include a multidisciplinary team-based approach, when appropriate.***

Nearly one-quarter of assessments for children were more than a year old; in many cases, the assessments were three to five years old.

- ***DBHR needs to work with the RSNs to ensure that providers update enrollees' assessments at least annually to reflect changes in the enrollee's functioning and life circumstances.***

Most progress notes for children did not document the child's response to the interventions identified in the treatment plan or progress toward meeting the goals negotiated with the child or family.

- ***DBHR needs to direct the RSNs to work with their providers to ensure that children's progress notes fully document the child's response to interventions and progress toward stated goals.***

PIPs. Some RSNs have prolonged their PIPs beyond a reasonable period without demonstrating sustained improvement. Many of the new PIPs reviewed in 2013 did not provide evidence to support the validity of the chosen study indicator. Some RSNs did not demonstrate the relevance of the PIP topic for the local Medicaid population.

- ***DBHR should establish a process to approve each RSN's PIP topics before the RSN begins implementation.***
- ***DBHR needs to define clear expectations for PIPs, requiring the RSNs to***
  - ***select a new topic after the PIP has completed a second remeasurement or if the PIP has been in place for more than three years***
  - ***ensure that study topics are informed by enrollee input, relevant to the local population, focused on a high-volume or high-risk population, and address a significant improvement opportunity that can be evidenced with data***

Information Systems Capabilities Assessment (ISCA). DBHR relies on its legacy Consumer Information System (CIS) as the primary data repository for producing mental health reports. Encounter data submitted by the RSNs to ProviderOne, the state's Medicaid management information system, must pass through several transitions before reaching the CIS database. The DBHR ISCA review and other EQR activities identified numerous issues related to CIS data quality, processing, and documentation (see Appendix C).

- ***DBHR needs to address state-level ISCA recommendations related to CIS data quality, accuracy, and completeness.***

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

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

Exhibit C of DBHR's updated contract contains more stringent requirements for RSNs and their provider agencies to safeguard Medicaid data security. The 2013 ISCA review found that all but two RSNs failed to demonstrate compliance with the updated criteria. In many cases, the RSNs had not yet aligned their policies and procedures with the new contract provisions. Provider agencies' implementation of the required practices was inconsistent. Some RSNs may have been confused about new requirements because of the manner in which DBHR disseminated the updates.

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

Encounter data validation (EDV). Acumentra Health's review found only a 65% rate of match between minutes of service recorded in enrollees' charts and the service minutes recorded in the state's encounter data set. This low match rate is attributed to conversions performed during data processing in ProviderOne. If the data sent to CMS from ProviderOne contain the errors that Acumentra Health detected, DBHR could be at risk of recoupment of program dollars by CMS.

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

Language information was missing from 14.8% of the state's demographic data records, and 18.6% of records contained invalid ethnicity data. The EDV also found low match rates for these fields between the state's data and enrollee charts at the provider agencies. RSNs need accurate data about ethnicity and language in order to tailor culturally and linguistically appropriate services.

- ***DBHR needs to ensure that ethnicity and language data can be accurately captured and reported to CMS and the RSNs.***

All RSNs validated enrollee records against encounters they had sent or expected to send to ProviderOne, rather than against the state's encounter data after processing. This hinders the RSNs from detecting discrepancies between the data they submit and the state's encounter data. Acumentra Health's EDV reviews, using the state-processed data, found issues with ethnicity, service minutes, and duplicate claim IDs that the RSNs did not identify.

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

Physical health care delivered by MCOs

Care coordination. TEAMonitor's 2013 review found that the MCOs are complying only partially with requirements to ensure the coordination and continuity of care for at-risk enrollees. Challenges in this area are likely to grow with the addition of thousands of new Medicaid managed care recipients who have complex medical and behavioral needs. High-risk enrollees account for more than 25% of enrollees for three of the five MCOs. HCA and DBHR need to align their efforts closely to improve the coordination and continuity of care across medical and mental health programs.

- ***HCA should ensure that all MCOs incorporate EQR recommendations into their quality improvement plans.***
- ***MCOs should explore strategies to incorporate the state's Predictive Risk Intelligence System (PRISM) into their care coordination activities.***

Technical assistance.

- ***In 2014, HCA should sponsor formal training for all MCOs on care transitions and coordination, program integrity, and access issues, to help the MCOs meet contractual and regulatory requirements.***
- ***HCA should encourage MCOs with emerging best practices to share those practices at the regularly scheduled joint MCO/RSN quality meetings.***

Data quality and completeness. The HEDIS audits revealed challenges related to the MCOs' ability to demonstrate comprehensive review and evaluation of their data. Delegation and vendor oversight proved especially challenging.

- ***HCA should continue to monitor efforts with the EQRO to ensure the reliability of data integration and overall integrity of MCO data systems.***
- ***MCOs need to closely monitor and evaluate incoming data and data transmission from vendors that perform delegated functions.***

The MCOs continue to struggle with capturing and reporting race and ethnicity data for Medicaid enrollees, which can inform interventions to address healthcare disparities.

- ***HCA should continue to work with state policy analysts to determine the best approach to collect reliable race and ethnicity data for Medicaid enrollees.***
- ***MCOs should dedicate resources to improve the collection, retention, and completeness of race/ethnicity data.***

ER utilization. Relatively low rates of ER use, compared with national rates, are a positive for Washington's Medicaid program. The state should press for sustained improvement in this area.

- ***MCOs should incorporate utilization reports from the Emergency Department Information Exchange (EDIE) into their care coordination and transition programs to ensure that enrollees receive timely care at the appropriate levels.***

Performance measure feedback to clinics. Clinical performance reports for providers can identify Medicaid enrollees who need services but lack access to care.

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

Washington Medicaid Integration Partnership (WMIP)

The WMIP can provide valuable lessons to help advance the state's goal of integrating primary care, mental health, chemical dependency, and long-term care services.

Encouragingly, the ER visit rate for WMIP enrollees fell significantly for the third straight year in 2013. If successful, the current PIP being conducted by Molina Healthcare of Washington (MHW), the WMIP contractor, could further reduce the rate of avoidable ER visits.

- ***MHW should continue efforts to reduce WMIP ER visit rates and hospital readmissions through its two clinical PIPs, and respond to TEAMonitor's request for more detailed documentation of the interventions for the hospital readmissions PIP.***

TEAMonitor's review of WMIP has identified deficiencies in timeliness and completeness of intake screenings and in assessment of high-risk enrollees.

- ***MHW should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.***
- ***MHW should ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and current, to meet standards for continuity and coordination of care.***
- ***MHW should conduct a root cause analysis or other investigation to determine why WMIP enrollees' utilization of mental health services decreased from 2012 to 2013.***
- ***The WMIP program should explore ways to increase enrollees' ongoing engagement in alcohol and drug dependence treatment.***

INTRODUCTION

Washington's Medicaid program provides medical benefits for slightly more than 1 million low-income residents, about 800,000 of whom are enrolled in managed care. More than 1.2 million Washingtonians are enrolled in managed mental health services, and about 3,800 beneficiaries are enrolled in the WMIP.

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

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

EQR requirements

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

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

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

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

In 2013, Acumentra Health also conducted an encounter data validation activity and a focused review of clinical records for the RSNs, as directed by DBHR.

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

Washington's Medicaid managed care programs

The Washington Medicaid program traditionally has provided managed medical care for children, mothers, and pregnant women through Healthy Options, the Children's Health Insurance Program (CHIP), and Basic Health Plus, and for a small number of adult SSI or SSI-related clients through the WMIP program in Snohomish County.

Since July 1, 2012, HCA has enrolled into Healthy Options approximately 90,000 disabled and blind SSI recipients, who previously received fee-for-service medical care. HCA has brought additional new populations into managed care through the Medical Care Services (MCS) program and the Washington Health Program (WHP). MCS, formerly Disability Lifeline/ General Assistance-Unemployable (GA-U), serves eligible adults who cannot work for physical or mental reasons and those eligible for state-funded alcohol and drug addiction treatment. HCA began offering the WHP statewide on November 1, 2012, to provide reduced-cost coverage for qualified residents in the interim before the state Health Benefit Exchange becomes operational. The net effect has been a major shift toward adult enrollment.

As of January 1, 2014, Washington Medicaid coverage will expand to include people ages 19–65 with annual incomes up to 138% of the Federal Poverty Level ($15,864 for an individual, $26,952 for a family of three), as authorized by the federal Affordable Care Act. All populations served by Medicaid are now rolled up under Apple Health.

Washington Medicaid Integration Partnership (WMIP)

This project, aimed at improving care for adult residents of Snohomish County who have complex health care needs, began in January 2005. WMIP seeks to coordinate Medicaid-funded medical, mental health, substance abuse, and long-term care within a patient-centered framework. Molina Healthcare of Washington (MHW) coordinates services for WMIP enrollees. As of December 2012, about 3,800 beneficiaries were enrolled in WMIP.

State quality improvement activities

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

Managed Care Quality Strategy

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

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

Performance improvement projects

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

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

The current HCA contract requires each MCO to conduct at least one clinical and one nonclinical PIP. The MCO may choose the topic of its clinical PIP. An additional clinical PIP will be required in 2014 if the MCO's well-child visit rates fall below contractual benchmarks. The MCOs also must collaborate in conducting a nonclinical statewide PIP on Transitional Healthcare Services, focused on enrollees who have special healthcare needs or are at risk for re-institutionalization, re-hospitalization, or substance use disorder recidivism. Reviews by TEAMonitor validate the PIPs' compliance with CMS standards.

For the WMIP program, MHW carried over two PIPs from 2012 to 2013, aimed at reducing avoidable hospital readmissions and emergency room visits by WMIP enrollees.

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

Performance measurement

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

Physical health performance measures

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

HEDIS results for a given measurement year (the year in which care is given) are reported the next year, called the reporting year. For reporting year 2013, HCA required each MCO to report only two utilization measures, inpatient and ambulatory care. HCA did not require additional measures because the MCOs were contracted for only six months in 2012 and HEDIS measures typically have a continuous enrollment requirement. For 2014–2015, MCOs will be required to report a full set of clinical measures.

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

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

To ensure data integrity, NCQA requires certification of each health plan's data collection process by a certified HEDIS auditor. HCA funded the 2013 HEDIS audit for the MCOs to fulfill the federal requirement for validation of performance measures. For the WMIP program, MHW underwent a certified HEDIS audit that incorporated the CMS ISCA tool.

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

In fall 2013, the CAHPS survey collected responses from both adult and child enrollees in the managed care SSI population; survey results are expected by April 2014. During 2014, the MCOs will collect CAHPS survey data for adults

receiving managed care services. The EQRO will conduct a statewide analysis of the results and will report to HCA.

Mental health performance measures

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

During 2013, Acumentra Health performed a full ISCA review for each RSN. The goal was to determine the extent to which each RSN's information technology systems supported the production of valid and reliable state performance measures and the capacity to manage the health care of RSN enrollees.

Compliance monitoring

HCA participates in TEAMonitor with ADSA and the Department of Health. TEAMonitor annually reviews each MCO's compliance with regulatory and contractual provisions related to access, timeliness, and quality of care. Activities include completion of a pre-assessment followed by a two-day site visit by TEAMonitor reviewers. The final review phase includes a follow-up process and corrective action plan.

Acumentra Health monitors the RSNs' compliance with regulations and contract provisions during annual site visits, using review methods adapted from the CMS protocol. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required the RSN to perform corrective action.

Quality oversight

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

EQR activities

Table 1 summarizes the mandatory and optional EQR activities.

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

Activity	How addressed for MCOs	How addressed for RSNs
Required		
Validation of PIPs	TEAMonitor reviews	EQRO onsite reviews
Validation of performance measures	HEDIS audit	Performance measure validation and ISCA by EQRO
Health plan compliance with regulatory and contractual standards	TEAMonitor onsite reviews	EQRO onsite reviews
Optional		
Administration or validation of consumer or provider surveys of quality of care	CAHPS survey by EQRO	Mental Health Statistics Improvement Program survey

METHODS

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

- 2013 HEDIS report of MCO performance in key clinical areas[1]
- 2013 TEAMonitor reports on MCOs' compliance with BBA regulations and state contractual requirements
- Acumentra Health reports on individual RSNs' regulatory and contractual compliance, PIP validation, and ISCA follow-up, submitted throughout 2013

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

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

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

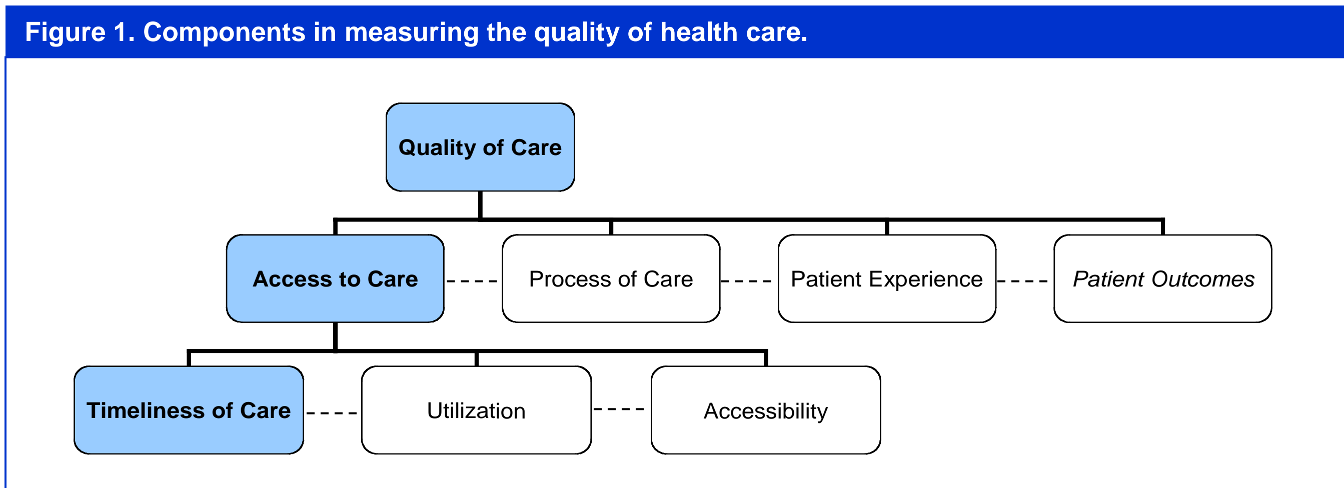
Quality of care encompasses access and timeliness as well as the *process* of care delivery (e.g., using evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall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

Access to care is the process of obtaining needed health care; thus, measures of access address the patient's experience *before* care is delivered. Access depends on many factors, including availability of appointments, the patient's ability to see a specialist, adequacy of the healthcare network, and availability of transportation and translation services.[2,3,4] Access to care affects a patient's experience as well as outcomes.

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

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

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



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

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

Mental Health Care Delivered by RSNs

During 2013, DBHR contracted with 11 RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs, in turn, contracted with provider groups, including community mental health agencies and private nonprofit agencies and hospitals, to deliver treatment services. RSNs are responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory standards for effective care.

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

Table 2 shows the approximate number of enrollees assigned to each RSN and the RSN's percentage of statewide enrollment during 2012.

NOTE: Southwest Washington Behavioral Health began operating as an RSN on October 1, 2012. The new RSN represents a merger of the former Clark County RSN, Southwest RSN, and a portion of Skamania County previously served by Greater Columbia Behavioral Health.

This annual report covers the 2012 activities of the RSNs listed below.

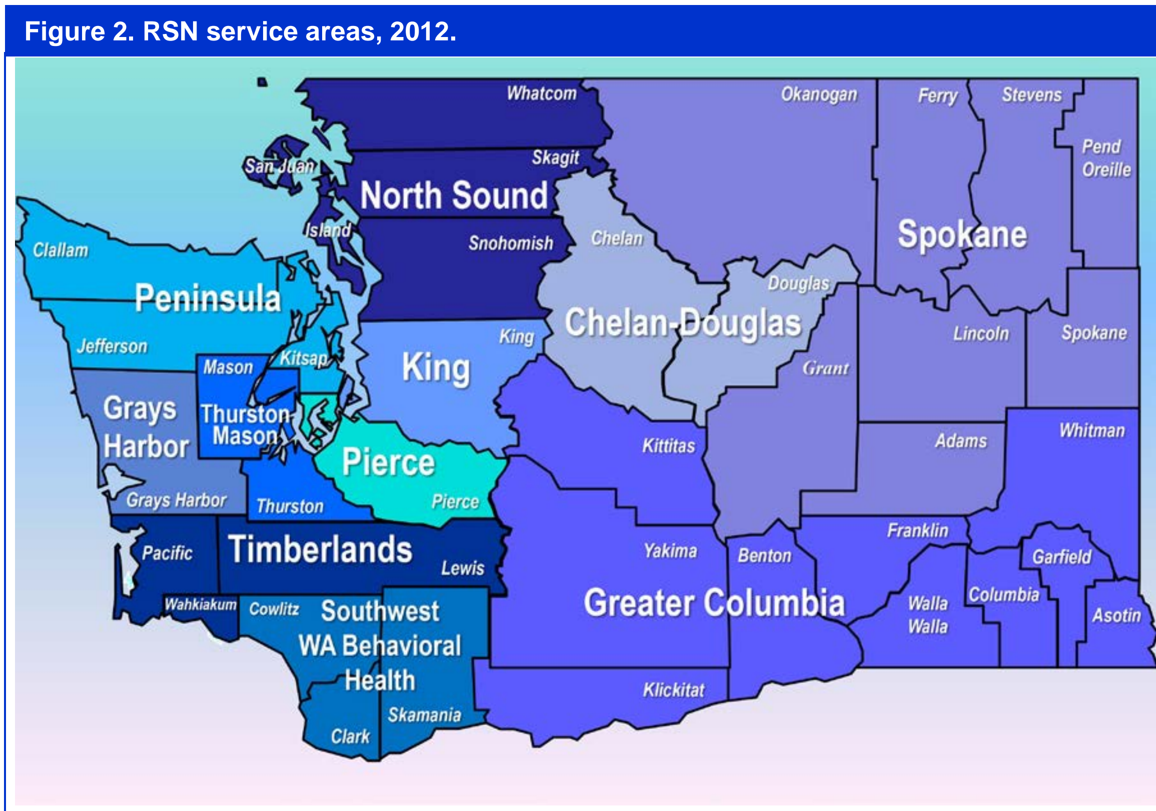
Table 2. Mental health regional support networks and enrollees, 2012.[a]

Health plan	Acronym	Number of enrollees	% of all enrollees
Chelan-Douglas RSN	CDRSN	27,855	2.2
Grays Harbor RSN	GHRSN	19,504	1.5
Greater Columbia Behavioral Health	GCBH	190,519	15.1
King County RSN	KCRSN	279,611	22.2
North Sound Mental Health Administration	NSMHA	189,150	15.0
Peninsula RSN	PRSN	56,335	4.5
OptumHealth Pierce RSN	OPRSN	163,563	13.0
Southwest Washington Behavioral Health	SWBH	71,925	5.7
Spokane County RSN	SCRSN	176,463	14.0
Thurston-Mason RSN	TMRSN	57,758	4.6
Timberlands RSN	TRSN	25,690	2.0
Total		**1,258,373**	**100.0**

[a] Source: Washington Mental Health Performance Indicator System. Enrollment for SWBH includes 2012 enrollees of former Clark County RSN; enrollment for SCRSN includes enrollees of former North Central Washington RSN. Percentages do not add to 100 because of rounding.

Figure 2 shows the counties served by each RSN in October 2012.

Figure 2. RSN service areas, 2012.



During 2013, Acumentra Health conducted the compliance review follow-up, PIP validation, and full ISCA review for each RSN. Together, these activities addressed the following questions:

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

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

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

General procedures consisted of these steps:

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

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

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

In addition to the above activities, Acumentra Health conducted an encounter data validation and a clinical record review for each RSN, using DBHR-approved methodologies. Acumentra Health also conducted a study to assess how effectively DBHR has worked with RSNs to achieve the expected outcomes stated in the 2012 Quality Strategy draft.

The following sections summarize the results of individual EQR reports for 11 RSNs completed during 2013. These results represent established measurements against which DBHR will compare the results of future reviews to assess the RSNs' improvement. Individual RSN reports delivered to DBHR during the year present the specific review results in greater detail.

Access to mental health care

These observations and recommendations arose from the RSN site reviews during 2013.

Strengths

- In clinical records reviewed by Acumentra Health, almost all progress notes for children documented that the child had access to unconditional treatment. This approach, based on a "no-fail" policy for children in treatment, focuses on teaching children to use more positive behaviors and skills to rebuild relationships with their families and caregivers.
- CDRSN's nonclinical PIP sought to increase outpatient services for older adults by implementing a gatekeeper program, in which volunteers were trained to identify older adults in the community who might need mental health services, and to refer them for treatment. As a result of the intervention, a survey of allied service providers revealed a statistically significant improvement in satisfaction with the community mental health system. This PIP earned a Fully Met rating with a perfect score of 100.

Opportunities for improvement

Many clinical records for children did not document access to other service agencies and systems in the treatment plans or the progress notes, when such involvement was indicated in the children's mental health assessments. Only 63% of the treatment plans and 54% of the progress notes incorporated coordination with other agencies and systems into treatment objectives when appropriate. More than 6% of the children whose records were reviewed lived in a foster home, often in the custody of child welfare. Other children had juvenile justice involvement or had individualized educational plans. At a minimum, mental health providers should coordinate care with agencies and systems involved in the child's life.

- ***DBHR needs to work with the RSNs to ensure that mental health clinicians include coordination-of-care objectives in individualized care plans for children, when allied service agencies are involved in the child's care.***

Almost half of the children's treatment plans did not include a multidisciplinary team-based approach to treatment.

- ***DBHR needs to work with the RSNs to ensure that children's treatment plans include a multidisciplinary team-based approach, when appropriate.***

Timeliness of mental health care

These observations and recommendations arose from the RSN site reviews during 2013.

Strengths

- All mental health assessments for children by CDRSN's providers were completed or updated within the past year.
- Several PIPs that addressed issues related to timeliness of care earned a rating of Fully Met.
    - NSMHA's clinical PIP focused on timely access to medication evaluations through "planful discharge" in outpatient services.
    - SWBH's nonclinical PIP (initiated by Clark County RSN in 2011) tested the use of collaborative discharge planning to improve the percentage of enrollees receiving non-crisis outpatient service within seven days after discharge from an inpatient psychiatric facility.

Opportunities for improvement

Nearly one-quarter of mental health assessments for children in the clinical record review were more than a year old, and in many cases, the assessments were three to five years old. In one case, there was no current assessment for a teenager; the only assessment in the record had been conducted when the child was less than 10 years old.

- ***DBHR needs to work with the RSNs to ensure that providers update enrollees' assessments at least annually to document changes in the enrollee's functioning and life circumstances.***

One PIP related to timeliness of care continued for more than three years without demonstrating statistically significant improvement in the study indicator.

- ***RSNs need to develop PIPs with the intention of completing the project within two remeasurement periods. DBHR should review and approve any PIP extensions beyond the second remeasurement period.***

Quality of mental health care

These observations and recommendations arose from the RSN site reviews in 2013.

Strengths

- Acumentra Health's clinical record review indicated that the RSNs did an excellent job of ensuring that mental health assessments for both adults and children documented medical necessity and justified the enrollee's diagnosis.
- On the whole, RSNs' provider agencies did an excellent job of documenting in the assessments the child's living environment, support systems, and involvement in activities outside of the home.
- The majority of treatment plans reviewed were consistent with information in the assessments. Almost all treatment plans contained individualized treatment objectives and had interventions and goals that were consistent with the child's assessment. More than three-quarters of treatment plans contained strength-based activities and documented family/guardian participation in developing the plans.
- The majority of progress notes for children demonstrated the use of services based on the children's strengths.
- "Golden thread" elements were generally stronger in the children's charts than in the adult charts. However, more adult records demonstrated continuity between the progress notes and treatment plan.
- Six PIPs that focused on quality of care earned Fully Met ratings:
  - CDRSN (Permanent Options for Recovery Centered Housing program)
  - KCRSN (weight reduction in adults with severe mental illness)
  - OPRSN (consumer voice in treatment planning)
  - PRSN (weight monitoring)
  - TMRSN (wraparound services for high-risk youth)
  - TRSN (improving care coordination and improving treatment outcomes for adults with depression)

Opportunities for improvement

Although children's treatment plans typically included interventions and goals identified in the assessment, documentation in the progress notes was inconsistent. Most progress notes did not document the child's response to the interventions identified in the treatment plan or the child's progress toward meeting the goals negotiated with the child or guardian. Many notes documented only that the child or guardian was present and that discussion centered around how well the child or guardian was doing.

- ***DBHR needs to direct the RSNs to work with their providers to ensure that progress notes fully document children's treatment, including the child's response to clinical interventions and progress toward stated goals.***

Many of the PIPs related to quality of care focused on care coordination but did not provide evidence to support the validity of the selected study indicator. Several RSNs did not provide data to demonstrate the relevance of the study topic for the local Medicaid population.

- ***DBHR should establish a process to approve each RSN's PIP topics before the RSN begins implementation.***

DBHR Quality Strategy review

Acumentra Health is contracted to review DBHR's Quality Strategy every three years. DBHR submitted its current Quality Strategy to CMS in 2007, and collaborated with HCA in drafting an updated joint Quality Strategy in 2012. At the time of this review, the agencies had not yet approved the joint strategy.

Acumentra Health was directed to assess how effectively DBHR has implemented processes designed to achieve the expected outcomes stated in the 2012 Quality Strategy draft:

- Ensure compliance with federal and state statutory and regulatory requirements for quality.
- Assess and improve the quality of managed care services using performance measurement, quality initiatives, and strategic planning.
- Further integrate behavioral and physical health care for the managed care delivery systems to achieve better outcomes for enrollees.

Acumentra Health negotiated a review process with DBHR staff. During the 2013 site visits, Acumentra Health reviewers asked the following questions of staff from each RSN.

1. How does DBHR support your efforts to deliver quality care to Medicaid enrollees (as defined in the Quality Strategy)?
2. How does DBHR ensure compliance with federal and state statutory and regulatory requirements for quality, access, and timeliness?
3. What processes are in place to assess and improve the quality of care using performance measurement, quality initiatives, and strategic planning (regional and statewide performance measures, redundancy of reviews, and disparities)?
4. In your opinion, which efforts have been successful in improving quality over time? Which efforts could be improved? Do you have any suggestions to make DBHR's efforts more effective?
5. What is DBHR doing to integrate behavioral and physical health care to achieve better outcomes for enrollees?
6. In your opinion, which efforts have been successful in integrating behavioral and physical health care? Which efforts could be improved? Do you have any suggestions to make DBHR's efforts more effective?

Summary of interviews with RSNs by outcome domain

1. DBHR's support of RSNs' efforts to deliver quality care to Medicaid enrollees

RSNs' positive comments

- RSNs participate in a state-sponsored performance measure workgroup.
- DBHR has sponsored Peer Support training for RSNs and statewide meetings for child care coordinators.
- DBHR has facilitated RSNs' access to the Predictive Risk Intelligence System (PRISM) database, designed to identify high-risk Medicaid clients who would likely benefit from chronic care management.
- DBHR gives RSNs access to System for Communicating Outcomes, Performance, & Evaluation (SCOPE-WA) reports through DSHS's Mental Health Performance Indicator reporting system. SCOPE-WA is a web-based query and reporting service for mental health and substance abuse professionals across the state.

RSNs' concerns

- RSN administrators expressed concerns about the lack of a current Quality Strategy.

- DBHR needs to involve the RSNs in developing revisions to the Washington Administrative Code (WAC), and provide training on WAC changes.
- Although DBHR added new grievance requirements to the RSN contract in 2012, new reporting forms were finalized only recently. RSNs found it difficult to revise their policies and procedures without the new forms.
- RSNs said staff turnover at DBHR has hampered the state's ability to respond to the RSNs' requests for clarification and assistance.

2. Compliance with federal and state regulatory and contractual requirements for quality, access, and timeliness

RSNs' positive comments

- DBHR has aligned the RSN contract with federal regulatory requirements over the past several years.
- EQR evaluations show that the RSNs have achieved full or substantial compliance with all standards.
- RSNs report that the annual EQRO site visits are helpful in providing technical assistance for each RSN.
- DBHR has sponsored trainings for the RSNs on compliance and on fraud, waste, and abuse.
- DBHR provides the RSNs with access reports that track the number of days between a request for service and the first clinical service, subsequent service following intake, and outpatient follow-up care after psychiatric hospitalization.
- The state held meetings for more than a year on how to reduce the burden of site reviews on the RSNs and providers. As a result, the various compliance reviewers agreed to accept other reviewers' results in areas of duplication, and DSHS has changed its oversight monitoring.

RSNs' concerns

- RSNs lack confidence in the accuracy of ProviderOne data. Most RSNs use their own data for management reporting and encounter data validation.
- RSNs said that contract amendments—most notably those involving instructions for reporting encounter data—sometimes are distributed with very short lead times for implementing the required activities.

3. Processes in place to assess and improve the quality of care using performance measurement, quality initiatives, and strategic planning

RSNs' positive comments

- DBHR has sponsored training for RSNs on utilization management, quality management, and PIPs.
- RSNs report that responding to the ISCA review has given them more confidence in their own data systems.
- The state sponsored a comprehensive Behavioral Health Disparity report that identified high-level findings related to:
  - specialist workforce issues
  - regulatory and infrastructure issues related to specialists
  - tribal issues
- The state has included RSNs in discussions of "scorecard" outcomes, such as adult employment rates and children's success in school.
- RSNs have regional performance measures.
- RSNs took part in a workgroup to clarify DBHR's Service Encounter Reporting Instructions. The RSNs benefit from uniform definitions.

RSNs' concerns

- Although a statewide workgroup on disparities has been working for more than a year, no concrete initiatives have come forth to address the identified gaps. The RSNs look forward to implementing the initiatives to identify enrollees and provide appropriate treatment.
- Performance measures need more work. Some RSNs would like to change their regional performance measures.
- The long lag time for processing hospital claims in ProviderOne is a cause for concern.
- RSNs report that the new requirements to track evidence-based practices are very difficult to put in practice, particularly in rural areas of the state.
- RSNs report dissatisfaction with the implementation of the Children's Mental Health Redesign. Requirements appear to be designed to satisfy the *T.R. v. Dreyfus* settlement, rather than to address system-wide gaps. According to some RSNs, their successful System of Care programs have been deconstructed rather than being advanced as models to emulate.

4. Integration of behavioral and physical health care to achieve better outcomes for enrollees

RSNs' positive comments

- Access to PRISM has the potential to facilitate physical and mental health care integration.
- The DBHR contract requires RSNs to collaborate with MCOs to coordinate care for managed care enrollees.
- DBHR and HCA host regular statewide Medicaid Quality Management meetings attended by MCOs and RSNs.

RSNs' concerns

- RSNs report a lack of continuity between the integration requirements for RSNs and MCOs. The state needs to align the MCO and RSN contract requirements for coordination of care.
- RSNs would like assistance related to data sharing and HIPAA. How can RSNs share data and maintain confidentiality?
- Enrollees often receive mental health services before receiving a full assessment, and therefore before medical necessity is established. To make integration work, the state needs to provide guidance about how and what mental health services can be submitted as encounters when performed in a medical clinic.
- RSNs and MCOs need guidance regarding which services can be provided with Medicaid funds and which cannot.

Summary and recommendations

DBHR has been able to implement some processes to address the goals of the 2012 Quality Strategy draft. However, DBHR has no current adopted Quality Strategy.

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

Mental health regulatory and contractual standards

In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required the RSN to perform corrective action. Table 3 summarizes the results of this follow-up review. As shown, all findings identified in 2012 have been resolved.

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

Table 3. Status of RSN corrective actions identified in 2012.

Compliance area	42 CFR citation (see Appendix D)	Number of issues	RSN	Status of corrections
Delivery Network	438.206(b)(3)	2	GCBH	Resolved
			GHRSN	Resolved
	438.206(b)(4)	1	GHRSN	Resolved
Coodination and Continuity of Care	438.208(c)(4)	1	GHRSN	Resolved
	438.208(c)(1)–(2)	1	NCWRSN	Resolved
Authorization of Sevices	438.210(b)–(c)	1	NCWRSN	Resolved
	438.210(d)(1)–(2)	1	NCWRSN	Resolved
	438.210; §438.114	1	NCWRSN	Resolved
Provider Selection	438.214(a)–(b)	2	TRSN	Resolved
			GCBH	Resolved
Subcontractual Relationships/Delegation	438.230	1	TRSN	Resolved
Practice Guidelines	438.236	2	NCWRSN	Resolved
			OPRSN	Resolved
	438.236(a)–(b)	3	GCBH	Resolved
			KCRSN	Resolved
			NCWRSN	Resolved
QAPI Program	438.240(a)-(b)(1): (d)	2	NCWRSN	Resolved
			KCRSN	Resolved
	438.240(b)(3)	2	GCRSN	Resolved
			GCBH	Resolved
Program Integrity	438.608(a)	1	CDRSN	Resolved

Note: Since the 2012 compliance review, North Central Washington RSN (NCWRSN) has merged with Spokane County RSN. Spokane County RSN addressed each of NCWRSN's findings.

Mental health PIP validation

Acumentra Health has evaluated the RSNs' PIPs each year since 2008, using data collection tools and procedures adapted from the CMS protocol. Through document review and onsite interviews, Acumentra Health evaluates these required elements of each PIP:

- a written project plan with a study design, an analysis plan, and a summary of results
- a clear, concise statement of the topic, the specific questions the study is designed to address, and the quantifiable indicators that will answer those questions
- a clear statement of the improvement strategies, their impact on the study question, and how that impact is assessed and measured
- evidence that the intervention services and materials are culturally and linguistically appropriate, per the 2012 CMS protocol
- an analysis plan that addresses project objectives, clearly defines the study indicators and population, identifies data sources and collection procedures, and discusses the methods for analyzing the data and performing statistical tests
- if applicable, a sampling methodology that yields a representative sample
- in the case of data collection that involves a clinical record review, procedures for checking inter-rater reliability
- validation of data at the point of data entry for accuracy and completeness
- when claims or encounter data are used for population-based analysis, assessment of data completeness
- a summary of the results of all data collection and analysis, explaining limitations inherent in the data and methodologies and discussing whether the strategies resulted in improvements

Children's PIP

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

DBHR offered RSNs the option of submitting the Children's PIP (even in early development stages) for the 2013 review, or completing any ongoing PIPs for 2013 and submitting the Children's PIP for review in 2014. Because of the timing of the review schedule and DBHR's rollout of contractual requirements, some RSNs did not have the opportunity to submit a Children's PIP for 2013. In all, six RSNs submitted Children's PIPs for the 2013 review.

PIP scoring

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

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

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

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

Table 5 shows the compliance ratings and associated scoring ranges for PIPs graded on the 90-point and 100-point scales. Appendix E presents a sample scoring worksheet.

Table 5. PIP scoring ranges.

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

Table 6 shows the topics of the PIPs submitted by each RSN for 2013.

Table 6. PIP topics by RSN, 2013.

RSN	PIP topic
CDRSN	Clinical: Permanent Supported Housing
	Nonclinical: Increased Penetration Rate for Older Adults
GCBH	Clinical: Lowered PRISM Scores in a High Medical Risk Psychiatric Inpatient Population
	Children's: Lowered Inpatient Readmission Rates through Enhanced Communication
GHRSN	Clinical: Reducing Self-Reported Symptoms of Depression Through Participation in Group Psychotherapy
	Nonclinical: Reducing Emergency Room Visits Through Community Care Coordination
KCRSN	Clinical: Lifestyle Intervention to Reduce Weight for Adults with Serious Mental Illness
	Children's: Improved Coordination with Primary Care for Children and Youth
NSMHA	Clinical: Decrease in the Days to Medication Evaluation Appointment After Request for Service
	Children's: Improving the Quality of Care Coordination for High-Risk Transition Age Youth
OPRSN	Clinical: Consumer Voice in Treatment Planning
	Nonclinical: Residential Satisfaction in Integrated Community Settings
PRSN	Nonclinical: Weight Monitoring
	Children's: Improved Identification of Intensive Needs Children and Youth
SCRSN	Clinical: Reducing Readmissions to Eastern State Hospital
	Nonclinical: Improved Cultural Sensitivity as a Result of Special Population Consultation Redesign
SWBH	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
	Children's: Medication Management Care for School-Aged Children Diagnosed with ADHD
TMRSN	Nonclinical: Implementing a Peer Support Program to Reduce Readmission in Voluntary Community Psychiatric Hospitalization
	Children's: High-Fidelity Wraparound
TRSN	Clinical: Improving Treatment Outcomes for Adults Diagnosed With a New Episode of Major Depressive Disorder
	Nonclinical: Improving Coordination of Care and Outcomes

Summary of 2013 PIP validation results

Acumentra Health reviewed 22 PIPs for the 11 RSNs in 2013. Six PIPs addressed children's mental health issues and 16 were geared toward the adult Medicaid population. Five of the six Children's PIPs were new and one was in its second year. Five of the 16 adult PIPs were new and 11 were continued from previous years.

New PIP topics:

- clinical—2 PIPs
- nonclinical—3 PIPs
- Children's—5 PIPs

Continuing PIP topics:

- clinical—6 PIPs
- nonclinical—5 PIPs
- Children's—1 PIP

Clinical and nonclinical PIP topics: In 2013, themes included:

- care coordination (3 PIPs)
- reducing hospital readmission rates (2 PIPs)
- weight reduction or monitoring (2 PIPs)
- depression (2 PIPs)
- improving service penetration rates (2 PIPs)
- community resources (2 PIPs).
- increasing the percentage of enrollees who receive outpatient services within seven days of discharge from a psychiatric inpatient facility (1 PIP)
- consumer participation in treatment (1 PIP)
- improving access to medical evaluation appointments (1 PIP)

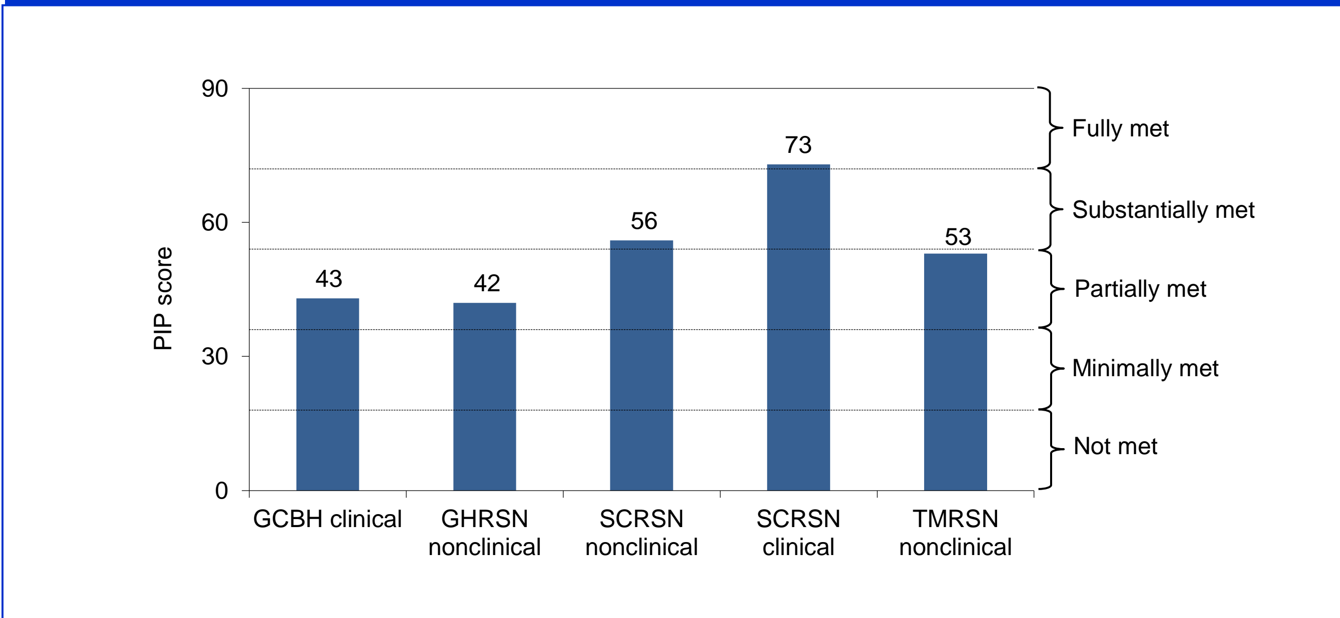
Children's PIP topics: Two of the Children's PIPs focused on care coordination. Other themes included reducing hospital readmission rates, improving identification of intensive needs children and youth, medication management for children with ADHD, and implementation of wraparound services for high-risk youth and their families.

The following analysis summarizes the RSNs' performance on clinical and nonclinical PIPs according to the PIPs' status as new or continuing projects. Analysis of the Children's PIPs includes both new and continuing projects.

Results for new clinical and nonclinical PIPs: As shown in Figure 3, three of the five clinical and nonclinical PIPs initiated in 2013 were rated as Partially Met. SCRSN's nonclinical PIP was rated as Substantially Met, and SCRSN's clinical earned a Fully Met rating. SCRSN achieved this highest rating by providing evidence that the study topic was relevant to the local Medicaid population; clearly defining all key indicator elements; listing all of the relevant numerator and denominator inclusion criteria; discussing procedures to ensure the validity and reliability of the data; thoroughly describing the intervention and how it addressed identified barriers; and documenting an intervention tracking and monitoring plan.

All of these PIPs needed to discuss in more detail how the interventions specifically addressed cultural and linguistic appropriateness, a new requirement in the 2012 CMS PIP protocol.

Figure 3. Overall scores for new clinical and nonclinical PIPs, 2013.



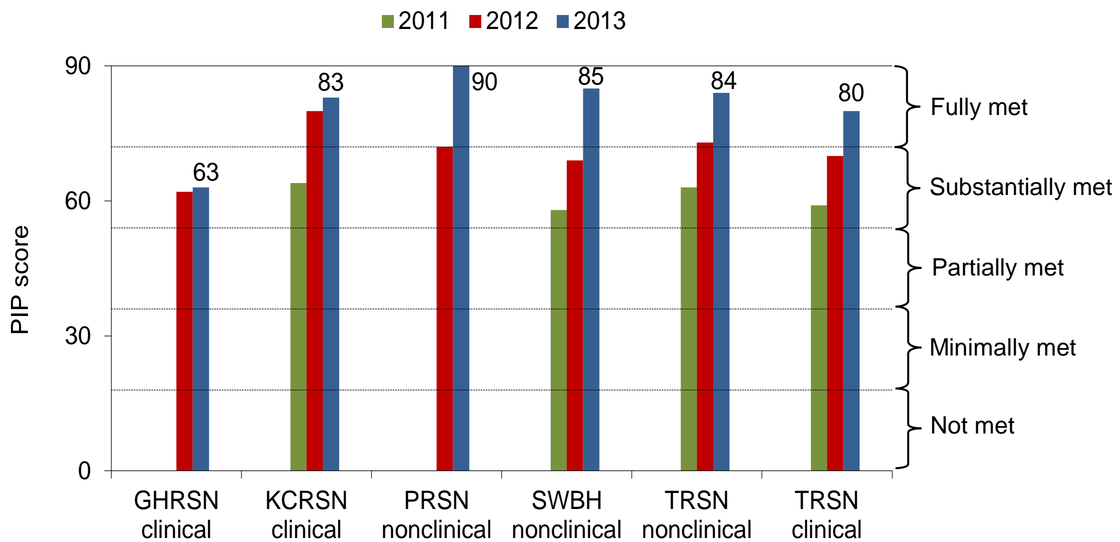
Results for continuing PIPs on the 90-point scale: Figure 4 shows progress in the overall scores for continuing PIPs on the 90-point scale (Standards 1–8) over the past three years.

Of the six PIPs in this category, five earned a rating of Fully Met in 2013, and the other earned a rating of Substantially Met. KCRSN's clinical PIP has addressed the same topic (morbidity and mortality among enrollees with serious mental illness) over the past six years through a series of different interventions focused on various aspects of metabolic syndrome.

Two PIPs (KCRSN, PRSN) documented statistically significant improvement in the study indicator. TRSN's clinical and nonclinical projects presented evidence of statistically significant improvement, but the meaningfulness of the results was compromised by very small study numbers in one PIP and a weak study indicator in the other. SWBH's nonclinical PIP showed no change in the study indicator, and GHRSN's clinical PIP presented no remeasurement results.

Three PIPs in their third and fourth years showed no meaningful improvement in the study indicator that could reasonably be attributed to the PIP intervention. KCRSN's PIP, in its sixth year, demonstrated significant improvement. In the past several years, some RSNs have prolonged their PIPs past a reasonable time frame without demonstrating success. The revised PIP review tool for 2014 will require RSNs to provide a rationale for extending a PIP past the second remeasurement period.

Figure 4. Overall scores for continuing PIPs, 90-point scale, 2011–2013.



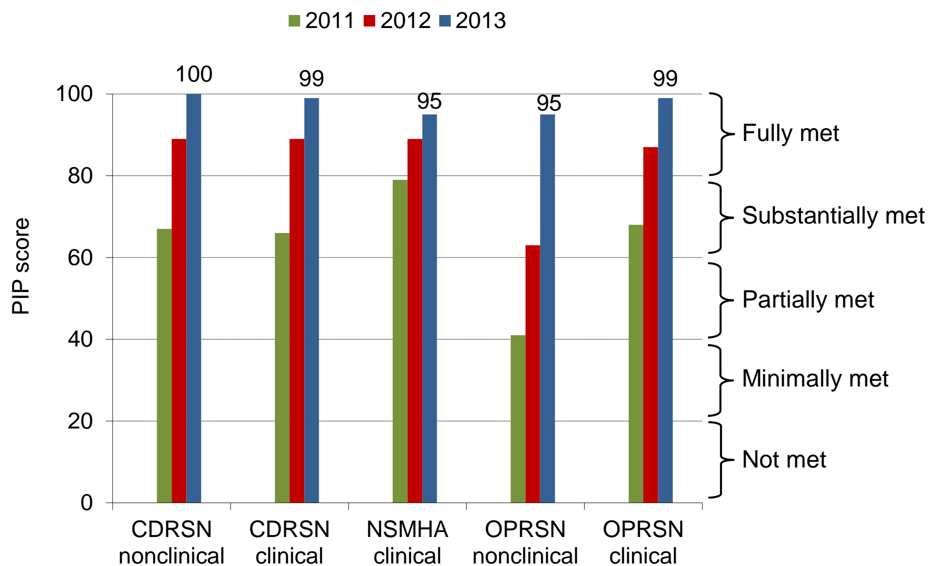
Results for continuing PIPs on the 100-point scale: Figure 5 shows progress in the overall scores for continuing PIPs on the 100-point scale (Standards 1–10) over the past three years.

All five PIPs earned overall ratings of Fully Met in 2013. Four PIPs progressed to Standards 9 and 10, where study modifications are discussed and final results are summarized following a second remeasurement. OPRSN's nonclinical PIP discussed planning for study modifications under Standard 9, but had not progressed to a second remeasurement in Standard 10. NSMHA did not submit complete second remeasurement data and results of tracking and monitoring, and therefore could not fully interpret its study results.

Both of OPRSN's PIPs demonstrated statistically significant improvement in the study indicators during the first remeasurement period, but the nonclinical PIP had not yet progressed to a second remeasurement and the clinical PIP did not show significant improvement following the second remeasurement. CDRSN's nonclinical PIP demonstrated significant improvement in the study indicator during the second remeasurement period, but the RSN did not attribute the improvement to the study intervention.

In the revised 2014 PIP review tool and scoring procedure, the scoring weights for Standards 9 and 10 will increase to reflect an emphasis by CMS on sustained improvement. Currently, PIPs are scored on documentation and calculation of remeasurement data and interpretation of the results. In 2014, PIPs will be scored on achieving statistically significant improvement as well. This change likely will result in lower scores on Standards 9 and 10, and thus lower overall scores, compared with previous years.

Figure 5. Overall scores for continuing PIPs, 100-point scale, 2011–2013.

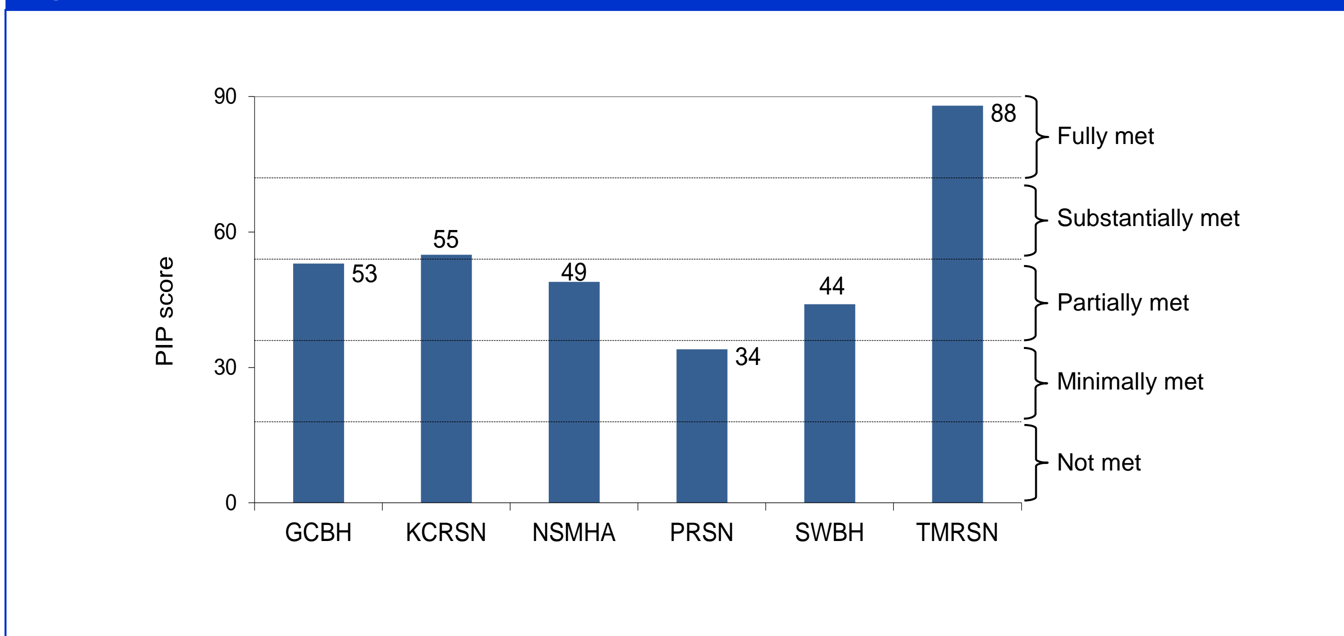


Results for Children's PIPs on the 90-point scale: Six RSNs submitted Children's PIPs for review in 2013. Five were new submissions and TMRSN's PIP was in its second year. Figure 6 shows the scores for all Children's PIPs.

The majority of these PIPs were still in early stages of development at the time of review. Three RSNs (GCBH, KCRSN, SWBH) had selected study topics but had not presented data to support the relevance of the topic to their local populations. NSMHA had selected a relevant topic and identified the study population, but had not fully defined the numerator and denominator or created a data analysis plan. PRSN decided to resubmit its clinical PIP as a Children's PIP after determining that the RSN needed to focus first on adequately identifying at-risk children and youth. KCRSN, NSMHA, and PRSN had not selected or fully fleshed out their intervention strategies. TMRSN's second-year PIP did not achieve statistically significant improvement in the study indicator during the first remeasurement; the RSN attributed this result to having a small study population.

Review of the Children's PIPs revealed some confusion related to the selection of study topics. Several RSNs reported that they had based the topic selection primarily on DBHR's contractual requirement to conduct a PIP targeting high-cost, high-need, high-utilizing children and youth. In addition to meeting this requirement, however, the RSNs also need to examine their data related to this population to identify the area of greatest need, and include consumer and provider input in the prioritization process.

Figure 6. Overall scores for Children's PIPs, 2013.

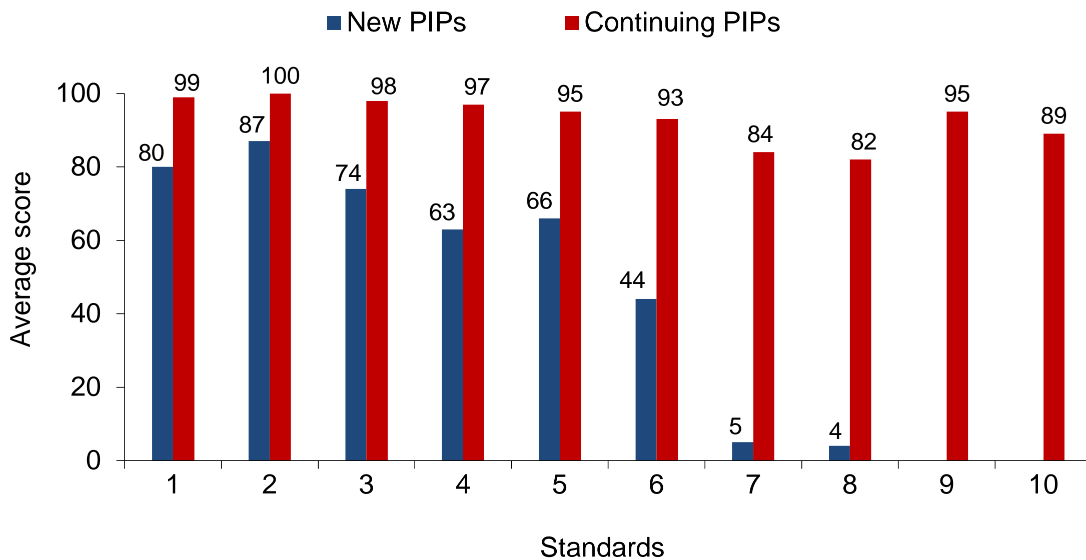


Scores by PIP validation standard: Average scores on the individual PIP validation standards illustrate the relatively strong development of the new PIPs through the planning stage, represented by Standards 1–5 (see Figure 7). On average, the continuing PIPs demonstrated stronger planning, following the first-year review, than did the newly initiated PIPs.

There appear to be two primary reasons for the differences in scoring between the new and continuing PIPs. First, many of the continuing PIPs were undertaken and managed by quality management (QM) staff who have significant experience with the PIP process. Several of the new PIPs were initiated by QM staff who were relatively new to developing and implementing PIPs. Second, some delays occurred in defining the criteria for the newly required Children's PIP. Five of the new PIPs were Children's PIPs, and the RSNs undertaking those projects described having to wait for clarification from DBHR regarding the criteria.

The average score for Standard 6, where the intervention is described, was significantly lower for new PIPs than for continuing PIPs, typically because the new projects had not yet identified or implemented an intervention. Again, this may have been due in part to delays in receiving and understanding criteria for the Children's PIP. For both new and continuing PIPs in which an intervention had been identified, a few RSNs had difficulties explaining why the intervention was expected to affect the chosen indicator.

Figure 7. Average scores by PIP validation standard, 2013.



Recommendations

The following recommendations address issues that appeared in PIPs submitted by more than one RSN. RSN recommendations 1–5 are similar to those presented in the 2012 Annual Report.

RSNs need to:

1. provide evidence to support the PIP topic's relevance to the local Medicaid population (Standard 1)
2. obtain input from stakeholders, especially enrollees, in selecting and prioritizing the study topic (Standard 1)
3. provide evidence to support the validity of the study indicator (Standard 4)
4. describe procedures used to ensure the collection of valid and reliable data (Standard 5)
5. plan and report on tracking measures to evaluate how effectively the intervention was implemented (Standard 8)
6. demonstrate that the selected intervention addresses barriers identified through a root cause analysis or other QI process (Standard 8)
7. describe how the intervention(s) address cultural and linguistic appropriateness (Standard 8)
8. design PIPs to be completed within no more than three or four years (Standard 10)
9. select a new PIP topic once a PIP reaches a second remeasurement, or if the study design is determined to be flawed such that achieving improvement is no longer feasible (Standard 10)

DBHR needs to:

1. clearly communicate expectations for PIPs
2. require the RSN to select a new topic after completion of the second remeasurement period or if four years have elapsed
3. ensure that the RSN selects a study topic that demonstrates
   - relevance to the local Medicaid population
   - inclusion of enrollee input in the prioritization and selection process
   - a focus on high-volume or high-risk study population

PIP descriptions and discussion

Chelan-Douglas RSN

Clinical: Permanent Supported Housing. This grant-funded project seeks to reduce homelessness among Medicaid enrollees through supported housing. Local providers identified 109 homeless people in 2010, 11% of the eligible population receiving noncrisis outpatient mental health services. The intervention assisted 45 individuals with housing, life skills, treatment planning, vocational skills, coordination with community services, and other support. Analysis of the first remeasurement data revealed a statistically significant increase in homelessness, contrary to what was expected. The homeless indicator fell during the second remeasurement period but was still higher than at baseline. CDRSN had planned to redefine the indicator to make it more sensitive to the kinds of changes documented during the intervention, but could not do so because of state-level coding changes.

Nonclinical: Increased Penetration Rate for Older Adults. This PIP addresses underutilization of mental health services by older adult enrollees. Local data showed a service penetration rate for older adults of 4.5% in 2011, whereas an estimated 20% of adults aged 65 and over may have mental health issues. CDRSN's intervention included gatekeeper recruitment and training, a referral system, and a "community response system" involving mental health providers. A provider agency trained 202 people as gatekeepers, who made six known referrals during the first remeasurement period and ten referrals during the second remeasurement period. CDRSN reported a statistically significant improvement in the penetration rate at the second remeasurement, but attributed the change to factors unrelated to the intervention. Allied providers' satisfaction with the local mental health system improved significantly during both remeasurement periods. CDRSN is retiring this PIP, but plans to continue to pursue strategies to improve access to mental health care for older adults.

Grays Harbor RSN

Clinical: Reducing Self-Reported Symptoms of Depression through Participation in Group Psychotherapy. This new project builds on GHRSN's previous PIP related to depression. GHRSN documented major depressive disorder (MDD) as the "second most commonly diagnosed condition" treated by the RSN. The current version of the PIP involves examining more closely the results of group treatment sessions for enrollees with MDD. GHRSN will compare scores on the PHQ-9 survey, administered at intake and again following six group sessions within 180 days. As of the PIP review, GHRSN had implemented the intervention but had not analyzed remeasurement data. The RSN needs to develop a tracking and monitoring plan for its intervention and describe the cultural and linguistic appropriateness of the intervention.

Nonclinical: Reducing Emergency Room Visits Through Community Care Coordination. GHRSN has worked with community partners since 2011 to coordinate care for enrollees who visit the ER frequently. This PIP expands on previous efforts by adding additional outreach and care coordination for enrollees with serious mental illness, co-occurring disorders, complex medical conditions, and profound psychosocial needs in less restrictive settings. As of the PIP review, GHRSN had not implemented the intervention. GHRSN needs to document why and how it prioritized the study topic, and provide more detail with regard to the implementation, tracking, and monitoring of the intervention.

Greater Columbia Behavioral Health

Clinical: Lowered Inpatient Readmission Rates Through Enhanced Communication. Local stakeholders reported inpatient recidivism as a topic of particular concern for children's mental health. Examining local data for October 2010–December 2012, GCBH found a 28% rate of hospital readmission within 90 days of discharge. GCBH has instituted its own Authorization Center for inpatient admissions to take over functions

previously performed by an independent contractor. For this first-year PIP, GCBH planned to administer a Child Inpatient Admission Review questionnaire for each child authorized for an inpatient stay. The purpose of the questionnaire is to facilitate enhanced communication between GCBH's in-house Authorization Center staff and inpatient provider utilization personnel, with the goal of improving discharge planning and ultimately reducing readmissions. At the time of the PIP review, GCBH had not implemented the intervention. GCBH needs to present data to support the selection of the study topic and intervention, and describe the data collection and validation plans more specifically.

Nonclinical: Lowered PRISM Scores in a High Medical Risk Psychiatric Inpatient Population. This first-year PIP focuses on integrating physical health information into mental health treatment plans. Healthcare providers use the PRISM database as a decision support tool to identify consumers most in need of comprehensive care coordination based upon a risk score. GCBH described its intervention strategy as the dissemination of a summary of the PRISM report on study enrollees by Authorization Center staff to the outpatient mental health provider at the time of enrollee discharge from an inpatient facility. At the time of the PIP review, GCBH had not yet implemented the intervention. GCBH needs to provide evidence of the relevance of the topic to the local Medicaid population, validity of the study indicator, and barrier analysis to support selection of the intervention.

King County RSN

Clinical: Lifestyle Intervention to Reduce Weight for Adults with Serious Mental Illness. This PIP, now in its sixth year, addresses the increased risk of morbidity and mortality among people who have serious mental illness, with attendant risk factors known collectively as metabolic syndrome. This is the first year with the current intervention strategy. KCRSN has piloted the Diabetes Prevention Program (DPP), a standardized lifestyle modification program sponsored by the Centers for Disease Control and Prevention, at six of its provider agencies. At the time of the PIP review, KCRSN had not finished collecting study results and provider and enrollee feedback. Analysis of data from four of the six agencies showed a significant decrease in the enrollees' mean weight from baseline to the last DPP session. As KCRSN has focused on the same PIP topic and target population for six years, the RSN should consider continuing any further work on this project as part of its ongoing QI program, and select a new focus for the 2014 PIP.

Nonclinical: Improved Coordination with Primary Care for Children and Youth. This first-year PIP focuses on improving coordination of care between KCRSN and physical health MCOs for Medicaid-enrolled children and youth who are high users of ER and hospital services. KCRSN has identified its intervention as coordination of care and data sharing agreements between the RSN and the MCOs. As of the PIP review date, specific details about the interventions were not yet available. KCRSN had not implemented an intervention and was identifying children and youth who met eligibility requirements for inclusion in the study population. The RSN needs to conduct a more thorough analysis to determine whether the selected interventions are appropriate and can be reasonably expected to have an effect on the number of psychiatrically-related ER and hospital admissions.

North Sound MHA

Clinical: Decrease in the Days to Medication Evaluation Appointment after Request for Service. This PIP, initiated in 2009, aims to reduce the number of days between an enrollee's request for service and a medication evaluation appointment. For its original intervention, NSMHA developed a decision tree tool for clinicians to use at the first ongoing appointment following intake, to help identify needs and make timely referrals. Following the first intervention period, the average interval from service request to medication evaluation showed no change from

baseline. NSMHA modified the intervention by adding elements to the decision tree tool to emphasize discharge planning and clinician training on medication management transfers to primary care providers (PCPs). Remeasurement data showed no significant improvement in the two periods following baseline. Data for a third remeasurement period were not available at the time of the PIP review. NSMHA identified significant confounding factors that may have affected the study results. The RSN should consider continuing any further work on this topic under its ongoing QI program, and discontinue this project as a PIP.

Nonclinical: Improving the Quality of Care Coordination for High-Risk Transition Age Youth. This first-year PIP focuses on improving care coordination for high-risk youth age 16–20. As of the PIP review, NSMHA had identified a general improvement strategy involving workforce development and implementation of practice guidelines, but had not selected specific interventions. NSMHA still needs to clarify the numerator and denominator definitions and inclusion/exclusion criteria, describe data validation procedures, refine the data analysis plan, and select appropriate interventions.

OptumHealth Pierce RSN

Clinical: Consumer Voice in Treatment Planning. This PIP is in its fourth year. OPRSN described the importance of documenting consumer involvement in treatment planning. A review of local mental health agencies indicated a need for improvement to meet a benchmark of 90% compliance. OPRSN conducted a barrier analysis to identify issues in treatment planning, and determined that training could encourage providers to give greater attention to consumer participation. The RSN hired two prominent trainers to conduct group training for all providers, followed by individual consultations at each agency. Fifty staff members from five agencies attended the group training. Data for the baseline and remeasurement periods showed a significant improvement from 81.7% to 89.0% compliance. Data for the second remeasurement period showed 83.3% compliance, down from the first remeasurement and a nonsignificant improvement compared to the baseline. OPRSN attributed the decline to dramatically lower scores for two of the five agencies. The RSN is retiring this PIP, but plans to continue working with these two agencies to increase documentation of consumer voice in treatment planning.

Nonclinical: Residential Satisfaction in Integrated Community Settings. This PIP is in its third year. In early 2012, OPRSN contracted with Recovery Innovations to implement a Community Building program that would engage people at residential treatment facilities in community-based housing alternatives. In association with this intervention, OPRSN is monitoring enrollees' satisfaction with their new environment. OPRSN adopted a validated survey instrument to measure housing satisfaction, designed specifically for people with psychiatric disabilities, and conducted a first survey before the intervention. A second survey of 16 people, who had moved out of residential treatment facilities and into community-based housing between September 2012 and June 2013, found significant improvement in satisfaction compared with baseline survey scores. OPRSN identified the small study population as a confounding variable in interpreting the results, and discussed several barriers encountered during the implementation of the intervention. The RSN plans to modify the PIP to enlarge the study population and standardize the timing of the follow-up surveys.

Peninsula RSN

Clinical: Improved Identification of Intensive Needs Children and Youth. This first-year PIP targets children and youth who need or who are at risk for needing intensive home and community-based mental health services. In selecting and prioritizing PIP topics, PRSN discovered that it lacked systems and processes to accurately identify the target population. PRSN planned to implement a standardized method of identifying high-risk, high-need children and youth as the

first step in ensuring that they receive increased support and needed services. PRSN needs to further define the study population, develop a data collection and analysis plan, select and describe the intervention, and report on baseline and first remeasurement data.

Nonclinical: Weight Monitoring. This PIP is in its second year. Local data showed that 76% of PRSN enrollees who were prescribed atypical antipsychotic medications were overweight or obese, putting them at risk of early death from diabetes and cardiovascular conditions. PRSN identified regular weight monitoring as an essential first step in clinical intervention to improve weight outcomes. This PIP focuses on weight monitoring at the provider agency with the lowest level of compliance. PRSN modified its policy to require that all enrollees receiving medical appointments at the agency have their weight documented in the electronic medical record. PRSN trained the agency's medical staff and supplied agency leadership with quarterly compliance reports. The RSN found significant improvement in recording of weight assessments in the first remeasurement period, and attributed the improvement to the intervention.

Southwest Washington Behavioral Health

Clinical: Follow-Up Medication Management Care for School-Aged Children Diagnosed with ADHD. This first-year PIP focuses on improving medication management follow-up for children age 6–12 with a diagnosis of attention-deficit/hyperactivity disorder. Although this topic met the 2013 contractual obligation to develop a child-focused PIP, SWBH could not demonstrate that the topic addresses an improvement need for the local Medicaid population. Following the onsite PIP review, SWBH decided to discontinue this PIP topic and shift its focus in 2014 to improving children's outcomes through the delivery of appropriate level-of-care services.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after a Psychiatric Hospitalization. This PIP continues a project initiated by Clark County RSN in 2011. SWBH reported that 63% of its adult enrollees received an outpatient follow-up appointment within seven days of discharge from psychiatric inpatient care during 2010, below the statewide performance target of 75%. For the first remeasurement, SWBH found no change in the study indicator compared to baseline. The RSN plans to modify its intervention by assigning specific coordination and monitoring responsibilities to newly-hired transition care managers.

Spokane County RSN

Clinical: Reducing Hospital Readmissions to Eastern State Hospital. This first-year PIP focuses on reducing readmissions within 30 days of discharge from Eastern State Hospital (ESH). Baseline data (January–June 2012) showed 10 readmissions within 30 days of discharge from ESH (13% of those discharged). In July 2012, SCRSN began implementing a series of action steps as part of an Enhanced Case Management intervention to address factors identified as contributing to a high readmission rate. At the next PIP review, SCRSN needs to present and interpret the results of analyses conducted during the first remeasurement period.

Nonclinical: Improved Cultural Sensitivity as a Result of Special Population Consultation Redesign. This first-year PIP focuses on improving the Special Population Consultation process and provider training to improve the overall cultural sensitivity of the RSN's system of care. The goal is to increase the percentage of cultural minority enrollees in the SCRSN system. A consultant on cultural competence developed a series of interventions, including staff training, new referral procedures, policy changes, and new service codes. SCRSN planned to implement the interventions in June 2013. Baseline data showed that ethnic minorities represented 14% of all enrollees, while the developmentally disabled and deaf represented 10%, but, it was not clear whether these data were collected in 2011 or 2012. SCRSN needs to clarify when it collected baseline data,

and report the results of the first remeasurement analysis at the next PIP review.

Thurston-Mason RSN

Clinical: High-Fidelity Wraparound. This PIP, in its second year, focuses on improving mental health services for high-risk children/youth and their families. TMRSN noted that the high rate of childhood adverse events in its region increases the need for mental health care and community services. In response, the RSN has implemented a wraparound model of care for at-risk children and youth. Assisted by the University of Washington Evidence-Based Practice Institute, TMRSN has measured outcomes through scores on the Strengths and Difficulties Questionnaire (SDQ), which measures overall emotional and behavioral functioning. Initial results showed that 6-month SDQ scores had improved, but not significantly, over baseline scores for the study population. The RSN stated that the lack of statistical significance was likely due to a small sample, and expects to demonstrate significance with a larger study population at the next remeasurement. TMRSN plans to incorporate the Children and Adolescent Needs and Strengths tool into this PIP to measure outcomes.

Nonclinical: Implementing a Peer Support Program to Reduce Readmission in Voluntary Community Psychiatric Hospitalization. This first-year PIP focuses on reducing voluntary psychiatric hospital readmissions for adult Medicaid enrollees, particularly those not engaged in outpatient services at the time of initial discharge. For its intervention, TMRSN planned to expand a peer support program being run by a newly contracted provider agency, Capital Recovery Center. TMRSN developed the intervention in consultation with community hospital and discharge planners, and expected to begin implementing the intervention in August 2013. TMRSN needs to provide data to support this topic as an area of local need, and conduct a root cause analysis to determine whether the selected intervention can reasonably be expected to lead to improvement.

Timberlands RSN

Clinical: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder. TRSN adopted a practice guideline and is monitoring the clinical outcomes of adult enrollees treated for MDD. This PIP, now in its third year, seeks to determine whether implementing the guideline will reduce clinical symptomatology for enrollees, as indicated by self-reported scores on the PHQ-9 survey. TRSN trained clinical staff at provider agencies on how to use the PHQ-9, and collected baseline data through May 2012. Though the results showed significant improvement between intake and six months post-intake, TRSN could not generalize the results to the larger MDD population because of very low study numbers. Chart reviews indicated only moderate adherence by clinicians to the new practice guideline. TRSN will discontinue this PIP but plans to modify the practice guideline, conduct additional staff training, and monitor guideline adherence through its ongoing QI program.

Nonclinical: Improving Coordination of Care and Outcomes. TRSN identified a need to improve coordination of care for RSN enrollees between mental health clinicians and PCPs. This PIP, in its fourth year, seeks to determine whether instituting a new standard protocol will increase the percentage of qualified enrollees who receive coordination of care (COC) services. The protocol outlines a systematic process for determining the level of care coordination with PCPs depending on enrollees' physical health functioning. TRSN implemented the new protocol January 1, 2012, and trained agency clinicians on the use of new service codes. TRSN demonstrated significant improvement in the percentage of enrollees receiving at least one COC service from 39.8% at baseline to 48.6% at first remeasurement. However, the RSN noted that a single COC service is not adequate (nor compliant with protocol guidelines) for enrollees with serious or severe physical health issues. TRSN plans to modify its intervention to focus on this higher-need subpopulation.

Mental health performance measure validation

Two core performance measures were reviewed in 2013: one that is calculated and reviewed by the state, and a second that is calculated by the RSNs and verified by Acumentra Health. An RSN that fails to meet performance expectations must submit a corrective action plan and follow through until all deficiencies have been mitigated.

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

Table 7. Performance measure validation ratings, 2013.

Performance measure	Compliance rating
Consumers receiving first routine service within 7 days of discharge from a psychiatric inpatient setting	Partially compliant
Mental health encounter data validation	Partially compliant

Routine service within 7 days of discharge

Each RSN must show improvement on a performance measure that is calculated and reviewed by the state: *Consumers receiving first routine service within 7 days of discharge from a psychiatric inpatient setting*. The state contracts with Olympia-based Looking Glass Analytics to calculate this measure according to state-supplied methodology, using encounter data regularly submitted from the RSNs to DBHR.

For 2013, DBHR calculated this statewide performance measure and submitted materials for use in validating it. Acumentra Health assessed the completeness and accuracy of the measure, seeking to answer these questions:

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

Following the CMS protocol for this activity, Acumentra Health validated this measure by:

1. requesting relevant documents from DBHR in advance of an onsite interview
2. using the documents to refine the questions to be asked at the onsite interview
3. using oral responses and written materials to assign a compliance rating (Fully compliant, Partially compliant, or Not valid)

Validation results

DBHR submitted for review the SAS statistical software programs Looking Glass uses to calculate this measure, including SAS code that processes and moves the data to the Looking Glass web servers. DBHR also submitted documentation describing the variables and data sets Looking Glass should use in calculating the measures. DBHR submitted a chart showing the flow of data from DBHR through the layers of processing; however, without a data dictionary, the chart was indecipherable to an outside reviewer. This flow chart was clarified during an onsite meeting with DBHR and Looking Glass representatives.

After receiving data files from CIS, the system that houses the state data tables, Looking Glass manages all data preparation using the Research and Data Analysis/Mental Health Division SAS server, which is housed at DBHR. This makes it difficult to determine what checks occur to ensure that Looking Glass uses accurate and complete

data—e.g., whether Looking Glass has checked DBHR's submission for missing and out-of-range data and logic errors, and how Looking Glass ensures the accuracy of its data manipulation. In addition, the SAS programs that calculate each performance measure contain no notes to explain what a particular portion of code does. Acumentra Health verified the lines of calculations that build the performance metric, but could not verify that the calculations were based on complete and reliable data.

The reports Looking Glass produces can be used to compare performance among RSNs and show RSN performance for a particular time period. Performance reports are easy to read and include all inclusion criteria and measure specifications. However, finding the correct report within the SCOPE-WA web portal was challenging because of the navigation and labeling schemes.

DBHR led the RSNs in a collaborative process to select specific codes to represent "routine outpatient" services. The inclusion criteria for the performance measure numerator changed as a result, so Looking Glass recalculated the measure starting at the baseline year. This strategy ensured that the new definitions were applied to all years of data, maintaining comparability between time periods.

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

Strengths

- The documentation describing how to construct the performance measure is thorough. The data set, variables, exclusions, and algorithms used to build each component of the measure are thoroughly explained. Actual SAS code that performs the calculations and exclusions was provided.
- The website displaying this measure provides layers of useful details. RSNs can see their performance by quarter, calendar year, and fiscal year, and in various formats (.pdf, .html, and .rtf). Performance measure rates are easily interpreted from the tables. Measure specifications and inclusion criteria are provided.
- Performance measure results are validated in several ways.
    - Looking Glass staff use the "analyzer" tool in SCOPE-WA to confirm measure calculations.
    - A DBHR staff member works closely with Looking Glass analysts to confirm each step of the process.
    - RSNs can request the raw data used to calculate the measure, enabling them to validate the data, suggest systemic improvements, and generally increase the validity of the performance measure results. Looking Glass and DBHR are developing a system to provide the raw data systematically.
    - Looking Glass code that performs the initial processing of the state data, automatically unzipping state files and placing them on Looking Glass servers, has built-in quality checks to alert staff if the downloads are unsuccessful.

Recommendations

Looking Glass has no documentation nor knowledge of the data specifications for the tables loaded from CIS. DBHR's contract with Looking Glass contains no documentation requirements.

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

Looking Glass provides DBHR with a flow chart of its data processes, but the system is large, complex, and difficult to understand without a data dictionary, which Looking Glass lacks.

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

Documentation of data processing before and during performance measure analyses is essential to help outside reviewers understand the calculation process. It is also invaluable to internal staff when they need to modify the existing data management system, especially if staffing changes occur.

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

DBHR and Looking Glass, in their respective data steps, use several checks to ensure the accuracy of the data pulled for the performance measure calculation. However, neither party checks for missing data. In addition, both DBHR and the RSNs noted concerns about the timeliness of hospital data submission.

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

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

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

A key feature of a valid performance measure is that it can be used to monitor the performance over time of health plans providing similar services, both within the state and nationally. The current reporting system lets the user choose the period for analysis—quarter, calendar year, or fiscal year—and choose filters (race/ethnicity, age group, inpatient setting) for the measure. Multiple years are presented automatically, a new feature in 2013. However, statistical tests are not used to help identify significant changes between time periods or to identify trends over time. The following recommendation appeared in the 2011 and 2012 annual reports and remains valid.

- ***DBHR should work with Looking Glass to extend the functionality of its performance measure reporting.***
  - *Statistical tests should be used to identify significant changes in performance measures from one time period to the next.*
  - *Trend tests should be used to detect shifts in rates over more than two time periods.*

In October 2012, North Central Washington RSN merged into SCRSN, and Clark County RSN and Southwest RSN merged to form SWBH. Lingering issues prevent the correct calculation and display of the performance measure results for these newly configured RSNs.

- ***DBHR should ensure that performance measure results are calculated and displayed correctly for all RSNs, including those with recent regional shifts.***

DBHR and Looking Glass are aware of and working to address two ongoing data issues. The first is the assignment of hospitalized enrollees to RSNs. Sometimes enrollees must be hospitalized away from home. Regardless of where the hospitalization occurs, the RSN providing routine outpatient service is assigned the enrollee for this performance measure, though the RSN is not always notified of the enrollee's hospitalization. The hospital is responsible for alerting the

enrollee's outpatient providers about the hospitalization.

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

The second ongoing issue relates to a small number of enrollees with Medicare and Medicaid dual coverage. These enrollees do not require prior authorization, so the RSNs are not alerted to their hospitalization. Dual-eligible enrollees are not identifiable in data sets and so cannot be excluded from the measure, but are attributed to RSNs in the calculation.

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

Because of the issues identified with regard to data reliability, this performance measure is *partially compliant* (see Table 7).

Encounter data validation

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

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

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

Review results

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

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

Two RSN mergers occurred during the 2012 review year. Because the RSNs conducted EDV activities before the mergers, Acumentra Health reviewed each procedure separately for each RSN as constituted before the mergers. No EDV documentation was submitted for one RSN that has since merged with another. Thus, Acumentra Health reviewed documentation for 12 RSNs.

Almost all RSNs used their internal data, rather than data downloaded from ProviderOne, to compare with provider agency data, although most RSNs stated that the data they used had been accepted by ProviderOne. Several RSNs went beyond contract requirements and reviewed a wide range of demographic data, such as living situation and education level, in addition to the required encounter data fields. Almost all RSNs reviewed the minimum data elements: procedure code, service date, service duration, service location, provider type, and an assessment of whether the service code matched the service described in the chart.

RSN sampling procedures. Acumentra Health evaluated each RSN's sampling procedure on the basis of two criteria. First, was the sample large

enough to meet contract requirements? Second, was it a random sample?

The minimum sample size varied according to the number of community mental health agencies (CMHAs) in the RSN, but all RSNs pulled samples of adequate size. Several RSNs oversampled by a significant margin. Of the 12 RSNs that submitted EDV documentation, 5 used procedures that should have resulted in a random sample; 6 provided insufficient documentation to establish whether the sample would be random; and 1 used a manual sampling process.

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

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

Data entry tools. Four of the 12 RSNs used data entry tools (MS Access) to capture EDV results. These tools were examined in 2012 and found to be working properly. Three RSNs entered data directly into Excel for calculation. Four RSNs manually entered the results of their data checks onto hard-copy forms and then entered the results into Excel or Access. One RSN provided no information about the system used for analysis. Acumentra Health recommends that these RSNs develop database systems to reduce the potential for error involved in using unsecured data sets (MS Excel) or entering results twice.

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

Analytical procedures. None of the RSNs had developed code using statistical software such as SAS or SPSS to analyze the EDV results. All used either Access or Excel to calculate the summary statistics reported in the EDV deliverable. In 2012, Acumentra Health reviewed the Excel formulas and Access databases to ensure that they worked properly. Some RSNs made changes to their systems following 2012, but most are using the same tools.

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

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

Four RSNs did not assess "missing" encounters as part of their EDV activities, and one RSN did not break out any "No Match" subcategories.

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

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

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

Summary and recommendations

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

In reviewing individual RSNs' EDV procedures, Acumentra Health often recommended that the RSN enter results directly into the data entry tool rather than recording results on paper and

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

Many RSNs required corrective action plans from CMHAs that did not meet defined improvement targets (5% no match; 2% unsubstantiated). Many provided technical assistance or training, thereby building a relationship with their contracted providers and improving data validity. One RSN applied a financial withhold.

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

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

All RSNs validated enrollee records against encounters they expected to send to ProviderOne, or that had already been accepted. Using these data, rather than encounters processed by the state (state data), hinders the RSNs from identifying discrepancies between the data they submitted and the data after processing. Acumentra Health used the state data for the EDV reviews and identified issues with ethnicity, minutes, and duplicate claim IDs that were not identified by the RSNs.

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

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

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

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

Information Systems Capabilities Assessment

Acumentra Health conducted a full ISCA for DBHR and for all RSNs in 2013, building on similar full reviews in 2011 and 2009. These reviews, coupled with follow-up reviews in even-numbered years, have examined the state and RSN information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable performance measures and the capacity to manage enrollees' mental health care.

The assessments have followed the CMS protocol for this review activity, involving

- collection of standard information by means of the ISCA data collection tool (ISCA-T) and other relevant documents submitted by DBHR or the RSN
- a data center security walkthrough and in-depth interviews with DBHR or RSN staff, and in the case of RSN reviews, interviews with provider agency staff
- post-onsite analysis of the review results, focusing on the implications for encounter data completeness, accuracy, and security

The ISCA review was organized in two main sections—(1) Data Processing Procedures and Personnel and (2) Data Acquisition Capabilities—each containing review elements corresponding to relevant federal standards. Each review was divided into eight subsections.

Acumentra Health used the information collected in the ISCA-T, responses to interview questions, and results from the security walkthrough to score the entity's performance on each review element on a scale from 1 to 3 (see Table 8).

After scoring the individual elements, Acumentra Health combined the scores and calculated a weighted average score for each subsection.

Table 8. Scoring scheme for ISCA elements.

Score	Rating	Definition
2.6–3.0	Fully met (pass)	Meets or exceeds the element requirements.
2.0–2.5	Partially met (pass)	Meets essential requirements of the element but is deficient in some areas.
< 2.0	Not met (fail)	Does not meet the essential requirements of the element.

DBHR information systems

Since 2010, DBHR has used the ProviderOne management information system to process Medicaid claims and encounter data. DBHR's Consumer Information System (CIS) houses demographic information for all mental health consumers and non-Medicaid mental health service data. The CIS is used to run crucial data reports such as those connected with statewide performance measures.

DBHR contracts with Maryland-based CNSI to operate and maintain ProviderOne hardware in a co-location facility in Ashburn, VA. CNSI also operates a replicated (mirrored) system with a copy of the production data in its Integrated Testing Facility (ITF) in San Jose, CA, where it tests patches and changes to ProviderOne.

DBHR exports data from ProviderOne to CIS for use in calculating performance measures. DBHR uses two data warehouses for performance measure reporting: one at the ProviderOne facility and another in Boston.

The 2013 ISCA review examined DBHR's information systems, data processing procedures, and oversight and monitoring of Looking Glass Analytics and RSN-contracted activities. The review found that DBHR *fully met* the federal standards related to data processing procedures and personnel, and *fully met* the data acquisition capabilities standards (see Table 9).

The following discussion presents high-level themes identified by the state ISCA. More detailed review information appears in Appendix C.

Table 9. Weighted average scores and ratings on DBHR ISCA sections, 2013.

Review section/subsection	Score	Compliance rating
Section 1: Data Processing Procedures and Personnel		
A. Information Systems	2.6	Fully met
B. Staffing	2.9	Fully met
C. Hardware Systems	2.9	Fully met
D. Security	2.4	Partially met
Section 2: Data Acquisition Capabilities		
A. Administrative Data (claims and encounter data)	2.8	Fully met
B. Enrollment System (Medicaid eligibility)	2.8	Fully met
C. Performance Measure Repository	2.4	Partially met
D. Report Production	2.4	Partially met

State-level strengths

- CNSI reports to DBHR daily on the health and maintenance of the ProviderOne systems and network.
- CNSI replicates ProviderOne to the ITF in near real time, providing quick and easy access to nearly complete backup data.
- ProviderOne is a fully automated auto-adjudication application. DBHR performs automated edits and verification checks in ProviderOne before adjudication to ensure the completeness and accuracy of submitted encounter data.
- DBHR and CNSI use software configuration and source code (version control) management software.
- DBHR, CNSI, and Looking Glass use security measures that make it difficult for unauthorized users to gain access to data and other network resources. DBHR uses full disk encryption strategies for all laptops and other portable devices.
- DBHR's data center facilities and hardware systems are well designed and maintained.
- DBHR provides exception reports to RSNs to help them examine possible encounter errors and to make corrections.
- DBHR receives full eligibility data from the state's Automated Client Eligibility System each night, and updates daily. RSNs receive full eligibility data files monthly and updates weekly.
- ProviderOne accepts up to 12 diagnoses per mental health service encounter.
- DBHR produces performance measure reports quarterly for the RSNs. Through Looking Glass, DBHR can display the performance measure data in a web-based dynamic format for RSN and public use.

State-level recommendations

Information Systems

DBHR still lacks robust documentation of IT systems, staffing, and data processing and reporting procedures. Insufficient documentation can create problems related to data recovery, staff turnover, and overall system supportability.

- ***DBHR needs to fully document its IT systems, staffing responsibilities, and data processing and reporting procedures.***

DBHR has no budget for training to keep programmers abreast of rapid changes in information technology.

- ***DBHR needs to develop a plan for programmer training during this period of budget austerity.***

CNSI has not upgraded its ProviderOne software since implementation in 2010.

- ***DBHR should develop a planned upgrade schedule to ensure continuing support for critical software.***

Staffing

DBHR employs limited staff to analyze mental health data and oversee the flow of encounter data throughout the process.

- ***DBHR should consider allocating more resources for staff to analyze and oversee the flow of mental health data.***

Hardware Systems

DBHR lacks a formal policy and plan for replacing hardware to avoid disruption of services caused by hardware failures.

- ***DBHR should formalize its hardware replacement policy to ensure that current equipment does not reach end of life and fall out of warranty while in production.***

Security

DBHR has a policy to remove access within five days for an employee or contractor who no longer requires access to Medicaid data systems. This practice does not align with industry standards.

- ***DBHR needs to revise its access policy to ensure immediate removal of access when a previously authorized person no longer requires access.***

Administrative Data

DBHR has a process for screening encounters upon receipt. However, several issues noted during the ISCA review call into question the accuracy and completeness of the state's encounter data.

- ***DBHR needs to ensure that encounter data submitted electronically by the RSNs pass through a stringent screening process to ensure accuracy and validity.***

DBHR uses the HIPAA-compliant 837 electronic format, which accepts multiple diagnoses. However, some RSNs report that they submit only the primary diagnosis or do not submit diagnoses on the 837. DBHR has no method in place to ensure that the diagnosis being treated at the time of service is reported on the 837.

- ***DBHR needs to implement a method to ensure that the diagnosis being treated at the time of service is reported on the 837.***

Enrollment Systems

Although DBHR developed a process that RSNs can use to update eligibility data (e.g., change of address or name), RSNs are not sufficiently aware of this new process to use it effectively.

- ***DBHR needs to clearly communicate to RSNs the process by which they can update eligibility data.***

RSNs submit to the state all encounters paid for with RSN funds. Many RSNs are not tracking which services are being paid for with Medicaid funds, since all encounters are included in the same file. DBHR provides no specification for RSNs to distinguish services paid by Medicaid from those paid by other sources, such as state-only or block grant funds. The funding source for individual services can be difficult to reconstruct, as some services for a Medicaid-eligible person may not be covered by Medicaid (e.g., jail services).

- ***DBHR needs to work with the RSNs to develop and/or clarify reporting rules to identify services and encounters that RSNs pay for with Medicaid funds.***
- ProviderOne accepts all encounters regardless of funding source. DBHR uses internal processes to determine if a person was Medicaid-eligible at the time of a service, and attaches a revenue code to the encounter. This practice may not account for all RSN funding sources and does not replicate RSN processing rules, such as ensuring that non-Medicaid-eligible services are excluded.
- ***DBHR needs to develop internal practices for tracking services paid for by Medicaid.***

Performance Measure Reporting

DBHR does not keep a frozen data set for the calculated performance measures. ProviderOne data are dynamic, preventing replication of the performance measure reports if they are lost.

- ***In the absence of a frozen data set, DBHR needs to develop procedures to validate the integrity of data undergoing formatting changes in transition from ProviderOne to Looking Glass.***

The ProviderOne/CIS file consolidation project is complete, but documentation was not available at the time of the ISCA review.

- ***DBHR needs to fully document the process by which source data are extracted from CIS, aggregated and uploaded to DBHR's SAS server, and made available for Looking Glass to use.***

RSN information systems

In addition to the state-level ISCA, Acumentra Health conducted a full ISCA for each RSN in 2013, identifying strengths, challenges, and recommendations at the RSN level.

The ISCA procedures were adapted from the CMS protocol for this activity. In 2013, the review added a new subsection, Meaningful Use of Electronic Health Records, per the CMS protocol published in September 2012. Due to the timing of the CMS waiver, this section was reviewed in 2013 but was not scored.

Exhibit C of the updated RSN contract contains more stringent data security requirements. These new contract criteria were included in the 2013 ISCA for the first time.

The 2013 reviews, which examined the status of RSNs' information systems during 2012, revealed the following major themes.

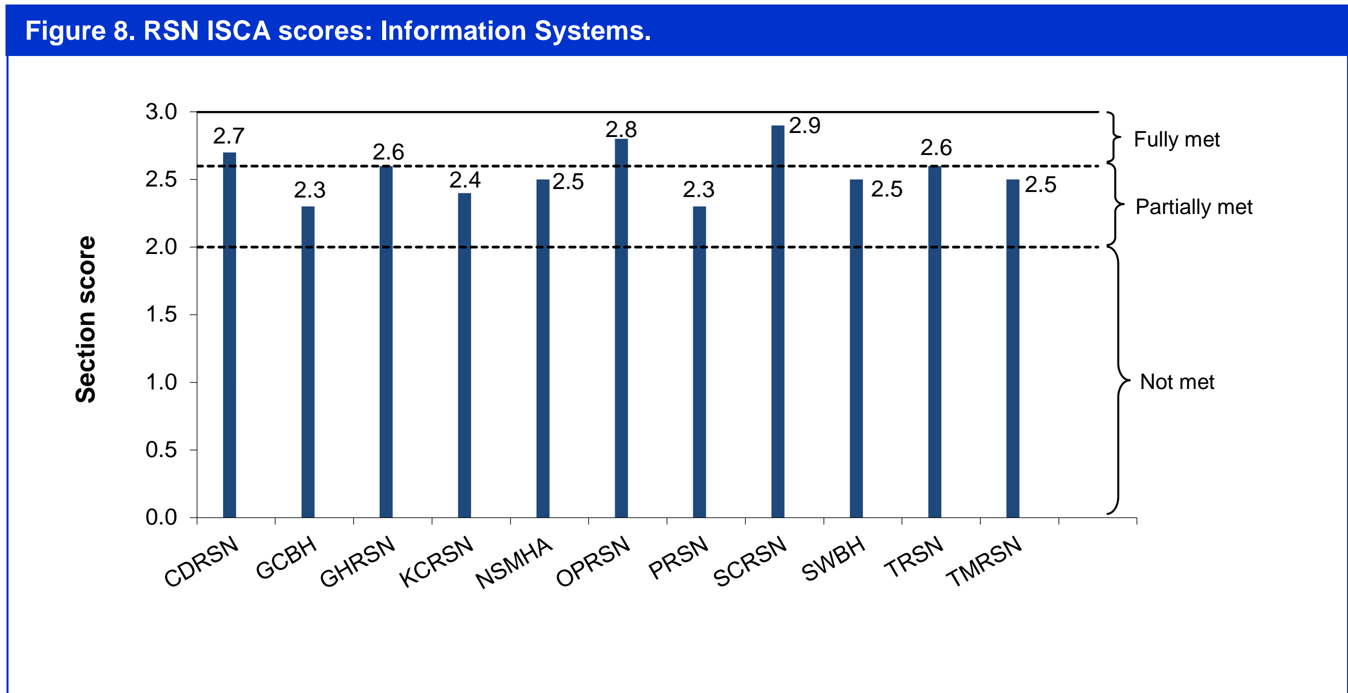
- All RSNs continue to perform well in meeting the Administrative Data standard. As a group, the RSNs are following most recommended practices aimed at ensuring the validity and timeliness of encounter and claims data.
- Most RSNs are fully meeting requirements related to staffing, enrollment systems, and provider data. RSNs have enhanced their provider profile directories to enable enrollees to make informed choices among network providers.
- RSNs' data center facilities and hardware systems are typically well designed and maintained. RSNs need to continue updating hardware at regular intervals to avoid disruption of services caused by hardware failures.
- Eligibility verification practices are inconsistent across RSNs. Some RSNs verify enrollee eligibility before they submit encounters to DBHR; others rely solely on their provider agencies to check eligibility on the ProviderOne web portal at the time of service. Some providers check eligibility at each visit, while others check much less frequently.
- All but two RSNs failed to demonstrate compliance with DBHR's more stringent criteria for data security. RSNs need to ensure that all contractual requirements are implemented at the RSN and provider agency levels, with particular attention to the following.
    - Update and test Business Continuity/ Disaster Recovery plans for the RSN and provider agencies at least annually (including plans for outsourced IT services).
    - Encrypt all data that will be in transit outside the RSN's internal network. Encrypt all data storage on portable devices or media with a key length of at least 128 bits.
    - Remove access to data immediately when a previously authorized person no longer requires access.
    - Require password security to meet complexity and forced changes at least every 90 days.
    - Monitor outsourced IT services and review for adherence to DBHR contract requirements.

Charts on the following pages display RSN scores on each subsection of the ISCA review protocol. The RSN profiles in Appendix A present more detailed strengths and recommendations.

Note: The subsections and criteria for the RSN reviews are similar to those used for the state-level ISCA. However, the RSNs are not evaluated for Performance Measure Repository and Report Production, but for Vendor Data Integration (how the RSN integrates the data submitted by providers with administrative data) and Provider Data.

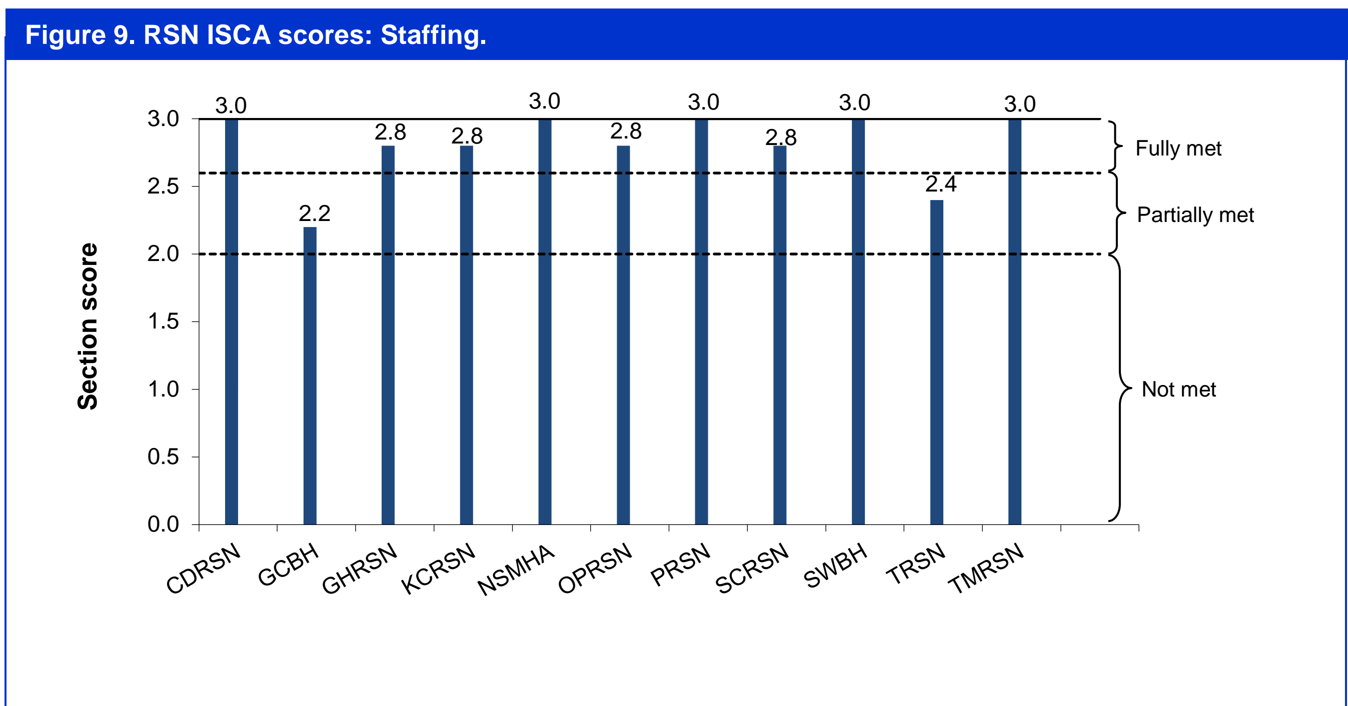
Information Systems: As shown in Figure 8, five RSNs fully met the criteria for this subsection, and six RSNs partially met the criteria.

Figure 8. RSN ISCA scores: Information Systems.



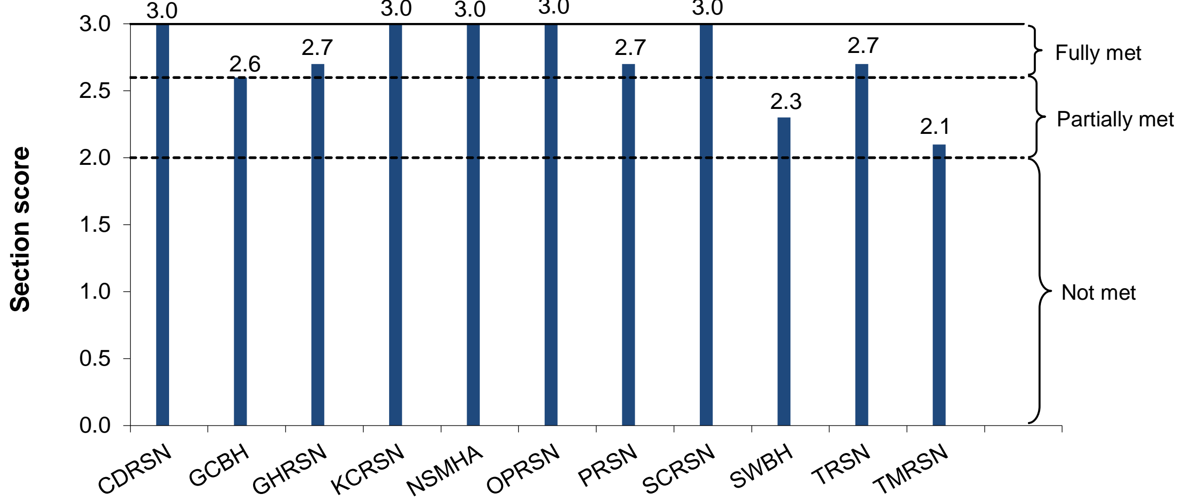
Staffing: As shown in Figure 9, all RSNs fully met the criteria for this subsection except for GCBH and TRSN, which partially met the criteria.

Figure 9. RSN ISCA scores: Staffing.



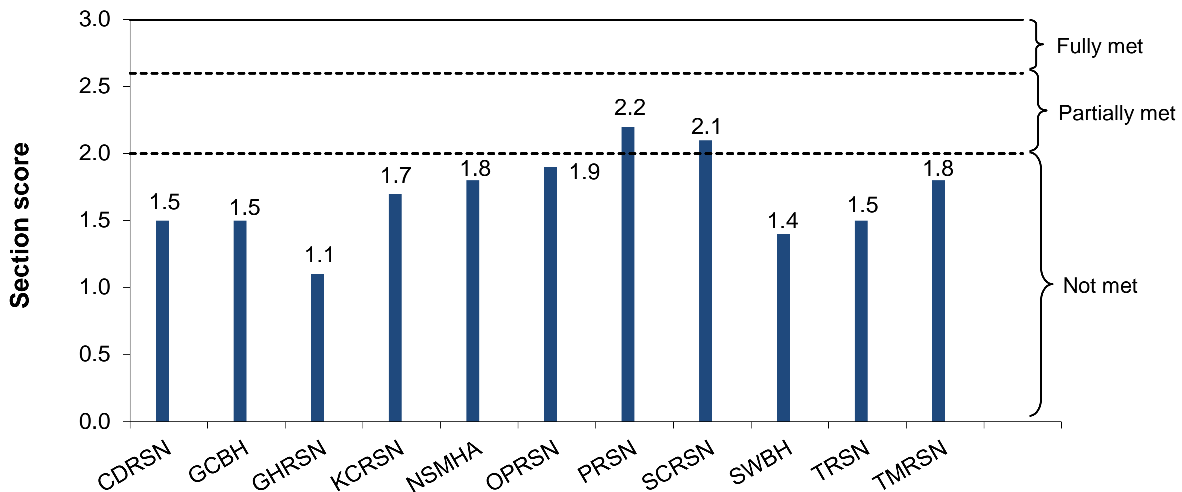
Hardware Systems: As shown in Figure 10, all RSNs fully met the criteria for this subsection except for SWBH and TMRSN, which partially met the criteria..

Figure 10. RSN ISCA scores: Hardware Systems.



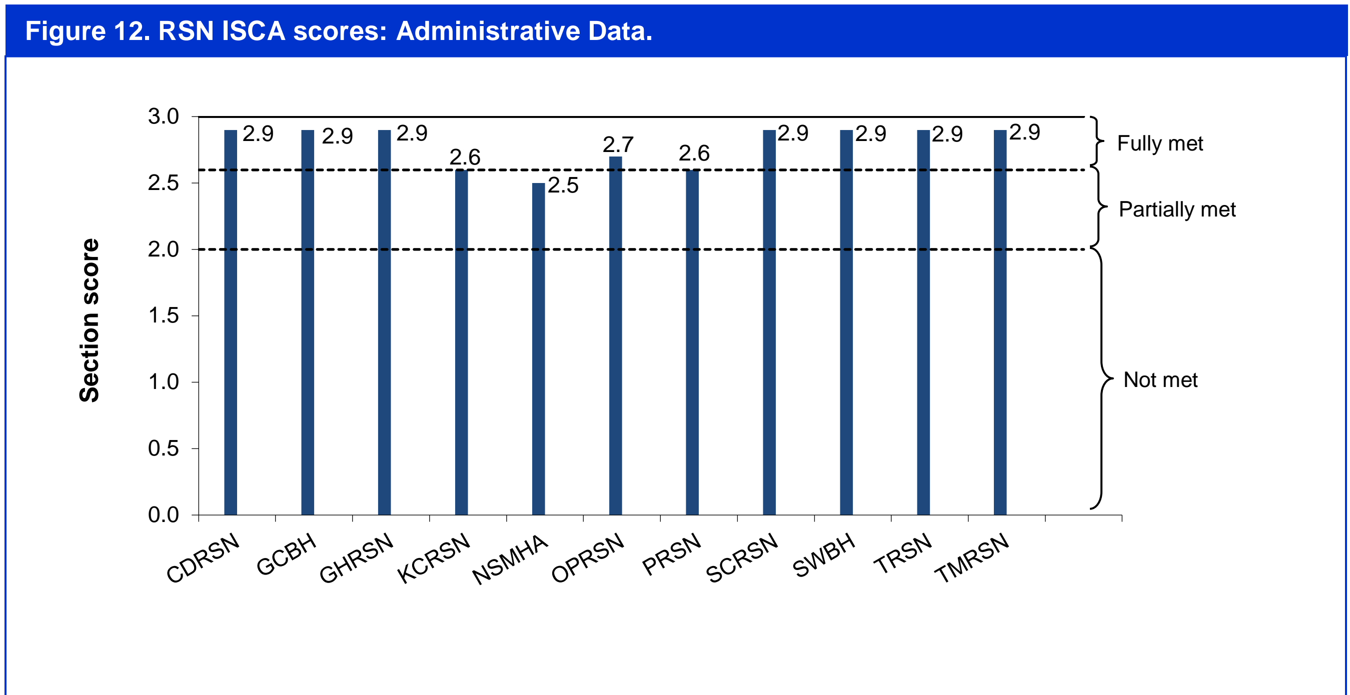
Security: As shown in Figure 11, only two RSNs—PRSN and SCRSN—partially met the criteria for this subsection; the remaining RSNs failed to demonstrate compliance.

Figure 11. RSN ISCA scores: Security.



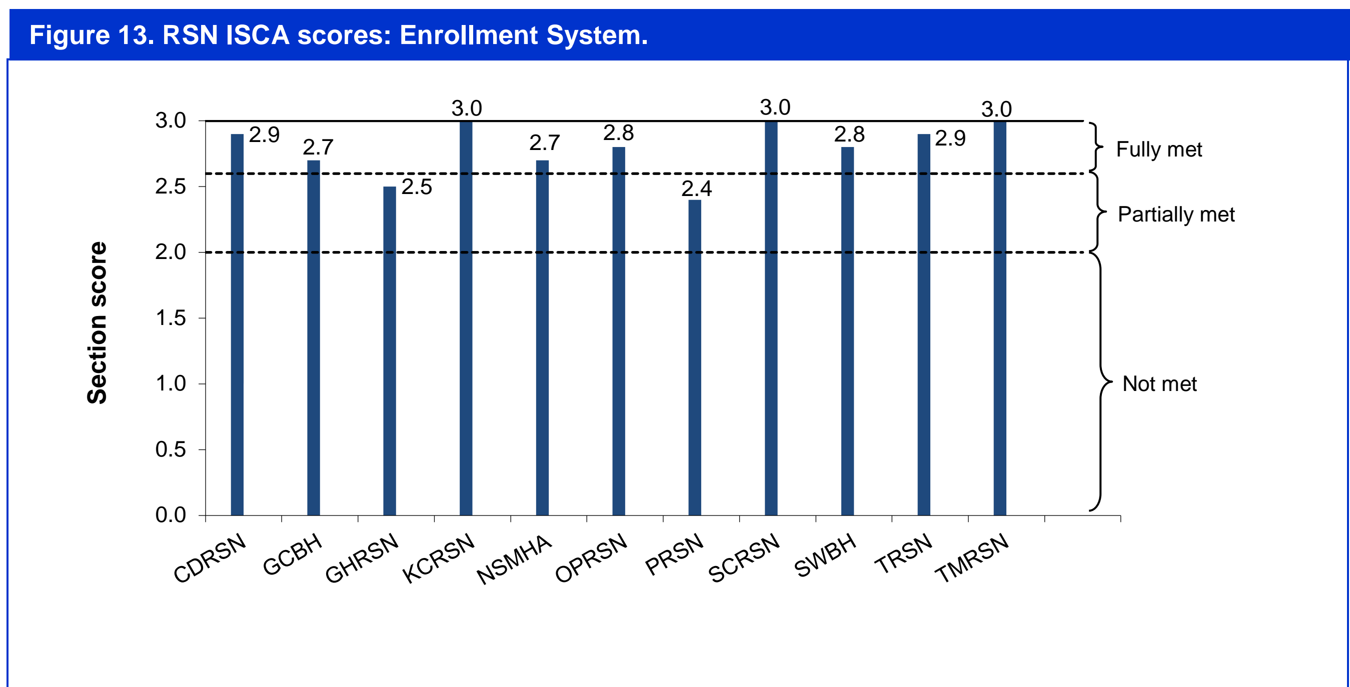
Administrative Data: As shown in Figure 12, all RSNs fully met the criteria for this subsection except for NSMHA, which partially met the criteria.

Figure 12. RSN ISCA scores: Administrative Data.



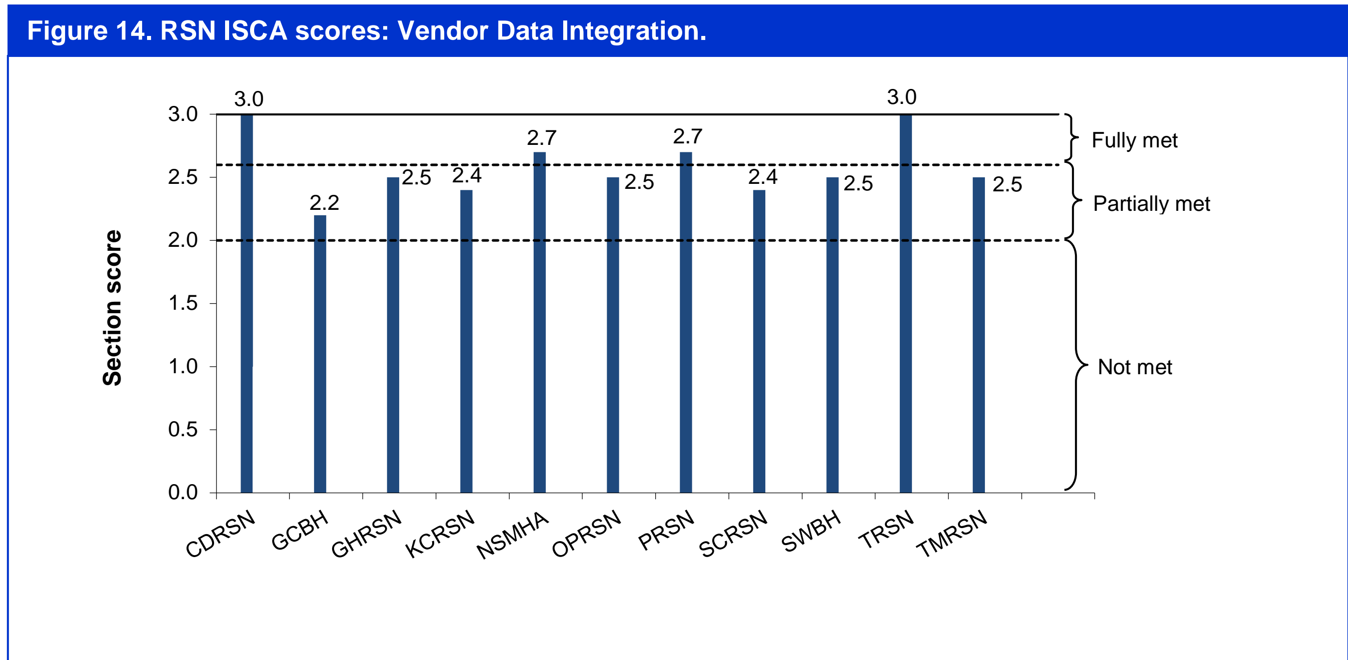
Enrollment System: As shown in Figure 13, all RSNs fully met the criteria for this subsection except for GHRSN and PRSN, which partially met the criteria.

Figure 13. RSN ISCA scores: Enrollment System.



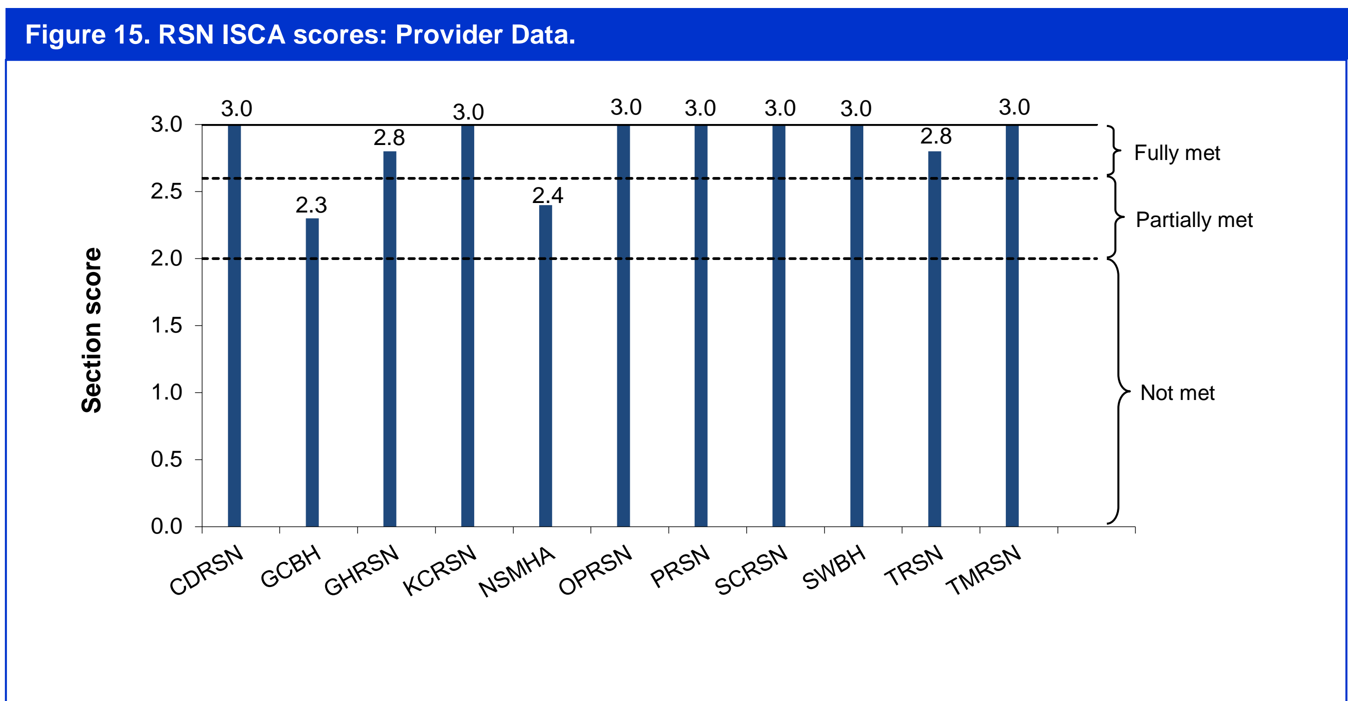
Vendor Data Integration: As shown in Figure 14, four RSNs fully met the criteria for this subsection, while seven partially met the criteria.

Figure 14. RSN ISCA scores: Vendor Data Integration.



Provider Data: As shown in Figure 15, all RSNs fully met the criteria for this subsection except for GCBH and NSMHA, which partially met the criteria.

Figure 15. RSN ISCA scores: Provider Data.



Mental health encounter data validation

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

As an independent check of the RSNs' EDV results, Acumentra Health audited and verified the EDV process for each RSN in 2013. For each RSN, the EDV involved:

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

As a special topic, the 2013 EDV also examined the degree to which providers' clinical records demonstrated adherence to the "golden thread" of mental health therapy:

1. Does the assessment in the clinical record substantiate the individual's diagnosis?
2. Are the documented goals of the treatment plan consistent with the diagnosis?
3. Do the progress notes address the individual's progress toward meeting the treatment plan goals?

Validation results

This report presents the EDV results for all RSNs combined in three parts: first, the results of electronic data checks; second, the results of comparing the clinical chart documentation with the state's electronic data, as part of the onsite review; and finally, the results of the "golden thread" analysis.

Electronic data checks

Acumentra Health analysts checked data fields in 3,554,958 outpatient encounters for missing and out-of-range data and logic problems, representing all outpatient encounters reported by the RSNs during October 2011–September 2012. The fields examined included RSN ID, consumer ID, agency ID, primary diagnosis, service date and location, provider type, procedure code, claim number, and minutes of service. (See Table 10.)

All fields were complete and within expected limits except for minutes of service. The minutes reported exceeded those allowed by DBHR's Service Encounter Reporting Instructions (SERI) in 3,189 records (0.1%).

Analysts found 23,389 records (0.7%) with a duplicate Claim ID number, 60.7% of which occurred at a single RSN. However, each RSN's encounters included duplicate claim IDs.

Next, analysts checked the demographic data set, examining 141,306 records. The fields examined included RSN ID, consumer ID, first and last names, date of birth, gender, ethnicity, Hispanic origin, language preference, Social Security number (SSN), and sexual orientation.

Considering mandatory fields, analysts found 26,287 records (18.6%) with out-of-range ethnicity information, indicating the submission of invalid codes. These appear to be multiple three-digit codes strung together to form out-of-range values. It could be that providers need a "multiethnic" option.

- ***DBHR needs to explore options that would facilitate accurate ethnicity documentation in ProviderOne.***

Language preference was omitted in 20,920 records (14.8%), and sexual orientation information was out-of-range in 326 records (0.2%). All other mandatory fields were complete with expected values.

Considering optional fields, 25,123 records (17.8%) omitted SSN information. All other fields were complete with expected values.

Table 10. Results of 2013 electronic data checks for 11 RSNs.		
Field	**State standard**	**% complete[a]**
Outpatient encounter data		
RSN ID	100% complete (non-missing values), with values known to DBHR	100.0
Consumer ID	100% complete (non-missing values), with values known to DBHR	100.0
Agency ID	100% complete (non-missing values)	100.0
Primary diagnosis	100% complete (non-missing values), one diagnosis must be present	100.0
Service date	100% complete (non-missing values), must be in valid date format	100.0
Service location	100% complete (non-missing values), with values specified in data dictionary	100.0
Provider type	100% complete (non-missing values), with values specified in data dictionary	100.0
Procedure code	100% complete (non-missing values), with values specified in service instructions	100.0
Claim number	100% complete (non-missing values)	100.0
Minutes of service	100% complete for records with no per diem CPT/HCPCS codes	99.9
Demographic data		
RSN ID	100% complete (non-missing values), with values known to DBHR	100.0
Consumer ID	100% complete (non-missing values)	100.0
First name	100% complete (non-missing values)	100.0
Last name	100% complete (non-missing values)	100.0
Date of birth	Optional per the state's Data Dictionary	100.0
Gender	Optional per the state's Data Dictionary	100.0
Ethnicity	100% complete (non-missing values), with values specified in data dictionary	81.4
Hispanic origin	100% complete (non-missing values)	100.0
Language preference	100% complete (non-missing values)	85.2
Social Security number	Optional per the state's Data Dictionary	82.2
Sexual orientation	100% complete (non-missing values)	99.8

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

Onsite review results

Acumentra Health staff audited 2,560 encounter records from the 11 RSNs. The encounters were reported in 1,154 charts. Data fields compared for each encounter included procedure code, provider type, minutes of service, service date, and service location. Reviewers checked the encounter notes to verify that the procedure code accurately described the treatment provided, and compared electronic data from the state's demographic data set with the chart documentation for the 1,154 enrollees. Demographic fields that were compared included first name, last name, date of birth, ethnicity, and language.

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

1. Chart matches state data
2. Data in chart missing from state data
3. Missing from both chart and state data
4. Could not locate in chart
5. Data found in chart do not match state data

Table 11 shows the results of Acumentra Health's validation activity.

Within the demographic data set, the chart information matched the state data in 94.7% of records for first name, 98.3% of records for last name, and 99.5% of records for date of birth. Ethnicity information in the chart matched the state data in 57.6% of records and language matched in 63.3% of records.

Within the encounter data set, the service code matched the service described in the chart note in 88.2% of records reviewed. The service location information matched in 92.0% of records; service date matched in 94.5% of records, procedure code matched in 89.2% of records; and provider type matched in 89.0% of records. Minutes of service matched in only 65.2% of records.

Acumentra Health also checked for "missing" encounters that were documented in the clinical record but did not appear in the state's electronic data. For May 2012, the only month reviewed, the reviewers found 102 "missing" encounters.

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

Field	Chart matches state data	Data in chart missing from state data	Missing from both chart and state data	Data could not be located in chart	Data found in chart do not match state data
Demographic information from each clinical record reviewed (N=1,154)					
First name	1,093 (94.7%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	60 (5.2%)
Last name	1,134 (98.3%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	19 (1.7%)
Date of birth	1,148 (99.5%)	1 (0.1%)	0 (0.0%)	1 (0.1%)	4 (0.4%)
Ethnicity	665 (57.6%)	0 (0.0%)	10 (0.9%)	19 (1.7%)	460 (40.0%)
Language	730 (63.3%)	46 (4.0%)	0 (0.0%)	35 (3.0%)	343 (29.7%)
Results from multiple encounters and a mix of services (N=2,560)					
Provider type	2,278 (89.0%)	4 (0.2%)	0 (0.0%)	255 (10.0%)	23 (0.9%)
Minutes of service	1,669 (65.2%)	3 (0.1%)	0 (0.0%)	181 (7.1%)	707 (27.6%)
Service location	2,355 (92.0%)	0 (0.0%)	0 (0.0%)	178 (7.0%)	27 (1.1%)
Procedure code	2,284 (89.2%)	0 (0.0%)	0 (0.0%)	198 (7.7%)	78 (3.1%)
Service date	2,415 (94.5%)	0 (0.0%)	0 (0.0%)	142 (5.6%)	0 (0.0%)

Discussion and recommendations

The state's outpatient encounter data generally were complete with expected values, as were demographic data except for the language and ethnicity fields. Language information was omitted in 14.8% of records, and 18.6% of records contained invalid ethnicity information.

Data validation between the state's demographic data and enrollee charts at the provider agencies also found low match rates in the ethnicity and language fields (57.6% and 63.3%, respectively). These low match rates raise concern because the RSNs need accurate information about enrollees' ethnicity and language so that service delivery can be culturally and linguistically appropriate. The 2012 modifications to CMS's EQR protocols emphasized Culturally and Linguistically Appropriate Services.

- ***DBHR needs to ensure that ethnicity and language data can be accurately captured and reported to CMS and the RSNs.***

The EDV showed moderate agreement between the enrollees' charts and the state data for the provider type, service location, procedure code, and service date fields (all ≥ 89.0% match). However, minutes of service matched in only 65.2% of records.

The low match rate for minutes of service has been attributed to conversions performed as part of data processing in ProviderOne.

The SERI manual requires RSNs to submit certain procedure codes expressing the service duration in minutes. Other codes are submitted with duration expressed in units that can vary in terms of the number or range of minutes, depending on the procedure. The RSNs are instructed to round down to the lower code if the actual service duration falls between the set ranges. However, ProviderOne accepts only units of service.

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

The high percentage of encounters with inaccurate minutes of service raises concern. On occasion, CMS has required states and providers to reimburse Medicaid for claims with incomplete or inaccurate documentation. If the percentage of inaccurate or incomplete documentation exceeds 20%, CMS could require proportionate reimbursement for the entire set of Medicaid encounters during a given period. If the data transmitted to CMS from ProviderOne contain the same errors Acumentra Health detected, DBHR could be at risk of recoupment.

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

At several agencies, many of the chart notes were not encounterable. That is, the charts recorded administrative services but no clinical contact—for example, leaving a voice-mail message, travel time with no enrollee contact, and cancelled appointments or no-shows.

- ***DBHR needs to provide guidance to the RSNs to ensure that:***
  - ***ethnicity and language data are entered in the chart correctly and match the data in the state's electronic data set***
  - ***service minutes are accurate for the encounter and comply with the parameters of the SERI***
  - ***all progress notes are encounterable***

"Golden thread" analysis

This portion of the EDV examines whether the enrollee's assessment substantiates the diagnosis, whether the treatment plan is consistent with the diagnosis, and whether progress notes address the treatment plan. Table 12 displays the results of the golden thread analysis for all RSNs combined.

The assessment substantiated the Category A diagnosis in 93.0% of children's charts and 94.0% of adult charts. A Category B diagnosis, when applicable, was substantiated in 93.8% of children's charts and 63.6% of adult charts. An additional 6.2% of children's charts and 27.3% of adult charts contained a Category B diagnosis that was partially substantiated.

The treatment plan was consistent with the assessment in 91.9% of children's charts and 88.1% of adult charts. Treatment plan objectives were individualized in 92.9% of children's charts and 92.4% of adult charts. The progress notes were consistent with the treatment plan in 74.4% of children's charts and 83.4% of adult charts. In an additional 8.3% of children's charts and 5.6% of adult charts, progress notes were partially consistent with the treatment plan.

Discussion and recommendations

The golden thread elements were generally stronger in the children's charts than in the adults' charts. However, more adult records demonstrated continuity between the progress notes and treatment plan. Almost all assessments for adults and children either fully or partially justified the enrollee's diagnosis.

Interventions and goals in the treatment plans generally were consistent with issues identified in the assessments, and treatment goals were individualized. However, 25% of the progress notes for children did not address interventions identified in the treatment plan and the child's progress toward meeting stated goals.

- ***DBHR needs to work with the RSNs to ensure that progress notes document use of the interventions identified in the treatment plan and the child's progress toward meeting the stated goals.***

Table 12. Results of "golden thread" analysis for 11 RSNs.

Assessment substantiates the diagnosis; treatment plan is consistent with the diagnosis; progress notes address the treatment plan

(Number of charts reviewed =1,055)

	Children		Adults		Total	
	% "Yes"	**% "Partially"**	**% "Yes"**	**% "Partially"**	**% "Yes"**	**% "Partially"**
1. Does the assessment substantiate the Category A diagnosis (if applicable)?	277 (93.0%)	12 (4.0%)	576 (94.0%)	18 (2.9%)	853 (93.6%)	30 (3.3%)
2. Does the assessment substantiate the Category B diagnosis (if applicable)?	106 (93.8%)	7 (6.2%)	7 (63.6%)	3 (27.3%)	113 (91.1%)	10 (8.1%)
3. Does the treatment plan include interventions and goals consistent with issues identified in the assessment?	384 (91.9%)	0 (0.0%)	553 (88.1%)	0 (0.0%)	937 (89.6%)	0 (0.0%)
4. Are the treatment plan objectives individualized?	393 (92.9%)	0 (0.0%)	580 (92.4%)	0 (0.0%)	973 (92.6%)	0 (0.0%)
5. Do the progress notes address interventions identified in the treatment plan and the individual's progress toward meeting stated goals?	323 (74.4%)	36 (8.3%)	518 (83.4%)	35 (5.6%)	841 (79.7%)	71 (6.7%)

Note: Proportions exclude "not applicable" or missing responses, so the denominator of each item may vary.

Mental health clinical record review

In conjunction with the 2013 EDV for all 11 RSNs, Acumentra Health reviewed clinical records at selected outpatient provider agencies to assess mental healthcare criteria as directed by DBHR. The clinical record study focused on the degree to which the RSN's system of care adhered to the principles of the Children's Mental Health Redesign, including the principles of the interim settlement of *T.R. v. Dreyfus*, regarding uniform screening and assessment of children with serious emotional disturbances.

The 427 charts reviewed for this activity were the same as those requested for the EDV. The sample included enrollees aged 0–20 served during October 2011–September 2012, each of whom had at least three outpatient service encounters during the review period.

To ensure consistency in reviewing the clinical records, Acumentra Health followed rigorous procedures to ensure inter-rater reliability. Before conducting the review at any RSN, Acumentra Health trained all reviewers to use a customized data collection tool and scoring criteria and guidelines approved by DBHR.

The data collection tool prompted reviewers to complete a series of questions concerning aspects of adherence to the *T.R. v. Dreyfus* principles. After examining the clinical record (chart) and progress notes, reviewers recorded responses to each question in the tool. Using the SAS Proc Freq function, analysts calculated the distribution of responses for each question.

Review results

While 77.3% of the charts reviewed contained an assessment that had been completed within the past year, 16.4% contained an assessment that was one to three years old; 3.3% contained an assessment that was three to five years old; and 3.1% contained an assessment that was more than five years old.

The child's living environment and support systems were assessed in nearly all records (98%). Three-quarters of the children lived with their parents. When appropriate, developmental, learning, or sensory impairment was considered in 91.9% of records; cultural issues were considered in 82.5% of records; and language needs were considered in 77.6% of records. The diagnosis was justified in 92.1% of records and partially justified in an additional 5.2% of records.

Most records (>80%) showed evidence that activities in the treatment plan built on strengths and promoted resiliency; the family was involved in developing the treatment plan; treatment objectives were individualized; and interventions and goals were consistent with the assessment. However, only 46.8% of records described the use of team-based services.

Service coordination was documented in the treatment plan in 57.8% of records, and in 54.8% of progress notes.

Progress notes often documented unconditional treatment and strength-based services (>80%). Progress notes were consistent with goals in the treatment plan in three-quarters of records, and partially consistent in an additional 8.3% of records. Notes were outcome-based in 64.5% of records, and partially outcome-based in an additional 16.1% of records.

Table 13 presents complete review results for the 11 RSNs.

Discussion and recommendations

Assessments. Overall, the RSNs' provider agencies did a good job of documenting the child's living environment, support systems, and involvement in activities outside of the home. The percentage of applicable assessments that addressed developmental, learning, and sensory impairment and cultural and language issues fell within the acceptable range. More than 90% of the assessments justified the enrollee's diagnosis.

However, more than one-third of the assessments were more than one year old. In many charts, the 180-day reviews did not provide a complete assessment of the enrollee's current status.

- ***DBHR needs to work with the RSNs to ensure that provider agencies update enrollees' assessments at least annually to document changes in the enrollee's functioning and life circumstances.***

Treatment plans. The majority of treatment plans reflected information included in the assessments. Ninety-three percent of the plans contained individualized treatment objectives and had interventions and goals consistent with the enrollee's assessment. More than three-quarters of the plans contained strength-based activities and documented family/guardian participation in developing the treatment plans.

However, only 63% of the treatment plans incorporated coordination with other agencies into the treatment objectives when appropriate. More than 6% of the children lived in a foster home, often in the custody of child welfare. Other children had juvenile justice involvement or had individualized educational plans. At a minimum, mental healthcare providers should coordinate care with agencies and systems involved in the child's life.

- ***DBHR needs to work with the RSNs to ensure that clinicians include coordination-of-care objectives in individualized care plans for children, when other agencies are involved in the child's care.***

Almost half of the children's treatment plans did not include a multidisciplinary team-based approach to treatment.

- ***DBHR needs to work with the RSNs to ensure that children's treatment plans include a multidisciplinary team-based approach, when appropriate.***

Progress notes. Provider agencies are to be commended as almost all of the progress notes demonstrated that the child received unconditional treatment. Also, the majority of progress notes demonstrated use of strength-based services.

Although the treatment plans typically included interventions and goals identified in the enrollee's assessment, the documentation in the progress notes was spotty. Most progress notes did not document the child's response to the interventions identified in the treatment plan or the child's progress toward meeting the goals negotiated with the family.

- ***DBHR needs to work with the RSNs to ensure that progress notes document use of the interventions identified in the treatment plan and the child's progress toward meeting the stated goals.***

The progress notes typically lacked documentation of coordination of care with other agencies and systems. Only 55% of progress notes indicated that services were team-based and that care was coordinated with other agencies and systems, when appropriate. These services should be documented in the progress notes to reflect a multidisciplinary team-based approach.

- ***DBHR needs to work with the RSNs to ensure that services for children are team-based and that care coordination occurs when necessary.***

Table 13. Results of clinical record review for 11 RSNs.		
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign		
(Number of charts reviewed = 427)		
Assessment	**% Yes**	**% No**
1. Is there a completed assessment within the past year?	77.3	22.7
Assessment includes:	**% Yes**	**% Partially**
1. Living environment and safety needs	97.9	
2. Documentation of current living situation		
Home (parental)	76.5	
Foster home	6.4	
Therapeutic foster home	0.5	
Other friend/family home	16.0	
Independent living	0.5	
Homeless/shelter	0.2	
3. Child's/family's natural systems of support	98.6	
4. Development, learning, or sensory impairment	91.9	
5. Cultural issues that may affect treatment	82.5	
6. Language needs taken into consideration	77.6	
7. Child/family involvement in activities outside of the home	91.7	
8. Justification of diagnosis	92.1	5.2
Treatment plan includes:	**% Yes**	**% Partially**
1. Activities and interventions that build on strengths to promote resiliency	82.4	
2. Treatment plan objectives are individualized	93.4	
3. Documentation showing family/guardian participation in developing the treatment plan	83.3	2.8
4. Coordination with agencies and collaboration with others identified in assessment	57.8	4.5
5. Interventions and goals consistent with issues identified in assessment	92.4	
6. Team-based services	46.8	
7. Case closure	33.1	
Progress notes include:	**% Yes**	**% Partially**
1. Interventions identified in the treatment plan and progress toward meeting stated goals	74.8	8.3
2. Unconditional treatment	96.9	
3. Documentation that services delivered are strength-based	86.7	
4. Progress notes care coordination with agencies and systems	54.8	
5. Outcome-based progress notes	64.5	16.1

PHYSICAL HEALTH CARE DELIVERED BY MCOS

HCA contracts with five MCOs to deliver physical healthcare services to Medicaid managed care enrollees. Table 14 shows the approximate number and percentage of enrollees assigned to each health plan during 2012. Figure 16 shows the counties served by each plan.

Traditionally, the state has provided managed medical care primarily for children, mothers, and pregnant women through Healthy Options, the Children's Health Insurance Program (CHIP), and Basic Health Plus, and for a small number of adult SSI or SSI-related clients through the WMIP program in Snohomish County.

Since July 1, 2012, HCA has enrolled into Healthy Options approximately 90,000 disabled and blind SSI recipients, who previously received fee-for-service medical care. HCA has brought other new populations into managed care through the Medical Care Services (MCS) program and the Washington Health Program (WHP). The MCS program, formerly Disability Lifeline/General Assistance-Unemployable (GA-U), serves eligible adults who cannot work for physical or mental reasons and those eligible for state-funded alcohol and drug addiction treatment. HCA began offering the WHP statewide on November 1, 2012, to provide reduced-cost coverage for qualified residents in the interim before the state Health Benefit Exchange became operational. The net effect has been a major shift toward adult enrollment.

Table 14. Managed care organizations and Medicaid enrollees, 2012.[a]

	2012 enrollment		
Health plan	**July**	**November**	**December**
Amerigroup Washington Inc. (AMG)			
Healthy Options/CHIP/Basic Health Plus	16,512	25,172	25,734
SSI recipients (included in above)	*2,352*	*10,898*	*10,443*
Community Health Plan of Washington (CHP)			
Healthy Options/CHIP/Basic Health Plus	277,616	269,923	267,644
SSI recipients (included in above)	*14,313*	*20,035*	*21,907*
Medical Care Services (formerly GA-U)	7,238	6,986	6,979
Washington Health Program	n.a.	9,307	9,640
CHP total	284,854	276,909	274,623
Coordinated Care Corp. (CCC)			
Healthy Options/CHIP/Basic Health Plus	33,714	53,288	55,074
SSI recipients (included in above)	*4,898*	*15,335*	*14,973*
Molina Healthcare of Washington (MHW)			
Healthy Options/CHIP/Basic Health Plus	372,837	392,454	392,466
SSI recipients (included in above)	*12,512*	*24,807*	*26,144*
WMIP	4,312	3,884	3,822
MHW total	377,149	396,338	396,288
UnitedHealthcare Community Plan (UHC)			
Healthy Options/CHIP/Basic Health Plus	24,627	40,155	51,865
SSI recipients (included in above)	*3,590*	*12,948*	*12,937*
Total	**736,856**	**791,862**	**803,584**

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

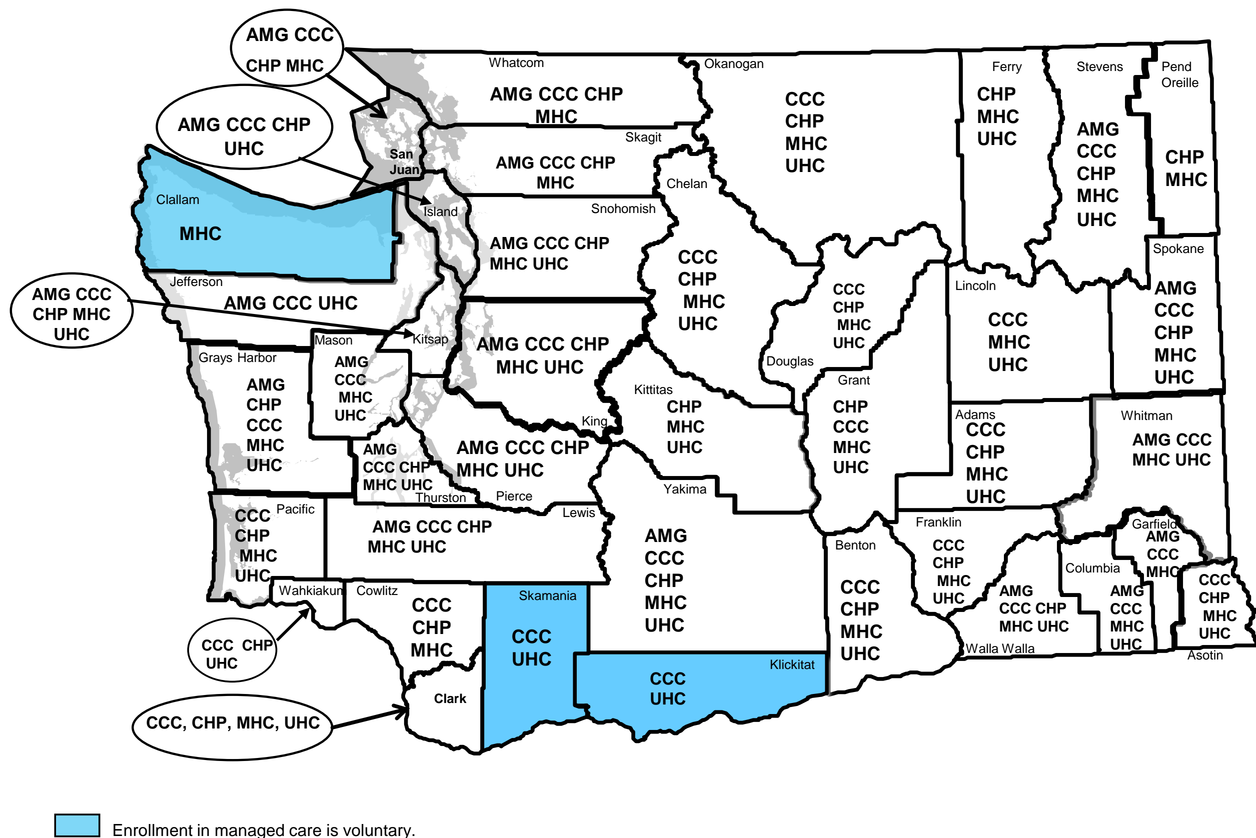
Figure 16 shows the geographical distribution of MCO services throughout the state as of November 1, 2012. When Medicaid expansion under the federal Affordable Care Act takes effect on January 1, 2014, the existing populations served by Washington Medicaid will be rolled up with many thousands of newly eligible enrollees under Apple Health.

HCA typically uses the annual HEDIS measures to gauge the MCOs' clinical performance against national benchmarks. Because HCA required the MCOs to submit only a limited set of utilization measures for 2013, comparisons of the MCOs' performance with state and national benchmarks related to quality, access, and timeliness are not feasible this year.

TEAMonitor conducts the regulatory/contractual compliance review for all MCOs and validates their PIPs. Review procedures are based on the CMS protocols for those activities.

In 2013, TEAMonitor reviewers scored all MCOs on their compliance with the required elements of federal regulations and HCA contract provisions, and followed up on corrective action items noted in 2012.

Figure 16. Healthy Options/CHIP service areas, November 2012.



Note: Healthy Options coverage includes blind/disabled and foster care populations.

Access to physical health care

Through TEAMonitor, HCA assesses the MCOs' compliance with regulatory and contractual requirements related to access. (See Appendix D.)

The HCA contract requires each MCO to monitor the capacity of its provider network in relation to service utilization patterns, and demonstrate that the network can serve all eligible enrollees, considering the numbers and types of providers required, the geographic location of providers and enrollees, and enrollees' cultural, ethnic, racial, and language needs. MCOs must provide enough information to enable enrollees to make informed decisions about enrollment and to understand benefit coverage and how to obtain care. Written information must discuss how to choose and change PCPs and how to obtain emergency services, hospital care, and services outside the network. The MCO must provide information on available specialists, advance directives, grievance procedures, well-child care, translation and interpretation services, and how to obtain a second opinion. The MCO must comply with regulations in 42 CFR §438 pertaining to:

- Availability of Services
- Furnishing of Services
- Coverage and Authorization of Services
- Additional Services for Enrollees with Special Healthcare Needs (SHCN)
- Emergency and Post-stabilization Services
- Enrollee Rights

TEAMonitor's 2013 review found that the MCOs, as a group, showed spotty compliance with access standards. The MCOs fully met between one-half and three-quarters of the elements of the relevant regulatory and contractual standards.

Among individual MCOs:

- AMG met all elements of Coverage and Authorization of Services.
- MHW met all elements of Availability of Services and Furnishing of Services.
- UHC met all elements of Availability of Services.

Many of the identified deficiencies related to inadequate or incomplete documentation of MCO policies and procedures. Commonly identified weaknesses included:

- deficiencies in completing the required initial health screens and assessments for enrollees with SHCN
- incomplete compliance with contractual requirements for providing outpatient mental health services—processes for assessing the appropriateness of children under age 5 receiving psychotropic medications, including the requirement to obtain an expert second opinion; transition plans for enrollees who exhaust the mental health benefit
- insufficient evidence of physical/behavioral health integration and/or involvement of behavioral health practitioners in utilization management
- incomplete information provided to enrollees regarding rights and benefits

Timeliness of physical health care

The HCA contract incorporates federal standards for timely care and makes MCOs responsible for monitoring their provider networks to ensure that those standards are met. (See Appendix D.) HCA assesses compliance with these standards through TEAMonitor review.

MCOs must ensure timely access to services, taking into account the urgency of the need for services. Per the HCA contract:

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

Federal regulations [42 CFR §438.206 (c)(1)] require each MCO to provide hours of operation for Medicaid enrollees that are no less than the hours for any other patient. The MCO must establish mechanisms to ensure compliance by providers, monitor compliance regularly, and take corrective action if providers fail to comply.

TEAMonitor's 2013 review found:

- AMG, CHP, and MHW fully met this standard.
- CCC and UHC did not meet the standard because they failed to provide evidence of an active monitoring process.

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

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

TEAMonitor found that all MCOs met these requirements, except that MHW's documentation did not always support timely notices of action and resolution of grievances.

42 CFR §438.10(f) requires MCOs to furnish timely information to enrollees regarding their rights, protections, and benefits, including but not limited to disenrollment rights, the termination of contracted providers, and detailed identification of providers in the enrollee's service area. According to TEAMonitor, only CCC fully met these requirements in the review period.

Quality of physical health care

The HCA contract and 42 CFR §438.320 define quality as the degree to which a managed care plan "increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." Appendix D itemizes many quality-related standards covered by TEAMonitor's compliance review.

Quality standards are embedded in the portions of the compliance review addressing

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

In 2013, TEAMonitor reviewed the MCOs' compliance with new contractual requirements related to Coordination and Continuity of Care. TEAMonitor found that the MCOs, as a group, had difficulty meeting these requirements, which focus on

- preventing the interruption of medically necessary care
- facilitating care for enrollees in transition from one setting or level of care to another (e.g., among state and community physical and behavioral health hospitals, RSNs, long-term care facilities, and inpatient and outpatient drug and alcohol treatment programs)
- ensuring coordination of care between PCPs and care managers from other service systems
- ensuring that enrollees at high risk of rehospitalization and/or substance use disorder treatment recidivism have a documented, individual plan for interventions to mitigate risk
- coordinating care for children in foster care

Considering other compliance areas, the MCOs typically met between one-half and three-quarters of the elements of the relevant regulatory and contractual standards. Incomplete documentation was a frequently identified shortcoming.

An exception was the Grievance Systems standard, for which the MCOs collectively met 87% of the elements. Also notable:

- MHW met all elements of the Practice Guidelines and QA/PI Program standards.
- UHC met all QA/PI Program elements and 94% of the Grievance System elements.

The weakest overall performance occurred in complying with the Provider Selection standard. Each MCO must follow a documented process for credentialing and recredentialing of contracted providers. MCOs may not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. MCOs may not employ or contract with providers that are excluded from participating in federal healthcare programs. TEAMonitor found that the MCOs generally failed to demonstrate compliance with these requirements.

Physical health regulatory and contractual standards

In 2013, TEAMonitor reviewers scored MCOs on their compliance with the required elements of federal regulations and HCA contract provisions, and followed up on corrective action items noted in 2012. TEAMonitor rated each MCO as having met, partially met, or not met the requirements for each standard listed in Table 15, as well as for the MCO's PIPs.

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

Separately, HCA and ADSA reviewed the WMIP contractor's compliance with relevant regulations and contract provisions (see page 84).

Compliance scoring methods

TEAMonitor assigned each of the required elements a score of Met, Partially Met, or Not Met, unless the element was not scored. Using scores from the TEAMonitor reports, Acumentra Health calculated compliance scores for each standard, expressed as a percentage of each standard's elements that were Met. These percentage scores appear in Table 15 and in the MCO profiles in Appendix B. The scores were calculated as follows.

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

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

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

Summary of compliance review results

Table 15 breaks out the 2013 compliance scores assigned by TEAMonitor for each standard by MCO. Figure 17 depicts the 2013 compliance scores on selected standards by MCO, along with the 2011–2012 scores for CHP and MHW.

Compliance patterns for the MCOs as a group were discussed in previous sections dealing with access, timeliness, and quality. In 2013, the average "fully met" scores were below 70% for 11 of the 16 standards, though most standards not fully met were at least partially met.

Perhaps not surprisingly, the three newly-contracted MCOs lagged in demonstrating compliance in many program areas. However, CHP and MHW, the "legacy" MCOs, also scored notably lower than before on standards such as Enrollee Rights, Patient Review and Coordination, and Provider Selection. TEAMonitor reviewers attributed this performance to key staff turnover at the legacy MCOs.

TEAMonitor reviewed several additional elements of Program Integrity in 2013, related to federal and state requirements for (1) disclosure of information on MCO ownership and control, (2) suspension of payments to providers being investigated for fraud, (3) payments to excluded individuals and entities, and (4) reporting of alleged fraud and abuse. As a group, the MCOs complied with only about one-third of the Program Integrity elements.

Table 15. MCO compliance scores for physical health regulatory and contractual standards, 2013.

Standard (# of elements)	AMG			CCC			CHP			MHW			UHC			State average		
	Percentage of elements Met, Partially Met, and Not Met																	
	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM
Availability of Services (5)	**20**	40	40	**20**	60	20	**40**	60	0	**100**	0	0	**100**	0	0	**56**	32	12
Furnishing of Services (2)	**50**	0	50	**0**	50	50	**100**	0	0	**100**	0	0	**50**	0	50	**60**	10	30
Program Integrity (5)	**60**	40	0	**20**	80	0	**40**	20	40	**0**	40	60	**40**	20	40	**32**	40	28
Claims Payment (1)	**100**	0	0	**100**	0	0	**0**	100	0	**100**	0	0	**100**	0	0	**80**	20	0
Continuity and Coordination of Care (5)	**80**	0	20	**60**	40	0	**40**	40	20	**40**	40	20	**60**	40	0	**56**	32	12
Additional Services for Enrollees with SHCN (5)	**80**	20	0	**80**	0	20	**80**	0	20	**60**	20	20	**80**	20	0	**76**	12	12
Patient Review and Coordination (8)	**63**	25	12	**63**	37	0	**50**	12	37	**63**	12	25	**63**	37	0	**60**	25	15
Coverage and Authorization of Services (4)	**100**	0	0	**50**	25	25	**50**	50	0	**50**	25	25	**75**	25	0	**65**	25	10
Emergency and Post-stabilization Services (2)	**50**	50	0	**50**	0	50	**50**	50	0	**0**	100	0	**50**	0	50	**40**	40	20
Enrollee Rights (15)	**47**	27	27	**87**	13	0	**53**	33	13	**53**	40	7	**53**	40	7	**59**	31	10
Enrollment/Disenrollment (2)	**100**	0	0	**100**	0	0	**50**	0	50	**50**	50	0	**50**	50	0	**70**	20	10
Grievance Systems (18)	**78**	11	11	**88**	6	6	**83**	17	0	**88**	6	6	**94**	6	0	**87**	9	4
Practice Guidelines (3)	**66**	0	33	**33**	0	66	**33**	66	0	**100**	0	0	**33**	66	0	**53**	27	20
Provider Selection (4)	**50**	25	25	**25**	50	25	**50**	50	0	**25**	50	25	**25**	50	25	**35**	45	20
QA/PI Program (4)	**25**	75	0	**75**	0	25	**50**	25	25	**100**	0	0	**100**	0	0	**70**	20	10
Subcontractual Relationships and Delegation (4)	**50**	25	25	**0**	100	0	**75**	25	0	**25**	50	25	**50**	50	0	**40**	50	10

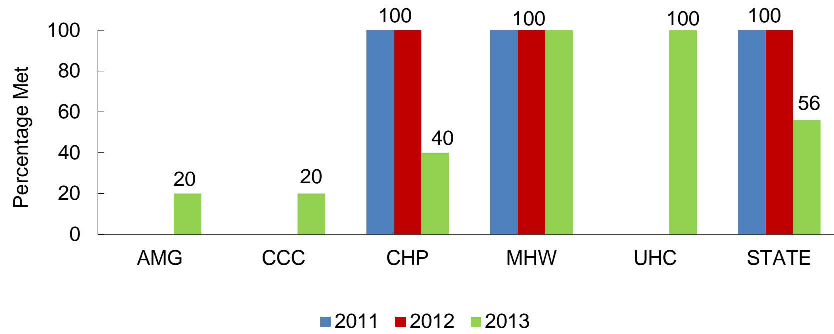
M=Met; PM=Partially Met; NM=Not Met

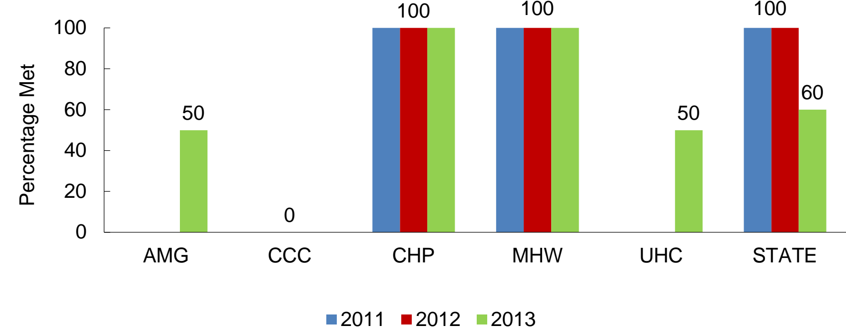
NOTE: These standards were scored during the first half of 2013. MCOs with a score of “Partially Met” or “Not Met” for any standard may have submitted corrective action plans to address deficiencies following review; therefore, the above scores may not reflect the status of plan performance as of December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

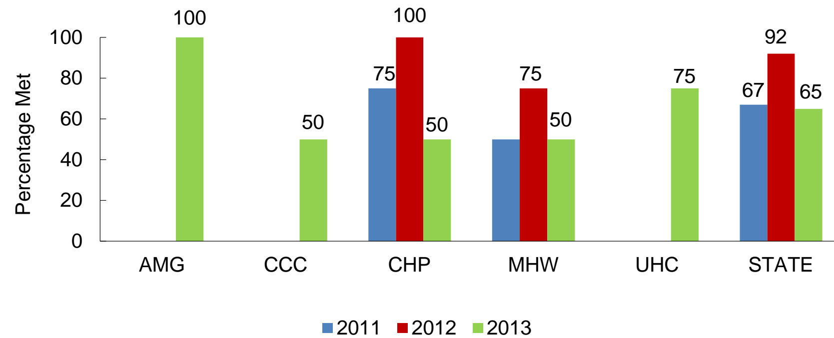
Percentages may not add to 100 because of rounding.

Figure 17. Changes in compliance scores for selected physical health regulatory standards by MCO, 2011–2013.

Access Standards







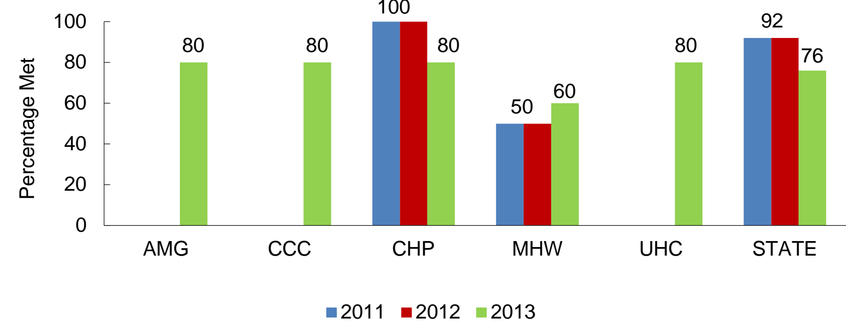
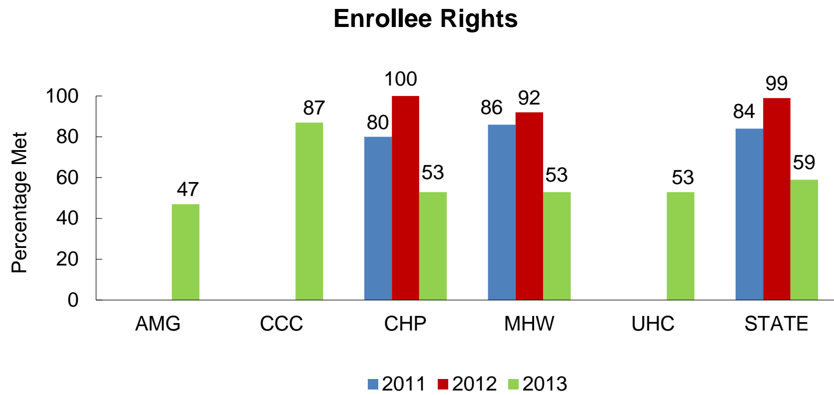
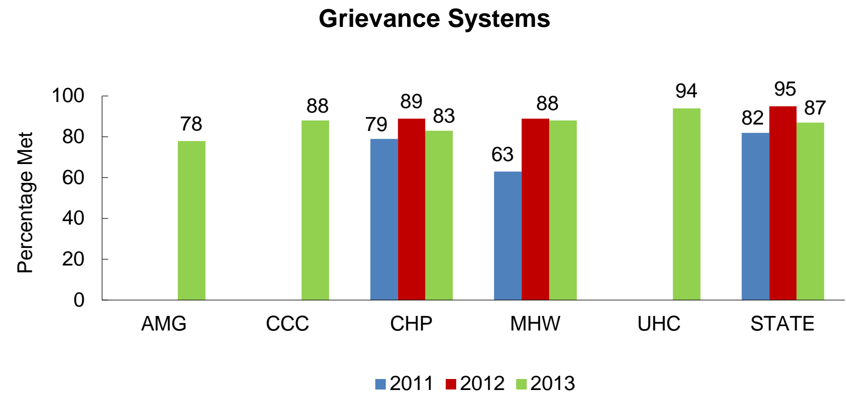
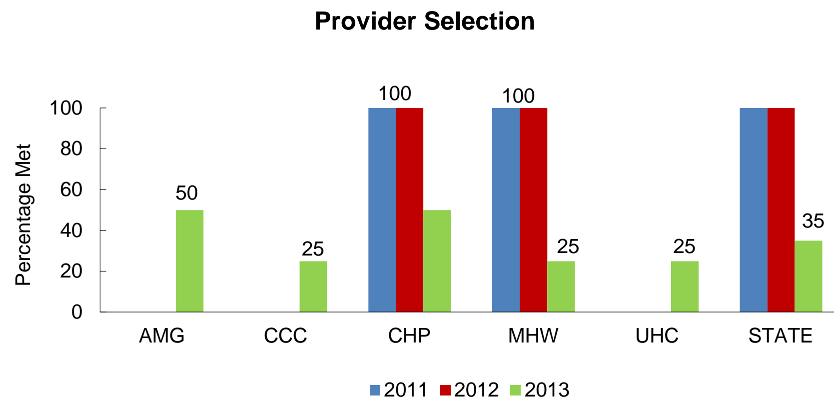


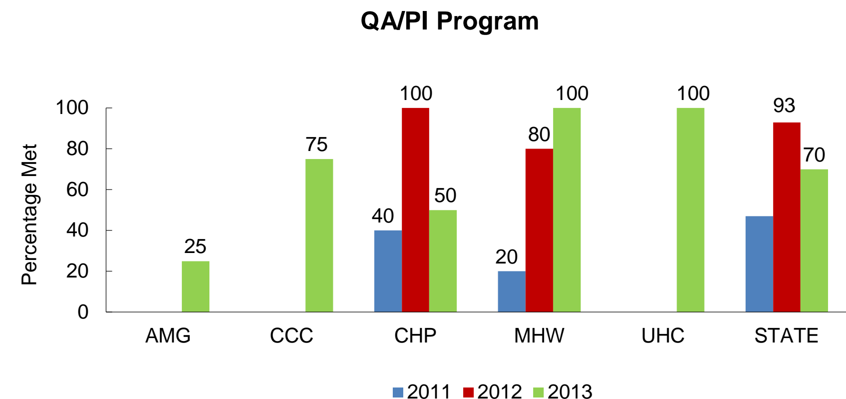
Figure 17. Changes in compliance scores for selected physical health regulatory standards by MCO, 2011–2013 (cont.).

Timeliness and Quality Standards









Corrective action plans

In 2013, TEAMonitor reviewed the MCOs' 2012 readiness review follow-up/corrective action plans (CAPs) and documented how the MCOs had resolved corrective actions. If the review identified old or new findings, TEAMonitor required the MCO to perform corrective action in 2013. Table 16 shows the disposition of CAPs required in 2013.

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

Table 16. Disposition of MCOs' corrective action plans.

Health plan	2013 CAPs required	2013 CAPs accepted	2013 percentage accepted	2012 CAP/readiness review follow-up status not resolved
AMG	34	34	100%	8
CCC	34	34	100%	5
CHP	34	33	97%	9
MHW/WMIP	35	32	91%	5
UHC	29	28	97%	2

Physical health PIP validation

The HCA contract requires each MCO to conduct

- one clinical PIP of the MCO's choosing
- a nonclinical statewide PIP on Transitional Healthcare Services, focused on enrollees with special healthcare needs or at risk for re-institutionalization, re-hospitalization, or substance use disorder recidivism

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

Table 17 shows the topics of each MCO's PIPs and the scores assigned by TEAMonitor.

Because the 2013 review covered only a six-month period (July–December 2012), TEAMonitor did not expect the MCOs to have had time to complete and evaluate two entire PIPs. The MCOs were required only to document the initial stages of each project, such as developing the study question and selecting data elements to measure. Beginning in 2014, TEAMonitor will require the MCOs to have implemented interventions, gathered data, and evaluated the results.

All MCOs took part in the statewide Transitional Healthcare Services PIP. The MCOs focused on reducing unnecessary hospital readmissions within 30 days of hospital discharge in a pilot area, with interventions focused on follow-up visits with a provider within 7 days of discharge. The MCOs submitted documentation to demonstrate progress through Standards 1–7. Although TEAMonitor reviewed these PIPs for compliance, scoring will not occur until 2014.

In the following discussion of each MCO's PIPs, the comments regarding strengths, opportunities for improvement, and other aspects of the PIPs are based on the TEAMonitor reports.

Table 17. PIP topics and scores by MCO, 2013.

MCO	PIP topic	Score
AMG	Clinical: Well-Child Visits During the First 15 Months of Life (5 or More Visits)	Not Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	n.a.*
	Nonclinical: Provider Denial Letters	n.a.*
CCC	Clinical: Increasing Compliance of Female Members Over Age 40 in Getting an Annual Screening Mammogram	Partially Met
	Clinical: Diabetes Compliance	n.a.*
	Nonclinical: Statewide Transitional Healthcare Services PIP	n.a.*
CHP	Clinical: Improving Use of Appropriate Medications for People with Asthma	Met
	Clinical: Improving PHQ-9 Results for MCS Members	Partially Met
	Nonclinical: Improving CSR Handling of Benefit Calls	Partially Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	n.a.*
MHW	Clinical: Improving Breast Cancer Screening	Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	n.a.*
UHC	Clinical: Improving the Medical Home for Emergencies that are Avoidable and Readmissions from Transitions	Partially Met
	Nonclinical: Statewide Transitional Healthcare Services PIP	n.a.*

*n.a.: PIP will be scored in 2014.

Amerigroup Washington

Table 18 displays the topics and scores of AMG's PIPs in 2013.

AMG submitted a clinical PIP aimed at increasing the percentage of infants receiving at least 5 well-child care (WCC) visits, a HEDIS measure. TEAMonitor scored the PIP "Not Met" because AMG did not demonstrate that it had undertaken an intervention to increase the WCC visit rate.

AMG took part in the statewide Transitional Healthcare Services PIP. TEAMonitor reviewed the PIP for compliance; however, scoring will not occur until 2014.

The MCO submitted an additional nonclinical PIP, Provider Denial Letters, which was not reviewed or scored by TEAMonitor.

Table 18. Amerigroup Washington PIP topics and scores, 2013.

Topic	Score
Clinical: Well-Child Visits During the First 15 Months of Life (5 or More Visits)	Not Met
Nonclinical PIP: Statewide Transitional Healthcare Services PIP	n.a.*
Nonclinical PIP: Provider Denial Letters	Not reviewed

*PIP will be scored in 2014.

Coordinated Care Corp.

Table 19 displays the topics and scores of CCC's PIPs in 2013.

CCC submitted a clinical PIP aimed at increasing the compliance of female members age 40 and older with recommended annual mammograms. The MCO initiated interventions consisting of mailings and outreach calls to women who had not yet had mammograms, to help them make appointments with their PCPs or to help with transportation if needed.

TEAMonitor scored this PIP "Partially Met," stating that the study appeared to be solid, using the HEDIS breast cancer screening measure, but that the PIP documentation was too brief.

CCC took part in the statewide Transitional Healthcare Services PIP. TEAMonitor reviewed the PIP for compliance; however, scoring will not occur until 2014. The MCO submitted an additional clinical PIP related to diabetes compliance, not reviewed or scored by TEAMonitor.

Table 19. Coordinated Care Corp. PIP topics and scores, 2013.

Topic	Score
Clinical: Increasing Compliance of Female Members Over Age 40 in Getting an Annual Screening Mammogram	Partially Met
Clinical PIP: Diabetes Compliance	Not reviewed
Nonclinical PIP: Statewide Transitional Healthcare Services PIP	n.a.*

*PIP will be scored in 2014.

Community Health Plan

Table 20 displays the topics and scores of CHP's PIPs in 2013.

For the Healthy Options blind and disabled population, CHP submitted a clinical PIP on improving the use of appropriate asthma medications. CHP's clinical PIP for the MCS population addressed improving results of the Patient Health Questionnaire (PHQ-9), used in measuring the severity of depression.

CHP took part in the statewide Transitional Healthcare Services PIP. TEAMonitor reviewed the PIP for compliance; however, scoring will not occur until 2014. CHP submitted an additional nonclinical PIP, aimed at improving the completeness and accuracy of benefit information provided to MCS enrollees by the MCO's customer service representatives. This PIP was carried over from 2012.

Strengths

- CHP's clinical PIP on asthma medications was generally well written and documented, featuring member education interventions and new provider feedback reports.
- TEAMonitor called CHP's clinical PIP on PHQ-9 results "a very promising project that seemed to yield interesting results." CHP reported a lowering of PHQ-9 scores for enrollees in need of mental health services who were referred for care coordination.
- TEAMonitor noted improvements in the design, data collection, and analysis of the nonclinical PIP.

Opportunities for improvement

- For the asthma medications PIP, CHP needs to improve its documentation to clarify that the MCO used hybrid data collection methods.
- The mental health PIP needs improvement in overall documentation—definitions, data analysis plan, data collection methods, and analysis of results.
- The nonclinical PIP failed to demonstrate that it adequately addressed the MCS population because the sample of MCS calls addressed was not large enough.

Table 20. Community Health Plan PIP topics and scores, 2013.

Topic	Score
Clinical: Improving Use of Appropriate Medications for People with Asthma	Met
Clinical: Improving PHQ-9 Results for MCS Members	Partially Met
Nonclinical: Improving CSR Handling of Benefit Calls	Partially Met
Nonclinical: Statewide Transitional Healthcare Services PIP	n.a.*

*PIP will be scored in 2014.

Molina Healthcare of Washington

Table 21 displays the topics and scores of MHW's PIPs in 2013.

For the Healthy Options blind and disabled population, MHW submitted a clinical PIP aimed at improving the HEDIS breast cancer screening measure. TEAMonitor found that this PIP was generally well documented, but that MHW needed to describe its interventions in greater detail.

MHW took part in the statewide Transitional Healthcare Services PIP. TEAMonitor reviewed the PIP for compliance; however, scoring will not occur until 2014.

Table 21. Molina Healthcare of Washington PIP topics and scores, 2013.

Topic	Score
Clinical: Improving Breast Cancer Screening	Met
Nonclinical: Statewide Transitional Healthcare Services PIP	n.a.*

*PIP will be scored in 2014.

UnitedHealthcare Community Plan

Table 22 displays the topics and scores of UHC's PIPs in 2013.

UHC's clinical PIP sought to reduce inpatient readmissions and avoidable ER visits following hospitalization, while encouraging seven-day post-discharge PCP follow-up visits. Interventions included administering a patient experience survey, linking enrollees with a nurse advice line or the PCP office, and notifying PCPs about recently hospitalized or discharged enrollees.

UHC took part in the statewide Transitional Healthcare Services PIP. TEAMonitor reviewed the PIP for compliance; however, scoring will not occur until 2014.

Strengths

- TEAMonitor called the clinical PIP an important and promising new project with clear, measurable indicators, aimed at assessing how a positive discharge experience affects service utilization by enrollees following hospitalization.

Opportunities for improvement

- TEAMonitor cited "documentation challenges" that limited the clinical PIP to a score of Partially Met.

Table 22. UnitedHealthcare Community Plan PIP topics and scores, 2013.

Topic	Score
Clinical: Improving the Medical Home for Emergencies that are Avoidable and Readmissions from Transitions	Partially Met
Nonclinical PIP: Statewide Transitional Healthcare Services PIP	n.a.*

*PIP will be scored in 2014.

Washington Medicaid Integration Partnership Evaluation

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

HCA contracts with MHW to conduct the WMIP in Snohomish County. MHW is expected to

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

The WMIP target population excludes children under 21, Healthy Options enrollees, and recipients of Temporary Assistance for Needy Families. As of December 2012, WMIP enrollment totaled about 3,800.

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

WMIP performance measures

For 2013, MHW reported nine HEDIS measures for the WMIP population:

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

Data were validated through the NCQA HEDIS compliance audit.

Table 23 on the next page presents the WMIP results for comprehensive diabetes care over the past three years. The 2013 results reflect little or no improvement. HbA1c testing for WMIP enrollees has dropped for the past two years, to 82.18% in 2013. The percentages of those receiving other preventive services—LDL-C screening and monitoring for nephropathy—were significantly lower in 2013 than in 2009. Fewer than half of WMIP enrollees (47.66%) had good control of their HbA1c levels in 2013, a significantly lower percentage than in 2010 when NCQA introduced this indicator. Almost as high a percentage of enrollees (44.32%) had poor control of their HbA1c levels in 2013.

Table 24 presents WMIP results for inpatient utilization, general hospital/acute care in the past three years. Compared with the 2012 rates, discharge rates rose slightly in 2013 for both medical and surgical care, but the changes were not statistically significant. Total inpatient (acute) and surgical days rose significantly from 2012 to 2013, while medical days dipped slightly.

WMIP enrollees' average length of stay (ALOS) for surgical care and for total inpatient (acute) care rose significantly in 2013, while the ALOS for medical care declined.

Looking at ambulatory care measures (Table 25), the ER visit rate for WMIP enrollees fell significantly for the third straight year in 2013, while the outpatient visit rate rose significantly.

Table 23. WMIP comprehensive diabetes care measures, 2011–2013.

	2011	2012	2013
HbA1c tests (percentage tested)	87.95	86.06	82.18
Enrollees with poor control of HbA1c levels (percentage >9.0%)	31.03	41.04	44.32
Enrollees with good control of HbA1c levels (percentage <8.0%)	60.00	50.40	47.66
Dilated retinal exams (percentage examined)	59.49	53.98	53.45
Lipid profile (LDL-C) performed (percentage profiled)	76.92	74.50	74.83
Lipids controlled (percentage with <100mg/dL)	39.23	34.46	35.41
Nephropathy monitored annually (percentage monitored)	86.41	83.07	79.73
Blood pressure control (percentage with <140/90 mm Hg)	64.36	60.36	64.59

Table 24. WMIP inpatient utilization, general hospital/acute care measures, 2011–2013.

	Discharges/1000MM[a]			Days/1000MM[a]			ALOS[b]		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Total inpatient	15.55	15.21	16.00	72.54	78.00	91.37 ↑	4.67	5.13	5.71 ↑
Medical	9.33	9.53	9.84	35.31	41.44	39.35	3.79	4.35	4.00
Surgical	5.55	5.24	5.75	35.15	35.23	51.03 ↑	6.33	6.73	8.87 ↑

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

↓↑ Indicates statistically significant difference in percentages from 2012 to 2013 ($p \leq 0.05$).

Table 25. WMIP ambulatory care measures, 2011–2013.

	Visits/1000MM[a]		
	2011	2012	2013
Outpatient visits	539.06	546.91	570.55 ↑
Emergency room visits	109.83	101.85	89.93 ↓

[a]1000MM = 1000 member months.

↓↑ Indicates statistically significant difference in percentages from 2012 to 2013 ($p \leq 0.05$).

Tables 26 and 27 present WMIP results for behavioral health and medication measures. The *antidepressant medication management* measure (Table 26) examines the percentage of patients beginning antidepressant drug treatment who received an effective acute phase trial of medications (three months) and the percentage who completed six months of continuous treatment for major depression. The percentage of WMIP enrollees receiving effective acute phase treatment and effective continuation phase treatment turned down in 2013, to 63.89% and 47.22%, respectively, though the declines were not statistically significant.

The *mental health follow-up* measure (Table 27) looks at continuity of care—the percentage of enrollees who were hospitalized for selected mental disorders and were seen by an outpatient mental health provider within 30 days or within 7 days after discharge from the hospital. The percentage of WMIP enrollees receiving follow-up care within 7 days dipped to 56.00% in 2013, while the 30-day follow-up rate rose to 72.00%. Neither change was statistically significant.

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

Table 26. WMIP antidepressant medication management measures, 2011–2013.

	Effective acute phase treatment			Effective continuation phase treatment		
	2011	2012	2013	2011	2012	2013
Percentage of patients receiving medication management	56.86	67.50	63.89	47.06	55.00	47.22

No statistically significant differences in percentages from 2012 to 2013 ($p \leq 0.05$).

Table 27. WMIP follow-up after hospitalization for mental illness measures, 2011–2013.

	30-day follow-up			7-day follow-up		
	2011	2012	2013	2011	2012	2013
Percentage of patients receiving follow-up	64.81	70.49	72.00	55.56	57.38	56.00

No statistically significant differences in percentages from 2012 to 2013 ($p \leq 0.05$).

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

	One prescription	At least two prescriptions
Percentage of patients receiving medication	7.08	2.29

Note: Measure reported in 2013 was not comparable with measures reported in previous years.

Tables 29–31 display the first two years of data on three additional HEDIS measures for WMIP (two utilization measures and an access/availability measure), defined below.

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

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

Identification of Alcohol and Other Drug (AOD) Services summarizes the percentage of enrollees with an AOD claim who received various types of chemical dependency services during the measurement year.

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

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

Changes in the mental health utilization and AOD identification measures from 2012 to 2013 were not statistically significant. The AOD initiation and engagement measure was not calculated in 2013 because the denominator was not large enough to support the calculation of a meaningful measure.

Table 29. WMIP mental health utilization, 2012–2013.

	2012	2013
Any service[a]	41.63	30.24
Inpatient	1.58	1.52
Intensive outpatient/partial hospitalization	1.33	0.78
Outpatient/ER	40.85	30.06

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

Table 30. WMIP identification of alcohol and other drug services, 2012–2013.

	2012	2013
Any service[a]	20.38	20.46
Inpatient	75.87	68.14
Intensive outpatient/partial hospitalization	0.00	0.00
Outpatient/ER	18.18	18.64

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

Table 31. WMIP initiation and engagement of alcohol and other drug dependence treatment, 2012–2013.

	2012	2013
Initiation	26.32	n.a.
Engagement	2.63	n.a.

Note: Measure was not calculated in 2013 because the denominator was not large enough.

WMIP compliance review

HCA and ADSA reviewed MHW's compliance with managed care regulations and contractual provisions. This review addressed many of the same standards addressed by TEAMonitor's MCO compliance reviews, as well as elements related to specific WMIP contract provisions. Table 32 reports the 2013 WMIP compliance scores.

MHW fully met five of the 13 standards. The MCO once again performed strongly in meeting the multiple elements of Availability of Services, Grievance Systems, Practice Guidelines, and QA/PI Program.

With regard to other standards, MHW's 2013 compliance scores fell considerably from 2012. This was particularly the case for Enrollee Rights, Coverage and Authorization of Services, Provider Selection, Subcontractual Relationships and Delegation, and Program Integrity. The review found that MHW had not completed numerous corrective actions required in the wake of the 2012 review, and that program documentation was deficient in many areas.

MHW continued to struggle with meeting the requirements for Coordination and Continuity of Care. The review found that WMIP files did not consistently demonstrate timely access to mental health intake evaluations.

Table 32. WMIP compliance scores, 2013.

Standard (# of elements)	Percentage of elements Met (M), Partially Met (PM), Not Met (NM)		
	M	**PM**	**NM**
Availability of Services (7)	**100**	0	0
Program Integrity (5)	**0**	40	60
Claims Payment (1)	**100**	0	0
Coordination and Continuity of Care (9)	**33**	33	33
Coverage and Authorization of Services (5)	**40**	40	20
Enrollment and Disenrollment (1)	**100**	0	0
Enrollee Rights (14)	**57**	36	7
Grievance Systems (19)	**89**	5	5
Performance Improvement Projects (4)	**50**	50	0
Practice Guidelines (3)	**100**	0	0
Provider Selection (4)	**25**	50	25
QA/PI Program (5)	**100**	0	0
Subcontractual Relationships and Delegation (4)	**25**	50	25

WMIP PIP validation

For 2013, MHW carried over two clinical PIPs conducted in 2012, aimed at reducing avoidable hospital readmissions and emergency room visits by WMIP enrollees. Table 33 lists the scores for each PIP in 2012 and 2013.

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

Strengths

- Both PIPs use clear, measurable indicators.

Opportunities for improvement

- Documentation of the hospital readmissions PIP was generally too brief and/or did not correspond to the required standard. MHW needs to provide more information about how the transitional care program works and describe the interventions in greater detail. The MCO also needs to correct data inconsistencies for one indicator.
- Results of the emergency room PIP are mixed, with avoidable visit rates rising in the third and fourth quarters of 2012.

Table 33. WMIP PIP topics and scores, 2012–2013.

Topic	2012	2013
Clinical: Decreasing Inpatient Hospital Readmission Rates	Met	Partially Met
Clinical: Decreasing Emergency Department Utilization	Met	Met

Recommendations for WMIP

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

Although the diabetes care indicators for WMIP enrollees have fluctuated over the past five years, the 2013 results reflect little or no improvement throughout that period. HbA1c testing has dropped to 82.18%, the lowest level since HEDIS measurements began for this program in 2007. Similarly, the percentages of enrollees receiving other preventive services—LDL-C screening and monitoring for nephropathy—were significantly lower in 2013 than in 2009. The percentage of enrollees with poor control of their HbA1c levels in 2013 (44.32%) was almost as high as the percentage of those with good control (47.66%).

The percentages of WMIP enrollees receiving effective antidepressant medication management turned down in 2013, though the declines were not statistically significant. The WMIP program may want to closely monitor enrollees who receive those services.

More encouragingly, the ER visit rate for WMIP enrollees fell significantly for the third straight year in 2013. MHW's current clinical PIP, if successful, could further reduce the rate of avoidable ER visits.

- ***MHW should continue efforts to reduce WMIP hospital readmissions and ER visit rates through the two clinical PIPs, and respond to TEAMonitor's request for more detailed documentation of the interventions for the hospital readmissions PIP.***

Other HEDIS measures for this population are generally too new for any significant trends to have become apparent yet.

The following themes identified in the 2012 annual report continue to apply for this review year.

TEAMonitor's review of WMIP has identified deficiencies in timely completion of initial intake screenings and in comprehensive assessment of high-risk enrollees.

- ***MHW should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.***
- ***MHW should ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and current, to meet standards for continuity and coordination of care.***
- ***MHW should conduct a root cause analysis or other investigation to determine why WMIP enrollees' utilization of mental health services decreased from 2012 to 2013.***

Acumentra Health continues to recommend that the WMIP program

- ***explore ways to increase enrollees' ongoing engagement in alcohol and drug dependence treatment, since a high percentage of WMIP enrollees receive AOD services***

Discussion and Recommendations

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

The 2013 report differs markedly from previous annual reports in the volume of data available for analysis of the MCOs' performance on physical health measures. With the inception in mid-2012 of a new contract cycle for five MCOs—three of which were new to Washington's Medicaid managed care program—HCA greatly reduced the HEDIS reporting requirements. In addition, no historical data are available on the performance of the three new MCOs. Future annual reports will build on this initial report in developing consistent multi-year data.

Medicaid managed care highlights

Children's Mental Health Redesign. DSHS continues to implement its multi-year program to redesign the delivery of mental health services for children, aiming toward a system of community-based, child-centered, culturally responsive care. The redesign plan responds to commitments based on the *T.R. et al. v. Dreyfus* Interim Agreement and state legislative mandates. DBHR is working to implement screening tools and protocols for referring children to public mental health services; evidence-based practices, including wraparound and intensive services; a workforce development model to support access to services; and statewide performance measures that rely on standardized encounter reporting by RSNs.[6]

To assess the RSNs' adherence to the principles of the mental health redesign, Acumentra Health reviewed the clinical records of a sample of children served by the RSNs. With a few exceptions, the RSNs are doing a good job of establishing medical necessity, justifying the children's diagnoses, and assessing the children's living environments, support systems, cultural and language issues, and impairments. Most treatment plans contain goals and interventions consistent with the child's assessment, include strength-based activities, and reflect family/guardian participation in developing the plans. Almost all of the progress notes demonstrated that the child received unconditional treatment.

Care integration. HCA requires the contracted MCOs to integrate physical and behavioral health care by providing a full range of health home services for enrollees with SHCN. Each MCO must implement an intensive care management program, in coordination with qualified community health homes or by contracting with RSNs, chemical dependency facilities, long-term care agencies, and other community organizations. The MCOs have begun conducting a collaborative statewide PIP on transitional healthcare services for enrollees who have SHCN or who are at risk for reinstitutionalization, rehospitalization, or substance use disorder recidivism.

HCA is developing a five-year State Health Care Innovation Plan, funded by a $1 million grant from the federal Center for Medicare & Medicaid Innovation. One key strategy of the plan is to coordinate and integrate the delivery system with community services, social services, and public health, by creating public-private partnerships called Accountable Communities of Health in nine regional service areas that will also serve as new Medicaid procurement areas.[7] HCA has collected public comments on the draft plan, and plans to complete and deliver the final plan by the end of 2013. This will enable Washington to compete with other states in a "model design" phase for $20–$60 million in an anticipated second round of funding.

Access to care. TEAMonitor's 2013 review found that the MCOs showed spotty compliance with federal and state standards related to access and timeliness. Documentation of MCO policies

and procedures was often deficient, notably in relation to screening and assessment of SHCN enrollees, physical/behavioral health integration, and requirements to provide outpatient mental health services. Several MCOs failed to provide evidence that they actively monitored providers' compliance with timeliness standards.

Acumentra Health did not assess the RSNs' compliance with access and timeliness standards in 2013. However, the clinical record review revealed an issue with the timeliness of mental health assessments for children. Nearly one-quarter of assessments were more than a year old, often much older. Several RSNs moved forward with PIPs aimed at improving access to and/or timeliness of mental health care, focusing on topics such as services for older adults and medical evaluation appointments.

Quality of care. TEAMonitor's 2013 review found that the MCOs, as a group, had difficulty demonstrating that they met state and federal quality standards, particularly those related to ensuring coordination and continuity of care for at-risk enrollees. The MCOs generally failed to demonstrate compliance with the requirements for provider selection. On a more positive note, the MCOs met the great majority of requirements for enrollee grievance systems.

Acumentra Health's review of clinical records for RSN enrollees revealed encouraging results with regard to the quality of mental health care. Overall, the records indicated that the RSNs are adhering to the "golden thread" of therapy that links essential elements of the enrollee's diagnosis and assessment, treatment plan, and progress notes. These elements were generally stronger in children's charts than in adults' charts.

Physical health measures. Because HCA required the MCOs to submit only a limited set of utilization measures for the 2013 HEDIS study, comparisons of the MCOs' performance with benchmarks related to access, timeliness, and quality were not feasible this year.

However, as in the past, Washington MCO enrollees visited outpatient and ER facilities at rates that were significantly below the national average rates. Utilization rates for general hospital care (medical and surgical) were also significantly lower than the national average rates, as were the average lengths of stay for Washington enrollees receiving that care.

The path to future improvements: Mental health care

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

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

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

Children's mental health treatment. Many clinical records for children did not document access to other service agencies and systems (e.g., child welfare, juvenile justice, special education) when the child's assessment indicated such involvement. Mental health providers need to coordinate care with other agencies and systems involved in the child's life.

- ***DBHR needs to work with the RSNs to ensure that mental health clinicians include coordination-of-care objectives in individualized care plans for children, when allied service agencies are involved in the child's care.***

Almost half of the children's treatment plans reviewed did not describe a multidisciplinary team-based approach to treatment.

- ***DBHR needs to work with the RSNs to ensure that children's treatment plans include a multidisciplinary team-based approach, when appropriate.***

Nearly one-quarter of assessments for children were more than a year old; in many cases, the assessments were three to five years old.

- ***DBHR needs to work with the RSNs to ensure that providers update enrollees' assessments at least annually to reflect changes in the enrollee's functioning and life circumstances.***

Most progress notes for children did not document the child's response to the interventions identified in the treatment plan or progress toward meeting the goals negotiated with the child or family.

- ***DBHR needs to direct the RSNs to work with their providers to ensure that children's progress notes fully document the child's response to interventions and progress toward stated goals.***

PIPs. Some RSNs have prolonged their PIPs beyond a reasonable period without demonstrating sustained improvement. Many of the new PIPs reviewed in 2013 did not provide evidence to support the validity of the chosen study indicator. Some RSNs did not demonstrate the relevance of the PIP topic for the local Medicaid population.

- ***DBHR should establish a process to approve each RSN's PIP topics before the RSN begins implementation.***
- ***DBHR needs to define clear expectations for PIPs, requiring the RSNs to***
    - ***select a new topic after the PIP has completed a second remeasurement or if the PIP has been in place for more than three years***
    - ***ensure that study topics are informed by enrollee input, relevant to the local population, focused on a high-volume or high-risk population, and address a significant improvement opportunity that can be evidenced with data***

Information Systems Capabilities Assessment (ISCA). DBHR relies on its legacy CIS as the primary data repository for producing mental health reports. Encounter data submitted by the RSNs to ProviderOne, the state's Medicaid management information system, must pass through several transitions before reaching the CIS database. The DBHR ISCA review and other EQR activities identified numerous issues related to CIS data quality, processing, and documentation, arising from different aspects of the ProviderOne and CIS data systems (see Appendix C).

- ***DBHR needs to address state-level ISCA recommendations related to CIS data quality, accuracy, and completeness.***

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

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

Exhibit C of DBHR's updated contract contains more stringent requirements for RSNs, provider agencies, and outside contractors to safeguard Medicaid data security. The 2013 ISCA review found that all but two RSNs failed to meet the updated security criteria.

- ***DBHR needs to work with RSNs to ensure that all requirements of Exhibit C of the RSN contract are implemented at the RSN and provider agency levels.***

Encounter data validation. Acumentra Health's review found only a 65% rate of match between minutes of service recorded in enrollees' charts and the service minutes recorded in the state's encounter data set. This low match rate is attributed to conversions performed as part of data processing in ProviderOne. If the data sent to CMS from ProviderOne contain the errors that Acumentra Health detected, DBHR could be at risk of recoupment of program dollars by CMS.

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

Language information was missing from 14.8% of the state's demographic data records, and 18.6% of records contained invalid ethnicity data. The EDV also found low match rates for these fields between the state's data and enrollee charts at the provider agencies. RSNs need accurate data about ethnicity and language in order to tailor culturally and linguistically appropriate services.

- ***DBHR needs to ensure that ethnicity and language data can be accurately captured and reported to CMS and the RSNs.***

In conducting their own EDV activities, all RSNs validated enrollee records against encounters they had sent or expected to send to ProviderOne. Using these data, rather than the state's encounter data after processing, hinders the RSNs from detecting discrepancies between the data they submit and the state's encounter data set. EDV reviews by Acumentra Health, using the state-processed data, found issues with ethnicity, service minutes, and duplicate claim IDs that the RSNs did not identify.

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

Response to 2012 recommendations

The 2012 EQR report offered recommendations as to how DBHR and the RSNs could work together to improve access to mental health care and the quality and timeliness of care. Table 34 outlines DBHR's response to those recommendations.

Table 34. DBHR response to 2012 EQR recommendations for mental health.

2012 recommendations	DBHR response	EQRO comments
Program evaluation		
Ensure that all RSNs complete end-of-year evaluations that synthesize the results of QA/PI activities defined in the RSN contract.	DBHR will work with each RSN to ensure that evaluations synthesizing the results of their respective QA/PI activities are completed yearly. Ongoing oversight will be maintained through routine contract monitoring activities.	*Status: The EQRO considers this action responsive, but continued oversight work with the RSNs is needed.*
Policy review		
Work with the RSNs to ensure that all policies and procedures are reviewed and updated regularly.	DBHR will develop a comprehensive policy review checklist to ensure that policies and procedures are updated regularly. Ongoing oversight will be maintained through routine contract monitoring activities.	At the time of this report, the EQRO had not received a completed comprehensive policy review checklist. *Status: DBHR needs to follow through with its stated intention.*
Program integrity		
Ensure that the RSNs screen for federal exclusion all staff, board members, committee members, and volunteers, and that the RSNs screen more often than yearly.	DBHR will implement new contract language requiring RSNs to screen for federal exclusion of all staff, board members, and volunteers on a semi-annual basis. Ongoing oversight will be maintained through routine contract monitoring activities.	DBHR has implemented new contract language requiring RSNs to screen all staff, board members, and volunteers for federal exclusion on a monthly basis. *Status: DBHR has addressed this recommendation.*
Ensure that each RSN has an independent compliance committee that meets regularly. The committee's overview should include fraud, waste, and abuse not only associated with encounter data but also related to internal financial practices, HIPAA, and other areas of risk that might have a negative impact on the RSN, providers, and enrollees. All issues need to be tracked, reviewed, investigated and resolved in a timely manner.	DBHR will implement new contract language requiring independent compliance committees that meet regularly to maintain overview of fraud, waste, and abuse.	Although the DBHR contract requires each RSN to have a compliance officer and compliance committee, it does not specify the frequency of the compliance committee meetings nor the scope of the committee's oversight of fraud, waste, and abuse. The contract also needs to require that the RSN track, review, investigate, and resolve issues in a timely manner. *Status: DBHR's response is in progress.*

Table 34. DBHR response to 2012 EQR recommendations for mental health (cont.).

2012 recommendations	DBHR response	EQRO comments
Confirm that the RSNs' and contracted providers' compliance officers have the necessary training to effectively maintain program integrity.	DBHR has worked with Acumentra Health to develop training resources.	The EQRO provided training in April 2013 and will provide ongoing training. *Status: DBHR has addressed this recommendation.*
Access to mental health care		
Continue to work with the RSNs to identify solutions to issues with routine access.	DBHR will implement new contract language designed to ensure that RSNs provide assistance to enrollees who request second opinions.	Access to second opinions is only one of the ongoing access issues. Others include routine access to intakes and the first subsequent appointment. DBHR needs to continue to work with the RSNs to resolve routine access issues. *Status: DBHR has partially addressed this recommendation.*
Timeliness of mental health care		
Establish a recommended period during which a PIP should be completed.	DBHR will implement new contract language requiring RSNs to limit PIP activities to a three-year life cycle.	DBHR is considering establishing a process to review all PIP topics and a recommended period during which all PIPs should be completed. *Status: DBHR needs to follow through with its stated intention.*
Quality of mental health care		
Continue to work with the RSNs to ensure consistency of review criteria for quality and appropriateness of care.	DBHR will review RSN service authorization policies and will assist the RSNs in establishing mechanisms to ensure consistent application of review criteria for authorizations and utilization management decision making.	*Status: DBHR needs to follow through with its stated intention.*
Encourage RSNs to invest adequate resources in PIPs. RSNs should design network-wide interventions that are likely to work and can sustain improvement.	DBHR will work with Acumentra Health to develop PIP criteria and to implement a statewide approval process for all PIPs.	Criteria for selecting PIP topics are only part of this issue. RSNs need to allocate adequate resources to develop network interventions that are likely to lead to sustained improvement. *Status: DBHR's response is in progress.*

Table 34. DBHR response to 2012 EQR recommendations for mental health (cont.).

2012 recommendations	DBHR response	EQRO comments
PIP topics, design, and conduct		
• *Work with the RSNs to select PIPs with a higher likelihood of improving enrollee satisfaction, processes, or outcomes of care.* • *Ensure that the RSNs understand the elements of a sound PIP design and common challenges to validity of study results.* • *Encourage more analysis in PIP planning. RSNs should examine the proposed target population—including individuals, providers, and other relevant stakeholders, systems, and resources—to identify specific risk factors and barriers to improvement, and use that information to evaluate the possibilities for improvement.*	DBHR will work with Acumentra Health to develop PIP criteria and to implement a statewide approval process for all PIPs.	DBHR has developed and implemented criteria for the Children's PIP. Acumentra Health recommends that DBHR expand this process by reviewing and approving all PIP topics. *Status: DBHR's response is in progress.*
Compliance: Coordination and Continuity of Care		
Ensure that all RSNs have developed and implemented policies and procedures on providing direct access to specialists.	DBHR will work with identified RSNs to develop policies and procedures for providing direct access to specialists. DBHR will develop a comprehensive policy review checklist to ensure that the policies and procedures are updated regularly. Implementation oversight will be maintained through routine contract monitoring activities.	DBHR uses mental health specialists to perform evaluations for enrollees with SHCN. The EQRO encourages DBHR to evaluate whether enrollees have access to mental health specialty services (e.g., for neuropsychiatric evaluations, eating disorders, transgender issues). *Status: DBHR's response is in progress.*
Compliance: Provider Selection		
Ensure that the RSNs' policies and procedures for credentialing and recredentialing include mechanisms to verify the qualifications of all licensed staff of contracted agencies, subcontractors, and the RSN, and to ensure that licenses are up to date.	DBHR will work with identified RSNs to develop policies that include mechanisms to verify and monitor the qualifications of all licensed staff of the RSN, its contractors, and its subcontractors. Implementation oversight will be maintained through routine contract monitoring activities.	DBHR needs to ensure that the RSNs are using licensing and certification site reviews and following up on identified issues between reviews. *Status: DBHR's response is in progress.*

Table 34. DBHR response to 2012 EQR recommendations for mental health (cont.).

2012 recommendations	DBHR response	EQRO comments
Compliance: Practice Guidelines		
Ensure that all RSNs routinely review and update practice guidelines to ensure they still apply to enrollees' needs and include current clinical recommendations.	DBHR will work RSNs to develop policies and procedures that include periodic review of practice guidelines.	DBHR needs to ensure that the RSNs review and update their guidelines regularly to ensure that they still apply to enrollees' needs and include current clinical recommendations. *Status: DBHR's response is in progress.*
Ensure that all RSNs have policies in place on the dissemination of practice guidelines.	DBHR will work with RSN to develop policies and procedures that include dissemination of practice guidelines. Implementation oversight will be maintained through routine contract monitoring activities.	*Status: DBHR's response is in progress.*
Mental health performance measure validation		
DBHR's contract should define clearly the review period for which performance measure results are to be calculated.	DBHR will implement new contract language clearly defining the review period for which performance results are calculated.	*Status: DBHR needs to follow through with its stated intention.*
DBHR should work with Looking Glass Analytics to extend the functionality of its performance measure reporting.	DBHR is working with Looking Glass Analytics to develop the capability to include multiple quarters in a single report for all measures.	*Status: DBHR has partially addressed this recommendation.*
DBHR should have a system in place to replicate the performance measure analyses performed by Looking Glass Analytics. This would allow DBHR to validate the Looking Glass calculations, creating greater confidence in the reported results.	DBHR is working with Looking Glass Analytics to develop a mechanism by which to replicate and validate their performance measure calculations.	*Status: DBHR needs to follow through with its stated intention.*
Looking Glass Analytics should develop detailed documentation of the calculation of each performance measure. Data flow diagrams should be created for each metric, showing the state data source, which variables are extracted and calculations performed, which new datasets are created and where they are stored, and which program uses those new datasets to calculate the measure. SAS code used to process the data and calculate the measures should include notes explaining what each portion of code does.	DBHR will work with Looking Glass Analytics to develop detailed documentation for each performance measure.	*Status: DBHR needs to follow through with its stated intention.*

Table 34. DBHR response to 2012 EQR recommendations for mental health (cont.).		
2012 recommendations	**DBHR response**	**EQRO comments**
Mental health encounter data validation		
Work with the RSNs to standardize data collection and analytical procedures for encounter data validation to improve the reliability of encounter data submitted to the state.	DBHR will consult with Acumentra Health to discuss development of a standardized database system to display the demographic and encounter data elements to be checked, and to record the EDV results.	DBHR has begun discussions with the EQRO about how to address this issue. *Status: DBHR's response is in progress.*
Provide guidance for RSNs as to when services can be bundled under a single service code and when services should be unbundled into separate service codes.	DBHR will modify its Service Encounter Reporting Instructions (SERI) to clarify when services can be bundled under a single service code and when services should be unbundled into separate service codes.	DBHR recently revised the SERI. The EQRO has not yet reviewed this change to ensure that this recommendation has been addressed. *Status: DBHR's response is in progress.*

The path to future improvements: Physical health care

The following recommendations apply to the newly contracted MCOs as well as to CHP and MHW.

Care coordination. TEAMonitor's 2013 review found that the MCOs are complying only partially with requirements to ensure the coordination and continuity of care for at-risk enrollees. Challenges in this area are likely to grow with the addition of thousands of new Medicaid managed care recipients who have complex medical and behavioral needs. High-risk enrollees account for more than 25% of enrollees for three of the five MCOs. HCA and DBHR need to align their efforts closely to improve the coordination and continuity of care across medical and mental health programs.

- ***HCA should ensure that all MCOs incorporate EQR recommendations into their quality improvement plans.***
- ***MCOs should explore strategies to incorporate the state's Predictive Risk Intelligence System (PRISM) into their care coordination activities.***

Technical assistance.

- ***During 2014, HCA should sponsor formal training for all MCOs on care transitions and coordination, program integrity, and access issues, to assist the MCOs in meeting related contractual and regulatory requirements.***
- ***HCA should encourage MCOs with emerging best practices to share those practices at the regularly scheduled joint MCO/RSN quality meetings.***

Data quality and completeness. The HEDIS audits revealed challenges related to the MCOs' ability to demonstrate comprehensive review and evaluation of their data. Delegation and vendor oversight proved especially challenging.

- ***HCA should continue to monitor efforts with the EQRO to ensure the reliability of data integration and overall integrity of MCO data systems.***
- ***MCOs need to closely monitor and evaluate incoming data and data transmission from vendors that perform delegated functions.***

The MCOs continue to struggle with capturing and reporting race and ethnicity data for Medicaid enrollees, which can inform interventions to address healthcare disparities.

- ***HCA should continue to work with state policy analysts to determine the best approach to collect reliable race and ethnicity data for Medicaid enrollees.***
- ***MCOs should dedicate resources to improve the collection, retention, and completeness of race/ethnicity data.***

ER utilization. Relatively low rates of ER use, compared with national rates, are a positive for Washington's Medicaid program. The state should press for ongoing improvement in this area.

- ***MCOs should incorporate ER utilization reports from the Emergency Department Information Exchange (EDIE) into their care coordination and transition programs to ensure that enrollees receive timely care at the appropriate levels.***

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

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

Response to 2012 recommendations

Table 35 outlines HCA's response to the recommendations presented in the 2012 EQR annual report.

Table 35. HCA response to 2012 EQR recommendations for physical health.

2012 recommendations	HCA response	EQRO comments
Care coordination		
HCA and DBHR should explore strategies to ensure that all eligible providers and managed care partners have access to PRISM, which provides current Medicaid utilization data to help facilitate appropriate levels of treatment and coordination.	HCA is deploying PRISM to all managed care plans and health home providers serving eligible high-risk, high-cost clients. Care coordinators use this information to identify gaps in health care or clients' self-management of their chronic conditions.	The EQRO considers this action responsive. HCA might consider monitoring the use of PRISM data through the TEAMonitor reviews.
PIP interventions		
Examine the MCOs' levels of expertise and performance gaps to help determine the level of technical assistance needed to facilitate a successful PIP.	HCA will take this recommendation under consideration as part of the 2014 review of MCOs' PIPs performed during the 2013 contract year.	In 2013, the EQRO provided PIP training for the MCOs. We recommend ongoing education to ensure that MCOs have the tools to conduct a complete PIP.
Data completeness		
HCA should continue to work with state policy analysts to determine the best approach to collect reliable race and ethnicity data for Medicaid enrollees.	HCA will take this recommendation under consideration as time and resources allow.	The EQRO will continue to monitor this data completeness issue.
MCOs should continue to explore new data sources to augment the state-supplied race/ethnicity data.	This recommendation is directed at the MCOs. HCA will share it with the MCOs for their consideration.	The EQRO will continue to monitor this data completeness issue.
Performance measure feedback to clinics		
To help facilitate targeted interventions, HCA should require the MCOs to provide performance measure feedback to clinics and providers regularly and often.	HCA will take this recommendation under advisement. We will suggest this as an intervention and consider it when the contract is being revised.	The EQRO considers this action responsive and will continue to monitor this quality data reporting issue.
Washington Medicaid Integration Partnership		
Molina Healthcare of Washington should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.	This recommendation is directed at the MCO. HCA will share it with the MCO with a recommendation that the MCO address this concern.	The EQRO considers this action responsive and will continue to monitor this health care access issue.
Acumentra Health recommends that the WMIP program • *ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and up-to-date to meet standards for continuity and coordination of care* • *explore ways to increase enrollees' ongoing engagement in alcohol and drug dependence treatment*		

Table 35. HCA response to 2012 EQR recommendations for physical health.

2012 recommendations	HCA response	EQRO comments
Quality-of-care studies		
Contracted MCOs should implement asthma health management strategies for their enrollees. Successful strategies might involve identifying members with asthma, targeting interventions based on severity of illness, and promoting effective communication and care coordination among providers.	This recommendation is directed at the MCOs. HCA will share it with the MCOs for their consideration.	The EQRO considers this action responsive and will continue to monitor this health care access issue.
HCA should study the reasons for disparate rates of antidepression treatment completion among enrollees in different demographic groups. HCA could then work with MCOs to design interventions aimed at improving antidepressant medication management rates, possibly including provider incentives for outcomes related to medication management.	HCA will take this recommendation under consideration as time and resources allow.	The EQRO considers this action responsive and will continue to monitor this health care access issue.
Acumentra Health recommends that HCA • *develop data quality control procedures to ensure a basic level of data integrity* • *develop a system of documentation, including data dictionaries, to help give analysts and programmers a more complete understanding of the variables in each of the claims, enrollment, and demographic datasets*	HCA will take this recommendation under consideration as time and resources allow.	The EQRO considers this action responsive and will continue to monitor this data quality issue.

The path to future improvements: WMIP

The WMIP can provide valuable lessons to help advance the state's goal of integrating primary care, mental health, chemical dependency, and long-term care services.

Encouragingly, the ER visit rate for WMIP enrollees fell significantly for the third straight year in 2013. MHW's current clinical PIP, if successful, could further reduce the rate of avoidable ER visits.

- ***MHW should continue efforts to reduce WMIP ER visit rates and hospital readmissions through the two clinical PIPs, and respond to TEAMonitor's request for more detailed documentation of the interventions for the hospital readmissions PIP.***

TEAMonitor's review of WMIP has identified deficiencies in timely completion of initial intake screenings and in comprehensive assessment of high-risk enrollees.

- ***MHW should continue to explore effective approaches to facilitate timely care assessments for WMIP enrollees.***
- ***MHW should ensure that screening, assessments, and treatment plans for WMIP enrollees are completed and current, to meet standards for continuity and coordination of care.***
- ***MHW should conduct a root cause analysis or other investigation to determine why WMIP enrollees' utilization of mental health services decreased from 2012 to 2013.***

Acumentra Health continues to recommend that the WMIP program

- ***explore ways to increase enrollees' ongoing engagement in alcohol and drug dependence treatment, since a high percentage of WMIP enrollees receive AOD services***

REFERENCES

[1] Acumentra Health. *2013 Performance Measure Comparative Analysis Report*. Washington State Department of Social & Health Services, Health Care Authority. November 2013.
[2] Berk ML, Schur CL. Measuring access to care: improving information for policymakers. *Health Aff*. 998;17(1):180–186.
[3] Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, DC: National Academy Press, 2001.
[4] Sinay T. Access to quality health services: determinants of access. *J Health Care Finance*. 2002;28(4):58–68.
[5] *Coverage Matters*.
[6] Washington Department of Social and Health Services. 2013–14 Children's Mental Health Key Activities. Available at www.dshs.wa.gov/pdf/dbhr/mh/cmhkeyactivities12_13_12.pdf. Accessed November 18, 2013.
[7] Washington Health Care Authority. Washington State Health Care Innovation Plan. Draft for public comment. Available at www.hca.wa.gov/shcip/Documents/shcip_draft_plan_for_public_review.pdf. Accessed December 11, 2013.

Appendix A. RSN Profiles

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

Chelan-Douglas RSN A-3
Grays Harbor RSN A-5
Greater Columbia Behavioral Health A-7
King County RSN A-9
North Sound Mental Health Administration A-11
OptumHealth Pierce RSN A-13
Peninsula RSN A-15
Southwest Washington Behavioral Health A-17
Spokane County RSN A-19
Thurston-Mason RSN A-21
Timberlands RSN A-23

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Chelan-Douglas Regional Support Network (CDRSN)

Activity

Regulatory and Contractual Standards

The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that CDRSN had addressed the only finding from 2012 by adopting a new policy and procedure to clarify the internal and administrative mechanisms in place to guard against fraud and abuse.

Performance Improvement Projects (PIPs)

Strengths	Opportunities for Improvement
Clinical—Permanent Supported Housing: Fully Met (99 out of 100)	
• Provided housing for 45 previously homeless individuals • Developed multifaceted infrastructure to address homelessness in local community	The study indicator measured homelessness in the entire community and was subject to influence from multiple variables outside of CDRSN's control. CDRSN should consider measuring outcomes only for individuals in the study population.
Nonclinical—Increased Penetration Rate for Older Adults: Fully Met (100 out of 100)	
• Well-developed and documented study design • Achieved sustained improvement in the allied provider survey	CDRSN may want to consider a tracking and monitoring plan that gives the RSN more direct control of the intervention and enables more frequent updates.

Information Systems Capabilities Assessment (ISCA)

Information Systems—Fully Met (2.7 out of 3)	**Administrative Data: Fully Met (2.9 out of 3)**
Staffing—Fully Met (3 out of 3)	**Enrollment Systems: Fully Met (2.9 out of 3)**
Hardware Systems—Fully Met (3 out of 3)	**Vendor Data Integration: Fully Met (3 out of 3)**
Security—Not Met (1.5 out of 3)	**Provider Data: Fully Met (3 out of 3)**

Strengths	Opportunities for Improvement
• **Information Systems:** CDRSN provides ongoing annual training for RSN programmers, report writers, and IS staff. • **Staffing:** Outpatient authorizations are requested, processed, and housed in the same system as encounter data. • **Hardware Systems:** Data center facilities and hardware systems are well designed and maintained. • **Security:** Netsmart employs an outside vendor to perform penetration testing of its network to ensure that proper security measures and safeguards are in place. • **Administrative Data:** CDRSN reviews state data to verify agreement with data submitted by the provider agencies. • **Enrollment Systems:** o RSN checks eligibility before submitting encounters to DBHR. o Provider agencies check eligibility on each visit. • **Vendor Data Integration:** CDRSN regularly reviews agency productivity. • **Provider Data:** RSN maintains up-to-date provider-level profile information in an accessible repository	**Findings** **Security:** CDRSN needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to: • Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services). • Encrypt all data that will be in transit outside the contractor's internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits. • Remove access to data immediately when an authorized person no longer requires access. • Require password security to meet complexity and forced changes at least every 90 days. • Implement process for frequent backup of systems data. CDRSN and WSC need to work with Netsmart to schedule and complete restoration testing. • Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements.

CDRSN, headquartered in East Wenatchee, contracts with providers to deliver managed mental health services to enrollees in Chelan and Douglas counties. The RSN's governing board of six local elected officials makes recommendations to the Douglas County Board of Commissioners, which acts as the legal authority. During 2012, CDRSN had about 28,000 enrollees in its service area.

Data source: Chelan-Douglas RSN 2013 External Quality Review Report (Acumentra Health).

Chelan-Douglas Regional Support Network (continued)

Activity						
Encounter Data Validation (n=54,619)						
Completeness—Number of fields with data 100% complete						
Outpatient encounter data	9 out of 10 fields	Demographic data	2 out of 11 fields			
Accuracy—Percentage of charts with data matching state's electronic data						
Procedure code (n=441)	90.9%	First name (n=103)	73.8%			
Provider type (n=441)	69.8%	Last name (n=103)	95.2%			
Minutes of service (n=441))	84.6%	Date of birth* (n=103)	100.0%			
Service location (n=441)	84.1%	Ethnicity (n=103)	45.6%			
Service date (n=441)	93.2%	Language (n=103)	73.8%			
Golden Thread review—Percentage of charts meeting criteria (n=97)						
	Children		**Adults**		**Total**	
	Yes	**Partially**	**Yes**	**Partially**	**Yes**	**Partially**
Assessment substantiates Category A diagnosis (if applicable)	94.5%	4.6%	93.0%	4.7%	93.8%	4.6%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	96.1%	0.0%	93.2%	0.0%	94.7%	0.0%
Treatment plan objectives are individualized	92.2%	0.0%	95.4%	0.0%	93.7%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	90.2%	5.9%	90.9%	4.5%	90.5%	5.3%
Clinical Record Review (n=48)						
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign						
Percentage of children's charts with completed assessment in the past year: 100%						
Percentage of applicable assessments that include:						
Living environment and safety needs	100.0%	Cultural issues that may affect treatment	96.3%			
Documentation of current living situation	100.0%	Language needs taken into consideration	100.0%			
Child's/family's natural systems of support	100.0%	Child/family involvement in activities outside home	100.0%			
Development/learning/sensory impairment	100.0%	Justification of diagnosis	95.8%			
Percentage of treatment plans that include:						
Strength-based activities and interventions	87.5%	Coordination/collaboration with other agencies identified in assessment	95.3%			
Individualized treatment objectives	95.8%	Team-based services	59.1%			
Documentation of family/guardian participation in developing treatment plan	100.0%	Interventions and goals consistent with issues identified in assessment	97.9%			
Percentage of progress notes that include:						
Interventions identified in treatment plan and progress toward meeting stated goals	93.8%	Care coordination with agencies and systems	61.4%			
Unconditional treatment	100.0%	Outcome-based progress notes	97.9%			
Delivery of strength-based services	97.9%					

Grays Harbor Regional Support Network (GHRSN)

Activity	
Regulatory and Contractual Standards	
The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that GHRSN had completed all three of the corrective actions required by DBHR.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Reducing Self-Reported Symptoms of Depression Through Group Psychotherapy: Substantially Met (63 out of 90)	
• Well-developed root cause analysis • Uses validated measurement tool	GHRSN needs to document a plan for validating survey data, and develop a plan to track and monitor the implementation of its intervention.
Nonclinical— Reducing Emergency Room Visits Through Community Care Coordination: Partially Met (42 out of 90)	
• Well-researched study topic • Collaboration with local community partners	GHRSN needs to determine whether the topic is an area of need by conducting a root cause analysis, and then further develop its intervention plan.
Information Systems Capabilities Assessment (ISCA)	
Information Systems—Fully Met (2.6 out of 3)	**Administrative Data: Fully Met (2.9 out of 3)**
Staffing—Fully Met (2.8 out of 3)	**Enrollment Systems: Partially Met (2.5 out of 3)**
Hardware Systems—Fully Met (2.7 out of 3)	**Vendor Data Integration: Partially Met (2.5 out of 3)**
Security—Not Met (1.1 out of 3)	**Provider Data: Fully Met (2.8 out of 3)**
Strengths	**Opportunities for Improvement**
• **Information Systems:** GHRSN and Netsmart provide ongoing annual training for programmers, report writers, and IS staff. • **Staffing:** GHRSN has established and monitored productivity goals for IS staff and NetSmart to ensure adherence to DBHR's reporting requirements. • **Hardware Systems**: Data center facilities and hardware systems are well designed and maintained. • **Security:** Netsmart employs an outside vendor to perform penetration testing of its network to ensure that proper security measures and safeguards are in place. • **Administrative Data:** RSN's formal procedures for rectifying encounter data submitted with missing, incomplete, or invalid fields are adhered to and well documented. • **Vendor Data Integration:** GHRSN's encounter data cover all services provided to Medicaid enrollees, creating a complete picture of care. • **Provider Data:** GHRSN's annual onsite review of all provider agencies includes encounter data validation.	**Findings** **Security:** GHRSN needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to: • Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services). • Encrypt all data that will be in transit outside the contractor's internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits. • Remove access to data immediately when an authorized person no longer requires access. • Require password security to meet complexity and forced changes at least every 90 days. • Implement process for frequent backup of systems data. GHRSN and WSC need to work with Netsmart to schedule and complete restoration testing. • Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements. **Vendor Data Integrity:** GHRSN's encounter data validation reports for 2012 showed the two provider agencies not meeting contractual requirements for encounter data accuracy.
GHRSN, headquartered in Aberdeen, authorizes Medicaid-funded mental health services in Grays Harbor County. The RSN contracts with Sea Mar Community Health Centers and Behavioral Health Resources to provide outpatient services, and contracts with Behavioral Health Options for utilization management. During 2012, GHRSN had about 19,000 enrollees in its service area.	
Data source: Grays Harbor RSN 2013 External Quality Review Report (Acumentra Health).	

Grays Harbor Regional Support Network (continued)

Activity			
Encounter Data Validation (n=35,569)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	9 out of 10 fields	Demographic data	2 out of 11 fields
Accuracy—Percentage of charts with data matching state's electronic data			
Procedure code (n=464)	96.1%	First name (n=111)	99.1%
Provider type (n=464)	94.2%	Last name (n=111)	100.0%
Minutes of service (n=464))	87.1%	Date of birth* (n=111)	99.1%
Service location (n=464)	95.3%	Ethnicity (n=111)	65.8%
Service date (n=464)	96.8%	Language (n=111)	77.5%

Golden Thread review—Percentage of charts meeting criteria (n=109)

.	Children		Adults		Total	
	Yes	Partially	Yes	Partially	Yes	Partially
Assessment substantiates Category A diagnosis (if applicable)	75.0%	0.0%	95.9%	0.0%	93.0%	0.0%
Assessment substantiates Category B diagnosis (if applicable)	83.3%	16.7%	71.4%	28.6%	81.1%	18.9%
Treatment plan includes interventions and goals consistent with issues identified in assessment	81.4%	0.0%	90.1%	0.0%	86.5%	0.0%
Treatment plan objectives are individualized	83.7%	0.0%	94.3%	0.0%	89.6%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	62.8%	0.0%	76.9%	3.8%	70.5%	2.1%

Clinical Record Review (n=43)			
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign			
Percentage of children's charts with completed assessment in the past year: 95.2%			
Percentage of applicable assessments that include:			
Living environment and safety needs	97.6%	Cultural issues that may affect treatment	80.0%
Documentation of current living situation	100.0%	Language needs taken into consideration	80.0%
Child's/family's natural systems of support	100.0%	Child/family involvement in activities outside home	90.0%
Development/learning/sensory impairment	100.0%	Justification of diagnosis	82.5%
Percentage of treatment plans that include:			
Strength-based activities and interventions	42.9%	Coordination/collaboration with other agencies identified in assessment	15.4%
Individualized treatment objectives	83.3%	Team-based services	35.0%
Documentation of family/guardian participation in developing treatment plan	72.5%	Interventions and goals consistent with issues identified in assessment	81.0%
Percentage of progress notes that include:			
Interventions identified in treatment plan and progress toward meeting stated goals	61.9%	Care coordination with agencies and systems	36.1%
Unconditional treatment	97.6%	Outcome-based progress notes	43.9%
Delivery of strength-based services	73.8%		

Greater Columbia Behavioral Health (GCBH)

Activity	
Regulatory and Contractual Standards	
The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that GCBH had addressed all four findings from the 2012 review, related to second opinions, provider credentialing and recredentialing, practice guidelines, and monitoring for over- and underutilization.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Lowered PRISM Scores in a High Medical Risk Psychiatric Inpatient Population: Partially Met (43 out of 90)	
• Well-researched study topic • Inclusion of enrollees and family members in committees responsible for selecting PIP topic	GCBH needs to determine whether the study topic is an area of need, conduct a root cause analysis, and then determine whether the selected intervention can be expected to lead to improvement.
Nonclinical—Lowered Inpatient Readmission Rates through Enhanced Communication: Partially Met (53 out of 90)	
• Well-researched study topic • Utilization of already established resources and processes	GCBH needs to determine whether the study topic is an area of need, conduct a root cause analysis, and then determine whether the selected intervention can be expected to lead to improvement.
Information Systems Capabilities Assessment (ISCA)	
Information Systems—Partially Met (2.3 out of 3)	**Administrative Data: Fully Met (2.9 out of 3)**
Staffing— Partially Met (2.2 out of 3)	**Enrollment Systems: Fully Met (2.7 out of 3)**
Hardware Systems—Fully Met (2.6 out of 3)	**Vendor Data Integration: Partially Met (2.2 out of 3)**
Security—Not Met (1.5 out of 3)	**Provider Data: Partially Met (2.3 out of 3)**
Strengths	**Opportunities for Improvement**
• **Staffing:** GCBH's credentialed utilization management specialists understand locally available resources. • **Hardware Systems**: Servers are housed in a secure location away from personnel who are not authorized to have physical access. GCBH takes advantage of redundant software and hardware designs. • **Security:** All RSN data tapes containing protected health information are encrypted. • **Administrative Data:** GCBH has been able to meet DBHR requirements for submission of encounter data even with staff turnover issues. • **Vendor Data Integration:** GCBH's provider agencies met contract requirements for encounter data validation.	**Findings** **Security:** GCBH needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to: • Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services). • Encrypt all data that will be in transit outside the contractor's internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits. • Remove access to data immediately when an authorized person no longer requires access. • Require password security to meet complexity and forced changes at least every 90 days. **Enrollment Systems:** GCBH needs to ensure that eligibility checks occur before submitting encounter data to the state.
GCBH, headquartered in Kennewick, provides public mental health services for 10 counties and the Yakama Nation in south central Washington. A citizen's advisory board advises the GCBH board of directors, reviews and provides recommendations on plans and policies, and serves on RSN workgroups and committees. During 2012, GCBH had about 190,000 enrollees in its service area.	
Data source: Greater Columbia Behavioral Health 2013 External Quality Review Report (Acumentra Health).	

Greater Columbia Behavioral Health (continued)

Activity				
Encounter Data Validation (n=329,813)				
Completeness—Number of fields with data 100% complete				
Outpatient encounter data	10 out of 10 fields	Demographic data	9 out of 11 fields	
Accuracy—Percentage of charts with data matching state's electronic data				
Procedure code (n=394)	80.2%	First name (n=107)	99.1%	
Provider type (n=394)	89.6%	Last name (n=107)	99.1%	
Minutes of service (n=394))	38.6%	Date of birth* (n=107)	100.0%	
Service location (n=394)	89.9%	Ethnicity (n=107)	83.2%	
Service date (n=394)	92.9%	Language (n=107)	91.6%	

Golden Thread review—Percentage of charts meeting criteria (n=102)

	Children		Adults		Total	
	Yes	Partially	Yes	Partially	Yes	Partially
Assessment substantiates Category A diagnosis (if applicable)	89.5%	5.3%	89.7%	3.4%	89.6%	4.2%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	95.1%	0.0%	67.2%	0.0%	78.4%	0.0%
Treatment plan objectives are individualized	95.0%	0.0%	82.0%	0.0%	87.1%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	92.9%	0.0%	78.3%	3.3%	84.3%	2.0%

Clinical Record Review (n=43)			
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign			
Percentage of children's charts with completed assessment in the past year: 71.8%			
Percentage of applicable assessments that include:			
Living environment and safety needs	93.0%	Cultural issues that may affect treatment	63.6%
Documentation of current living situation	100.0%	Language needs taken into consideration	80.0%
Child's/family's natural systems of support	95.4%	Child/family involvement in activities outside home	97.7%
Development/learning/sensory impairment	90.9%	Justification of diagnosis	90.7%
Percentage of treatment plans that include:			
Strength-based activities and interventions	92.7%	Coordination/collaboration with other agencies identified in assessment	63.6%
Individualized treatment objectives	95.0%	Team-based services	36.8%
Documentation of family/guardian participation in developing treatment plan	82.1%	Interventions and goals consistent with issues identified in assessment	95.1%
Percentage of progress notes that include:			
Interventions identified in treatment plan and progress toward meeting stated goals	92.9%	Care coordination with agencies and systems	54.5%
Unconditional treatment	100.0%	Outcome-based progress notes	80.0%
Delivery of strength-based services	95.4%		

King County Regional Support Network (KCRSN)

<table>
<tr><th colspan="2">Activity</th></tr>
<tr><td colspan="2">Regulatory and Contractual Standards</td></tr>
<tr><td colspan="2">The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that KCRSN had addressed the only finding from 2012, related to periodic review of its practice guidelines.</td></tr>
<tr><td colspan="2">Performance Improvement Projects (PIPs)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td colspan="2">Clinical—Lifestyle Intervention to Reduce Weight for Adults with Serious Mental Illness: Fully Met (85 out of 90)</td></tr>
<tr><td>• Selection of a standardized lifestyle intervention program supported by Centers for Disease Control and Prevention
• Four of six agencies showed a statistically significant decrease in mean weight compared to baseline</td><td>KCRSN should consider conducting any continuing work on this project through its internal quality improvement program and selecting a new PIP topic for 2014.</td></tr>
<tr><td colspan="2">Nonclinical—Improved Coordination with Primary Care for Children and Youth: Substantially Met (55 out of 90)</td></tr>
<tr><td>• Well-researched study topic
• Uses established resources and processes in collaboration with local physical health plans</td><td>KCRSN needs to determine whether the study topic is an area of need, conduct a root cause analysis, and then determine whether the selected intervention can be expected to lead to improvement.</td></tr>
<tr><td colspan="2">Information Systems Capabilities Assessment (ISCA)</td></tr>
<tr><td>Information Systems: Partially Met (2.4 out of 3)</td><td>Administrative Data: Fully Met (2.6 out of 3)</td></tr>
<tr><td>Staffing: Fully Met (2.8 out of 3)</td><td>Enrollment Systems: Fully Met (3 out of 3)</td></tr>
<tr><td>Hardware Systems: Fully Met (3 out of 3)</td><td>Vendor Data Integration: Partially Met (2.4 out of 3)</td></tr>
<tr><td>Security: Not Met (1.7 out of 3)</td><td>Provider Data: Fully Met (3 out of 3)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td>• Information Systems: KCRSN has improved its software development monitoring processes since the HIPAA 5010 changes.
• Staffing: KCRSN maintains low staff turnover, a good indicator of effective management and employee satisfaction.
• Hardware Systems: IT staff members were able to physically locate Medicaid servers during the data center walkthrough.
• Security: King County performs quarterly penetration testing of its network to ensure that proper security measures and safeguards are in place.
• Administrative Data: KCRSN performs regular audits of encounter claims to ensure data integrity and validity.
• Enrollment Systems: Eligibility and encounter data are stored in the same system, providing a complete picture of care.
• Vendor Data Integration: KCRSN's annual onsite review of each provider agency includes encounter data validation.
• Provider Data: KCRSN maintains up-to-date provider profile information in an accessible repository, and can produce reports upon request.</td><td>Findings
Security: KCRSN needs to ensure that all aspects of the DBHR contract are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to:
• Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services).
• Encrypt all data that will be in transit outside the contractor's internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits.
• Remove access to data immediately when an authorized person no longer requires access.
• Require password security to meet complexity and forced changes at least every 90 days.
• Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements.
Vendor Data Integration: Thirteen of KCRSN's 17 provider agencies did not meet the required 95% match rate. KCRSN's EDV report did not include corrective action plans for agencies not meeting the 95% match rate.</td></tr>
<tr><td colspan="2">KCRSN, managed by the county's Mental Health, Chemical Abuse and Dependency Services Division, serves adults with chronic mental illness and severely emotionally disturbed children living in King County. The RSN administers services provided by a certified pool of community mental health centers. A citizen advisory board provides policy direction, prioritizes and advocates for service needs, and oversees evaluation of services. During 2012, KCRSN had about 280,000 enrollees in its service area.</td></tr>
<tr><td colspan="2">Data source: King County RSN 2013 External Quality Review Report (Acumentra Health).</td></tr>
</table>

King County Regional Support Network (continued)

Activity						
Encounter Data Validation (n=1,123,319)						
Completeness—Number of fields with data 100% complete						
Outpatient encounter data	9 out of 10 fields		Demographic data		7 out of 11 fields	
Accuracy—Percentage of charts with data matching state's electronic data						
Procedure code (n=719)	70.0%		First name (n=118)		83.9%	
Provider type (n=719)	72.1%		Last name (n=118)		92.4%	
Minutes of service (n=719))	57.7%		Date of birth* (n=118)		97.5%	
Service location (n=719)	74.8%		Ethnicity (n=118)		46.6%	
Service date (n=719)	84.1%		Language (n=118)		11.9%	
Golden Thread review—Percentage of charts meeting criteria (n=112)						
	Children		**Adults**		**Total**	
	Yes	**Partially**	**Yes**	**Partially**	**Yes**	**Partially**
Assessment substantiates Category A diagnosis (if applicable)	85.3%	8.8%	91.5%	7.0%	89.5%	7.6%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	97.4%	0.0%	88.7%	0.0%	91.7%	0.0%
Treatment plan objectives are individualized	95.0%	0.0%	87.3%	0.0%	90.1%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	67.5%	10.0%	93.0%	1.4%	83.8%	4.5%

Clinical Record Review (n=40)			
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign			
Percentage of children's charts with completed assessment in the past year: 60.0%			
Percentage of applicable assessments that include:			
Living environment and safety needs	100.0%	Cultural issues that may affect treatment	87.0%
Documentation of current living situation	100.0%	Language needs taken into consideration	100.0%
Child's/family's natural systems of support	100.0%	Child/family involvement in activities outside home	94.9%
Development/learning/sensory impairment	100.0%	Justification of diagnosis	84.6%
Percentage of treatment plans that include:			
Strength-based activities and interventions	92.5%	Coordination/collaboration with other agencies identified in assessment	66.7%
Individualized treatment objectives	95.0%	Team-based services	59.4%
Documentation of family/guardian participation in developing treatment plan	72.5%	Interventions and goals consistent with issues identified in assessment	97.4%
Percentage of progress notes that include:			
Interventions identified in treatment plan and progress toward meeting stated goals	67.5%	Care coordination with agencies and systems	70.6%
Unconditional treatment	95.0%	Outcome-based progress notes	69.4%
Delivery of strength-based services	77.5%		

North Sound Mental Health Administration (NSMHA)

<table>
<tr><th colspan="2">Activity</th></tr>
<tr><td colspan="2">Regulatory and Contractual Standards</td></tr>
<tr><td colspan="2">The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN’s response to the specific 2012 EQR findings for which DBHR required the RSN to perform corrective action. NSMHA had no such findings in the 2012 EQR review.</td></tr>
<tr><td colspan="2">Performance Improvement Projects (PIPs)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td colspan="2">Clinical—Decrease in Days to Medication Evaluation Appointment After Request for Service: Fully Met (95 out of 100)</td></tr>
<tr><td>• Established the importance of the topic for the local Medicaid population
• Well-developed intervention plan; modified as needed</td><td>NSMHA should consider conducting any continuing work on this project through its internal quality improvement program and selecting a new PIP topic for 2014.</td></tr>
<tr><td colspan="2">Nonclinical—Improving the Quality of Care Coordination for High-Risk Transition Age Youth: Partially Met (49 out of 90)</td></tr>
<tr><td>• Established the importance of the topic for the local Medicaid population
• Well-researched study topic and possible interventions</td><td>NSMHA needs to clarify the numerator and denominator definitions and inclusion/exclusion criteria, describe its data validation procedures, refine the data analysis plan, and select appropriate interventions.</td></tr>
<tr><td colspan="2">Information Systems Capabilities Assessment (ISCA)</td></tr>
<tr><td>Information Systems: Partially Met (2.5 out of 3)</td><td>Administrative Data: Partially Met (2.5 out of 3)</td></tr>
<tr><td>Staffing: Fully Met (3 out of 3)</td><td>Enrollment Systems: Fully Met (2.7 out of 3)</td></tr>
<tr><td>Hardware Systems: Fully Met (3 out of 3)</td><td>Vendor Data Integration: Fully Met (2.7 out of 3)</td></tr>
<tr><td>Security: Not Met (1.8 out of 3)</td><td>Provider Data: Partially Met (2.4 out of 3)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td>• Information Systems: NSMHA’s encounter processing database is secure, robust, and scalable, giving programmers the flexibility to develop processing methods.
• Staffing: NSMHA maintains low staff turnover, indicating effective management and employee satisfaction.
• Hardware Systems: NSMHA upgraded its hardware and has begun virtualizing some of its servers.
• Security: NSMHA sends data backups offsite to a commercial secure storage facility,
• Administrative Data: NSMHA performs regular audits of encounter claims to ensure data integrity and validity, and uses state-supplied data extracts for some internal reporting.
• Vendor Data Integration: NSMHA transmits all encounter data to DBHR in HIPAA-compliant 837 format.</td><td>Findings
Security: NSMHA needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to:
• Update and test Business Continuity/Disaster Recovery plans at least annually.
• Encrypt all data that will be in transit outside the contractor’s internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits.
• Require password security to meet complexity and forced changes at least every 90 days.</td></tr>
<tr><td colspan="2">NSMHA, headquartered in Mount Vernon, serves public mental health enrollees in Island, San Juan, Skagit, Snohomish, and Whatcom counties. A nine-member board of directors drawn from each county’s executive and legislative branches of government sets the RSN’s policy direction, and a citizen advisory board provides independent advice to the board and feedback to local jurisdictions and service providers. During 2012, NSMHA had about 189,000 enrollees in its service area.</td></tr>
<tr><td colspan="2">Data source: North Sound Mental Health Administration 2013 External Quality Review Report (Acumentra Health).</td></tr>
</table>

North Sound Mental Health Administration (continued)

Activity						
Encounter Data Validation (n=521,040)						
Completeness—Number of fields with data 100% complete						
Outpatient encounter data	9 out of 10 fields	Demographic data	8 out of 11 fields			
Accuracy—Percentage of charts with data matching state's electronic data						
Procedure code (n=461)	88.1%	First name (n=109)	100.0%			
Provider type (n=461)	95.4%	Last name (n=109)	100.0%			
Minutes of service (n=461))	58.8%	Date of birth* (n=109)	100.0%			
Service location (n=461)	94.8%	Ethnicity (n=109)	68.8%			
Service date (n=461)	96.1%	Language (n=109)	68.8%			
Golden Thread review—Percentage of charts meeting criteria (n=102)						
	Children		**Adults**		**Total**	
	Yes	**Partially**	**Yes**	**Partially**	**Yes**	**Partially**
Assessment substantiates Category A diagnosis (if applicable)	96.6%	3.5%	96.6%	3.4%	96.6%	3.4%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	97.6%	0.0%	98.4%	0.0%	98.0%	0.0%
Treatment plan objectives are individualized	100.0%	0.0%	98.3%	0.0%	99.0%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	90.5%	2.4%	95.0%	1.7%	93.1%	2.0%
Clinical Record Review (n=43)						
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign						
Percentage of children's charts with completed assessment in the past year: 82.5%						
Percentage of applicable assessments that include:						
Living environment and safety needs	100.0%	Cultural issues that may affect treatment	90.9%			
Documentation of current living situation	100.0%	Language needs taken into consideration	100.0%			
Child's/family's natural systems of support	100.0%	Child/family involvement in activities outside home	100.0%			
Development/learning/sensory impairment	100.0%	Justification of diagnosis	97.5%			
Percentage of treatment plans that include:						
Strength-based activities and interventions	100.0%	Coordination/collaboration with other agencies identified in assessment	65.6%			
Individualized treatment objectives	100.0%	Team-based services	41.9%			
Documentation of family/guardian participation in developing treatment plan	89.5%	Interventions and goals consistent with issues identified in assessment	97.5%			
Percentage of progress notes that include:						
Interventions identified in treatment plan and progress toward meeting stated goals	90.2%	Care coordination with agencies and systems	43.8%			
Unconditional treatment	95.1%	Outcome-based progress notes	88.9%			
Delivery of strength-based services	90.2%					

OptumHealth Pierce Regional Support Network (OPRSN)

Activity	
Regulatory and Contractual Standards	
The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that OPRSN had responded appropriately to a 2012 finding by drafting and implementing a policy on the dissemination of its practice guidelines.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Consumer Voice in Treatment Planning: Fully Met (99 out of 100)	
• Well-informed selection of study intervention • Sustained improvement for three of five provider agencies	OPRSN should perform more frequent tracking and monitoring to help ensure that the intervention is achieving the desired effect.
Nonclinical—Consumer Residential Satisfaction : Fully Met (95 out of 100)	
• Involves an ambitious effort to develop integrated community housing with multiple phases • Sixteen people have been moved into community-based supported housing environments	OPRSN should consider adopting a "rolling" enrollment to help increase the study population and standardize the administration of the residential satisfaction survey so that results may be more comparable.
Information Systems Capabilities Assessment (ISCA)	
Information Systems: Fully Met (2.8 out of 3)	**Administrative Data: Fully Met (2.7 out of 3)**
Staffing: Fully Met (2.8 out of 3)	**Enrollment Systems: Fully Met (2.8 out of 3)**
Hardware Systems: Fully Met (3 out of 3)	**Vendor Data Integration: Partially Met (2.5 out of 3)**
Security: Not Met (1.9 out of 3)	**Provider Data: Fully Met (3 out of 3)**
Strengths	**Opportunities for Improvement**
• **Information Systems:** OPRSN's data control process includes a secondary review and a supervisory authorization prior to production of internal reports. • **Staffing:** OPRSN employs personnel with considerable industry experience in their areas of expertise. • **Hardware Systems:** OPRSN's IT governance provides strategic direction and decision making for hardware system replacements and upgrades. • **Security:** OPRSN has encrypted all laptop storage and prohibits users from moving data onto external devices. Onsite data are backed up regularly to a secure offsite location. • **Administrative Data:** OPRSN audits a sample of completed authorizations routinely—at least monthly—to ensure that policies and procedures are followed. • **Enrollment Systems:** OPRSN performs frequent audits of DBHR's eligibility files to check for anomalies. • **Provider Data:** OPRSN maintains up-to-date provider profile information to help enrollees make informed choices about access to providers that can meet their special care needs.	**Findings** **Security:** OPRSN needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to: • Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services). • Encrypt all data that will be in transit outside the contractor's internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits. • Require password security to meet complexity and forced changes at least every 90 days.
OptumHealth, a subsidiary of UnitedHealth Group, has operated the Pierce County RSN since 2009, with headquarters in Tacoma. A mental health advisory board, approved by the seven-member governing board, reviews issues of concern and relevance to mental health consumers and their families. OPRSN had about 163,000 enrollees in Pierce County during 2012.	
Data source: OptumHealth Pierce RSN 2013 External Quality Review Report (Acumentra Health).	

OptumHealth Pierce Regional Support Network (continued)

Activity			
Encounter Data Validation (n=308,522)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	8 out of 11 fields
Accuracy—Percentage of charts with data matching state's electronic data			
Procedure code (n=460)	95.9%	First name (n=108)	100.0%
Provider type (n=460)	95.2%	Last name (n=108)	100.0%
Minutes of service (n=460))	74.3%	Date of birth* (n=108)	100.0%
Service location (n=460)	97.4%	Ethnicity (n=108)	57.4%
Service date (n=460)	97.4%	Language (n=108)	73.1%

Golden Thread review—Percentage of charts meeting criteria (n=96)

	Children		Adults		Total	
	Yes	Partially	Yes	Partially	Yes	Partially
Assessment substantiates Category A diagnosis (if applicable)	91.9%	5.4%	96.5%	0.0%	94.7%	2.1%
Assessment substantiates Category B diagnosis (if applicable)	80.0%	20.0%	n.a.	n.a.	80.0%	20.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	92.5%	0.0%	92.9%	0.0%	92.7%	0.0%
Treatment plan objectives are individualized	97.4%	0.0%	98.2%	0.0%	97.9%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	65.1%	20.9%	94.3%	0.0%	81.3%	9.4%

Clinical Record Review (n=43)			
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign			
Percentage of children's charts with completed assessment in the past year: 97.7%			
Percentage of applicable assessments that include:			
Living environment and safety needs	95.4%	Cultural issues that may affect treatment	78.3%
Documentation of current living situation	100.0%	Language needs taken into consideration	100.0%
Child's/family's natural systems of support	97.7%	Child/family involvement in activities outside home	87.5%
Development/learning/sensory impairment	30.0%	Justification of diagnosis	90.7%
Percentage of treatment plans that include:			
Strength-based activities and interventions	82.0%	Coordination/collaboration with other agencies identified in assessment	46.4%
Individualized treatment objectives	97.4%	Team-based services	32.3%
Documentation of family/guardian participation in developing treatment plan	86.5%	Interventions and goals consistent with issues identified in assessment	94.9%
Percentage of progress notes that include:			
Interventions identified in treatment plan and progress toward meeting stated goals	66.7%	Care coordination with agencies and systems	58.6%
Unconditional treatment	97.6%	Outcome-based progress notes	56.1%
Delivery of strength-based services	97.6%		

Peninsula Regional Support Network (PRSN)

Activity	
Regulatory and Contractual Standards	
The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required the RSN to perform corrective action. PRSN had no such findings in the 2012 EQR review.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Improved Identification of Intensive Needs Children and Youth: Minimally Met: (34 out of 90)	
• Well-researched study topic selection • Targets high-need/high-risk population	PRSN needs to further define its study population, select an appropriate intervention, and develop a data collection and analysis plan.
Nonclinical——Weight Monitoring: Fully Met (90 out of 90)	
• Well-documented study design • Achieved significant improvement in first remeasurement	PRSN should consider initiating PIP topics less similar to those it has studied in previous years.
Information Systems Capabilities Assessment (ISCA)	
Information Systems: Partially Met (2.3 out of 3)	**Administrative Data: Fully Met (2.6 out of 3)**
Staffing: Fully Met (3 out of 3)	**Enrollment Systems: Partially Met (2.4 out of 3)**
Hardware Systems: Fully Met (2.7 out of 3)	**Vendor Data Integration: Fully Met (2.7 out of 3)**
Security: Partially Met (2.2 out of 3)	**Provider Data: Fully Met (3 out of 3)**
Strengths	**Opportunities for Improvement**
• **Information Systems:** Kitsap Mental Health Services (KMHS) created support documentation for the new Pro-Filer system. • **Staffing:** KMHS and PRSN maintain low staff turnover, indicating effective management and employee satisfaction. • **Hardware Systems:** KMHS monitors Pro-Filer servers for appropriate hardware system replacements and upgrades. • **Security:** Some contracted provider agencies store backup data appropriately, either offsite or in a fireproof media safe. • **Administrative Data:** As required by DBHR, PRSN verifies and certifies batched encounter data for accuracy and completeness before transmitting the data. • **Enrollment Systems:** Some providers check enrollee eligibility at every visit. • **Vendor Data Integration:** PRSN reported a high match rate between provider data and RSN data • **Provider Data:** PRSN has developed an accessible repository for provider profile information, from which the RSN can generate reports upon request, enabling the member services staff to help enrollees make informed decisions in choosing providers.	**Findings** **Security:** PRSN needs to ensure that all aspects of the DBHR contract are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to: • Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services). • Encrypt all data that will be in transit outside the contractor's internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits. • Remove access to data immediately when an authorized person no longer requires access. • Require password security to meet complexity and forced changes at least every 90 days. • Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements. **Enrollment Systems:** • KMHS indicated that it assumes that providers or the state check enrollee eligibility for services. PRSN needs to ensure that eligibility checks occur before submitting encounter data to DBHR. • Provider agencies have varied processes and standards for checking enrollee eligibility.
PRSN, headquartered in Port Orchard, is a consortium of the mental health programs of Clallam, Jefferson, and Kitsap counties, administered by Kitsap County. The executive board, comprising nine county commissioners, sets policy and has oversight responsibilities. During 2012, PRSN had about 56,000 enrollees in its service area.	
Data source: Peninsula RSN 2013 External Quality Review Report (Acumentra Health).	

Peninsula Regional Support Network (continued)

Activity

Encounter Data Validation (n=137,007)

Completeness—Number of fields with data 100% complete			
Outpatient encounter data	8 out of 10 fields	Demographic data	8 out of 11 fields

Accuracy—Percentage of charts with data matching state's electronic data			
Procedure code (n=397)	89.4%	First name (n=100)	93.0%
Provider type (n=397)	87.9%	Last name (n=100)	98.0%
Minutes of service (n=397))	69.5%	Date of birth* (n=100)	99.0%
Service location (n=397)	89.7%	Ethnicity (n=100)	51.0%
Service date (n=397)	89.9%	Language (n=100)	66.0%

Golden Thread review—Percentage of charts meeting criteria (n=89)

	Children		Adults		Total	
	Yes	Partially	Yes	Partially	Yes	Partially
Assessment substantiates Category A diagnosis (if applicable)	100.0%	0.0%	85.5%	1.8%	89.6%	1.3%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	80.7%	0.0%	76.8%	0.0%	78.2%	0.0%
Treatment plan objectives are individualized	85.3%	0.0%	92.7%	0.0%	89.9%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	75.7%	10.8%	82.8%	6.9%	80.0%	8.4%

Clinical Record Review (n=34)

Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign

Percentage of children's charts with completed assessment in the past year: 80.0%

Percentage of applicable assessments that include:			
Living environment and safety needs	100.0%	Cultural issues that may affect treatment	75.0%
Documentation of current living situation	99.9%	Language needs taken into consideration	N/A
Child's/family's natural systems of support	100.0%	Child/family involvement in activities outside home	84.9%
Development/learning/sensory impairment	100.0%	Justification of diagnosis	97.2%

Percentage of treatment plans that include:			
Strength-based activities and interventions	84.4%	Coordination/collaboration with other agencies identified in assessment	55.6%
Individualized treatment objectives	84.9%	Team-based services	65.0%
Documentation of family/guardian participation in developing treatment plan	80.0%	Interventions and goals consistent with issues identified in assessment	80.7%

Percentage of progress notes that include:			
Interventions identified in treatment plan and progress toward meeting stated goals	75.0%	Care coordination with agencies and systems	70.6%
Unconditional treatment	97.2%	Outcome-based progress notes	54.8%
Delivery of strength-based services	85.7%		

Southwest Washington Behavioral Health (SWBH)

Activity

Regulatory and Contractual Standards

The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN's response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that SWBH had not yet addressed the 2012 EQR recommendation, related to the consistent application of review criteria for authorization decisions.

Performance Improvement Projects (PIPs)

Strengths	Opportunities for Improvement
Clinical—Follow-Up Medication Management Care for School-Aged Children with ADHD: Partially Met (44 out of 90)	
• Use of validated HEDIS measure • Feasible because of availability of clinical and information systems resources	SWBH should consider revising its PIP topic, as the RSN has not demonstrated that this an area of need for the local Medicaid population.
Nonclinical—Improved Delivery of Outpatient Appointments after a Psychiatric Hospitalization: Fully Met (85 out of 90)	
• Addresses an area of need for the local Medicaid population • Intervention plan activates outpatient providers, using face-to-face contacts and client reminders	SWBH should consider modifying its intervention, as the first remeasurement found no change in the study indicator compared with baseline.

Information Systems Capabilities Assessment (ISCA)

Information Systems: Partially Met (2.5 out of 3)	**Administrative Data: Fully Met (2.9 out of 3)**
Staffing: Fully Met (3 out of 3)	**Enrollment Systems: Fully Met (2.8 out of 3)**
Hardware Systems: Partially Met (2.3 out of 3)	**Vendor Data Integration: Partially Met (2.5 out of 3)**
Security: Not Met (1.4 out of 3)	**Provider Data: Fully Met (3 out of 3)**

Strengths

- **Information Systems:** RSN actively participates in WSC User Group meetings. RSN and Netsmart provide ongoing annual training for programmers, report writers, and IS staff.
- **Staffing:** RSN has established productivity goals for IS staff and Netsmart to ensure adherence to DBHR's reporting requirements.
- **Hardware Systems:** Netsmart actively monitors the data center facility to identify performance and quality issues.
- **Security:** Netsmart employs an outside vendor to perform penetration testing of its network to ensure that proper security measures and safeguards are in place.
- **Administrative Data:** RSN performs regular encounter audits to ensure data integrity and validity.
- **Enrollment Systems:** RSN performs eligibility checks before submitting encounters to DBHR.
- **Vendor Data Integration:** RSN's encounter data cover all services provided to Medicaid enrollees, creating a complete picture of care.
- **Provider Data:** RSN maintains up-to-date provider profile information to help enrollees make informed decisions about access to providers meeting their special care needs.

Opportunities for Improvement

Findings

Security: SWBH needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to:

- Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services).
- Encrypt all data that will be in transit outside the contractor's internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits.
- Remove access to data immediately when an authorized person no longer requires access.
- Require password security to meet complexity and forced changes at least every 90 days.
- Implement process for frequent backup of systems data. SWBH and WSC need to work with Netsmart to schedule and complete restoration testing.
- Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements.

SWBH, headquartered in Vancouver, administers and coordinates public mental health services in Clark, Cowlitz, and Skamania counties as a multi-county RSN through an interlocal agreement. Commissioners from each county comprise the RSN's three-member governing board. In 2012, SWRSN and CCRSN had about 72,000 enrollees in their combined service area.

Data source: Southwest Washington Behavioral Health 2013 External Quality Review Report (Acumentra Health).

Southwest Washington Behavioral Health (continued)

Activity						
Encounter Data Validation (n=311,242)						
Completeness—Number of fields with data 100% complete						
Outpatient encounter data	9 out of 10 fields	Demographic data	9 out of 11 fields			
Accuracy—Percentage of charts with data matching state's electronic data						
Procedure code (n=195)	95.6%	First name (n=98)	99.0%			
Provider type (n=195)	97.8%	Last name (n=98)	99.0%			
Minutes of service (n=195))	75.6%	Date of birth* (n=98)	99.0%			
Service location (n=195)	97.2%	Ethnicity (n=98)	53.1%			
Service date (n=195)	98.8%	Language (n=98)	61.3%			
Golden Thread review—Percentage of charts meeting criteria (n=93)						
	Children		**Adults**		**Total**	
	Yes	**Partially**	**Yes**	**Partially**	**Yes**	**Partially**
Assessment substantiates Category A diagnosis (if applicable)	100.0%	0.0%	92.0%	8.0%	95.1%	4.9%
Assessment substantiates Category B diagnosis (if applicable)	75.0%	25.0%	0.0%	100.0%	60.0%	40.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	100.0%	0.0%	94.1%	0.0%	96.5%	0.0%
Treatment plan objectives are individualized	97.1%	0.0%	94.2%	0.0%	95.4%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	75.7%	2.7%	92.2%	2.0%	85.2%	2.2%
Clinical Record Review (n=35)						
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign						
Percentage of children's charts with completed assessment in the past year: 73.5%						
Percentage of applicable assessments that include:						
Living environment and safety needs	93.8%	Cultural issues that may affect treatment	81.3%			
Documentation of current living situation	100.0%	Language needs taken into consideration	85.7%			
Child's/family's natural systems of support	90.9%	Child/family involvement in activities outside home	63.6%			
Development/learning/sensory impairment	87.5%	Justification of diagnosis	93.9%			
Percentage of treatment plans that include:						
Strength-based activities and interventions	96.9%	Coordination/collaboration with other agencies identified in assessment	43.4%			
Individualized treatment objectives	96.9%	Team-based services	37.5%			
Documentation of family/guardian participation in developing treatment plan	78.1%	Interventions and goals consistent with issues identified in assessment	100.0%			
Percentage of progress notes that include:						
Interventions identified in treatment plan and progress toward meeting stated goals	76.5%	Care coordination with agencies and systems	34.4%			
Unconditional treatment	100.0%	Outcome-based progress notes	47.1%			
Delivery of strength-based services	91.2%					

Spokane County Regional Support Network (SCRSN)

<table>
<tr><th colspan="2">Activity</th></tr>
<tr><td colspan="2">Regulatory and Contractual Standards</td></tr>
<tr><td colspan="2">The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN’s response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that SCRSN had either completed or was in the process of implementing all corrective actions required by DBHR.</td></tr>
<tr><td colspan="2">Performance Improvement Projects (PIPs)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td colspan="2">Clinical—Reducing Readmissions to Eastern State Hospital: Fully Met (73 out of 90)</td></tr>
<tr><td>• Provided baseline data to support selection of topic; used root cause analysis and literature review to select intervention</td><td>SCRSN needs to present and interpret study results from its first remeasurement to determine effectiveness of the intervention.</td></tr>
<tr><td colspan="2">Nonclinical—Improved Cultural Sensitivity as a Result of Special Population Consultation Process Redesign: Substantially Met (56 out of 90)</td></tr>
<tr><td>• Reported baseline data to support selection of study topic
• Used an expert in the field to develop interventions</td><td>SCRSN needs to clarify when it collected baseline data, present and interpret results from its first remeasurement to determine effectiveness of the intervention.</td></tr>
<tr><td colspan="2">Information Systems Capabilities Assessment (ISCA)</td></tr>
<tr><td>Information Systems: Fully Met (2.9 out of 3)</td><td>Administrative Data: Fully Met (2.9 out of 3)</td></tr>
<tr><td>Staffing: Fully Met (2.8 out of 3)</td><td>Enrollment Systems: Fully Met (3 out of 3)</td></tr>
<tr><td>Hardware Systems: Fully Met (3 out of 3)</td><td>Vendor Data Integration: Partially Met (2.4 out of 3)</td></tr>
<tr><td>Security: Partially Met (2.1 out of 3)</td><td>Provider Data: Fully Met (3 out of 3)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td>• Information Systems: SCRSN demonstrated that it monitors and oversees Raintree-contracted activities.</td><td rowspan="8">Findings
Security: SCRSN needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to:
• Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services).
• Encrypt all data that will be in transit outside the contractor’s internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits.
• Remove access to data immediately when an authorized person no longer requires access.
• Require password security to meet complexity and forced changes at least every 90 days.
• Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements.
Vendor Data Integration: SCRSN’s encounter data validation reports for 2012 showed many agencies not meeting contractual requirements and under corrective action plans. SCRSN must work with its provider agencies to address this issue.</td></tr>
<tr><td>• Staffing: SCRSN provides adequate training to RSN staff for processing and tracking errors in encounter data submission.</td></tr>
<tr><td>• Hardware Systems: Raintree takes full advantage of redundant software and hardware designs.</td></tr>
<tr><td>• Security: Backup and restoration processes are well documented and tested. The contracted provider agencies maintain current disaster recovery plans.</td></tr>
<tr><td>• Administrative Data: SCRSN performs regular audits of encounter claims to ensure data integrity and validity.</td></tr>
<tr><td>• Enrollment Systems: SCRSN and its utilization management contractor audit DBHR’s eligibility enrollment files frequently to ensure that they are free of anomalies.</td></tr>
<tr><td>• Vendor Data Integration: SCRSN’s member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care.</td></tr>
<tr><td>• Provider Data: SCRSN conducts an onsite review of all provider agencies every year, including an encounter data validation.</td></tr>
<tr><td colspan="2">SCRSN administers public mental health funds for Spokane County and for counties formerly served by NCWRSN (Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties). SCRSN contracts with several dozen providers of community support, adult residential, and inpatient mental health services for Medicaid enrollees. In 2012, SCRSN had about 142,000 enrollees in its service area, and NCWRSN had about 34,000 enrollees.</td></tr>
<tr><td colspan="2">Data source: Spokane County RSN 2013 External Quality Review Report (Acumentra Health).</td></tr>
</table>

Spokane County Regional Support Network (continued)

Activity

Encounter Data Validation (n=368,817)

Completeness—Number of fields with data 100% complete

Outpatient encounter data	9 out of 10 fields	Demographic data	6 out of 11 fields

Accuracy—Percentage of charts with data matching state's electronic data

Procedure code (n=472)	88.9%	First name (n=108)	98.1%
Provider type (n=472)	85.7%	Last name (n=108)	98.1%
Minutes of service (n=472))	38.0%	Date of birth* (n=108)	100.0%
Service location (n=472)	46.4%	Ethnicity (n=108)	46.3%
Service date (n=472)	89.5%	Language (n=108)	45.4%

Golden Thread review—Percentage of charts meeting criteria (n=92)

	Children		Adults		Total	
	Yes	**Partially**	**Yes**	**Partially**	**Yes**	**Partially**
Assessment substantiates Category A diagnosis (if applicable)	100.0%	0.0%	98.2%	0.0%	98.8%	0.0%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	0.0%	0.0%	50.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	93.3%	0.0%	93.1%	0.0%	93.2%	0.0%
Treatment plan objectives are individualized	96.8%	0.0%	100.0%	0.0%	98.9%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	48.4%	22.6%	55.2%	27.6%	52.8%	25.8%

Clinical Record Review (n=32)

Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign

Percentage of children's charts with completed assessment in the past year: 75.9%

Percentage of applicable assessments that include:

Living environment and safety needs	100.0%	Cultural issues that may affect treatment	100.0%
Documentation of current living situation	100.0%	Language needs taken into consideration	9.1%
Child's/family's natural systems of support	100.0%	Child/family involvement in activities outside home	100.0%
Development/learning/sensory impairment	100.0%	Justification of diagnosis	96.7%

Percentage of treatment plans that include:

Strength-based activities and interventions	77.4%	Coordination/collaboration with other agencies identified in assessment	54.5%
Individualized treatment objectives	96.8%	Team-based services	65.2%
Documentation of family/guardian participation in developing treatment plan	83.3%	Interventions and goals consistent with issues identified in assessment	93.3%

Percentage of progress notes that include:

Interventions identified in treatment plan and progress toward meeting stated goals	48.4%	Care coordination with agencies and systems	61.9%
Unconditional treatment	93.6%	Outcome-based progress notes	30.0%
Delivery of strength-based services	71.0%		

Thurston-Mason Regional Support Network (TMRSN)

<table>
<tr><th colspan="2">Activity</th></tr>
<tr><td colspan="2">Regulatory and Contractual Standards</td></tr>
<tr><td colspan="2">The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN’s response to the specific 2012 EQR findings for which DBHR required the RSN to perform corrective action. TMRSN had no such findings in the 2012 EQR review.</td></tr>
<tr><td colspan="2">Performance Improvement Projects (PIPs)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td colspan="2">Clinical—High-Fidelity Wraparound: Fully Met (88 out of 90)</td></tr>
<tr><td>• Study topic addresses an area of need for Medicaid enrollees
• Collaboration with community partners</td><td>TMRSN needs to consider how to increase the size of the study population for the next remeasurement period.</td></tr>
<tr><td colspan="2">Nonclinical—Implementing a Peer Support Program to Reduce Readmission in Voluntary Community Psychiatric Hospitalization: Partially Met (53 out of 90)</td></tr>
<tr><td>• Collaboration with community partners
• Used and expanded established resources and processes</td><td>TMRSN needs to provide data to support the selection of this topic as addressing an area of need for the local Medicaid population.</td></tr>
<tr><td colspan="2">Information Systems Capabilities Assessment (ISCA)</td></tr>
<tr><td>Information Systems: (2.5 out of 3)</td><td>Administrative Data: Fully Met (2.9 out of 3)</td></tr>
<tr><td>Staffing: Fully Met (3 out of 3)</td><td>Enrollment Systems: Fully Met (3 out of 3)</td></tr>
<tr><td>Hardware Systems: Partially Met (2.1 out of 3)</td><td>Vendor Data Integration: Partially Met (2.5 out of 3)</td></tr>
<tr><td>Security: Not Met (1.8 out of 3)</td><td>Provider Data: Fully Met (3 out of 3)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td>• Information Systems: MIS is secure, robust, and scalable. TMRSN representatives regularly take part in national and regional user group meetings that provide information about MIS changes and updates.
• Staffing: TMRSN has maintained low staff turnover over the past three years.
• Security: Thurston County and TMRSN perform automated daily backups to an encrypted disk storage system. Encrypted backup tapes are transported to a secure offsite storage site weekly.
• Administrative Data: TMRSN performs automated edits and verification checks to ensure completeness and correctness of submitted encounter data, including provider identification, diagnosis and procedure codes, eligibility verification, and service authorization.
• Enrollment Systems: Eligibility and encounter data are stored in the same system, providing a complete picture of care.
• Vendor Data Integration: Agencies submit encounter data directly to TMRSN rather than through a third party.
• Provider Data: TMRSN’s annual onsite review of all provider agencies includes encounter data validation.</td><td>Findings
Security: TMRSN needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to:
• Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services).
• Encrypt all data that will be in transit outside the contractor’s internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits.
• Remove access to data immediately when an authorized person no longer requires access.
• Require password security to meet complexity and forced changes at least every 90 days.
• Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements.
Vendor Data Integration: TMRSN’s encounter data validation reports for 2012 showed several agencies not meeting contractual requirements.</td></tr>
<tr><td colspan="2">TMRSN, headquartered in Olympia, administers public mental health services for Thurston and Mason counties. The RSN contracts with Olympia-based Behavioral Health Resources (BHR) and Seattle-based Sea Mar Community Health Centers to provide outpatient, crisis, residential, and inpatient services. During 2012, TMRSN had about 58,000 enrollees in its service area.</td></tr>
<tr><td colspan="2">Data source: Thurston-Mason RSN 2013 External Quality Review Report (Acumentra Health).</td></tr>
</table>

Thurston-Mason Regional Support Network (continued)

Activity						
Encounter Data Validation (n=124,865)						
Completeness—Number of fields with data 100% complete						
Outpatient encounter data	9 out of 10 fields		Demographic data		8 out of 11 fields	
Accuracy—Percentage of charts with data matching state's electronic data						
Procedure code (n=428)	81.8%		First name (n=93)		96.8%	
Provider type (n=428)	72.4%		Last name (n=93)		100.0%	
Minutes of service (n=428))	56.1%		Date of birth* (n=93)		98.9%	
Service location (n=428)	75.7%		Ethnicity (n=93)		55.9%	
Service date (n=428)	89.0%		Language (n=93)		68.8%	
Golden Thread review—Percentage of charts meeting criteria (n=88)						
	Children		**Adults**		**Total**	
	Yes	**Partially**	**Yes**	**Partially**	**Yes**	**Partially**
Assessment substantiates Category A diagnosis (if applicable)	87.5%	6.3%	96.2%	1.9%	94.2%	2.9%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	78.8%	0.0%	88.5%	0.0%	84.7%	0.0%
Treatment plan objectives are individualized	84.9%	0.0%	88.9%	0.0%	87.4%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	62.5%	12.5%	73.5%	8.2%	69.1%	9.9%
Clinical Record Review (n=33)						
Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign						
Percentage of children's charts with completed assessment in the past year: 51.7%						
Percentage of applicable assessments that include:						
Living environment and safety needs	96.9%		Cultural issues that may affect treatment		69.2%	
Documentation of current living situation	100.0%		Language needs taken into consideration		100.0%	
Child's/family's natural systems of support	100.0%		Child/family involvement in activities outside home		83.3%	
Development/learning/sensory impairment	94.1%		Justification of diagnosis		93.8%	
Percentage of treatment plans that include:						
Strength-based activities and interventions	68.8%		Coordination/collaboration with other agencies identified in assessment		42.1%	
Individualized treatment objectives	84.4%		Team-based services		38.9%	
Documentation of family/guardian participation in developing treatment plan	70.4%		Interventions and goals consistent with issues identified in assessment		78.1%	
Percentage of progress notes that include:						
Interventions identified in treatment plan and progress toward meeting stated goals	61.3%		Care coordination with agencies and systems		52.9%	
Unconditional treatment	90.3%		Outcome-based progress notes		63.0%	
Delivery of strength-based services	73.3%					

Timberlands Regional Support Network (TRSN)

<table>
<tr><th colspan="2">Activity</th></tr>
<tr><td colspan="2">Regulatory and Contractual Standards</td></tr>
<tr><td colspan="2">The 2012 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2013, Acumentra Health reviewed each RSN’s response to the specific 2012 EQR findings for which DBHR required corrective action. The review found that TRSN had completed corrective action in response to the lone finding in the 2012 report, related to the credentialing and recredentialing of RSN staff.</td></tr>
<tr><td colspan="2">Performance Improvement Projects (PIPs)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td colspan="2">Clinical—Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder: Fully Met (80 out of 90)</td></tr>
<tr><td>• Addresses an area of need for the local Medicaid population
• Well-documented study design</td><td>TRSN should consider discontinuing this PIP, which is in its third year. The study population has remained quite small, and the project has not sustained adherence to the practice guideline.</td></tr>
<tr><td colspan="2">Nonclinical—Improving Coordination of Care and Outcomes: Fully Met (84 out of 90)</td></tr>
<tr><td>• Study topic focuses on physical/behavioral health integration
• Achieved significant improvement in first remeasurement compared to baseline</td><td>TRSN should consider modifying the study indicator. A single coordination-of-care service is not adequate to address the needs of enrollees with serious or severe physical health issues and is not consistent with level-of-care protocol guidelines.</td></tr>
<tr><td colspan="2">Information Systems Capabilities Assessment (ISCA)</td></tr>
<tr><td>Information Systems: Fully Met (2.6 out of 3)</td><td>Administrative Data: Fully Met (2.9 out of 3)</td></tr>
<tr><td>Staffing: Partially Met (2.4 out of 3)</td><td>Enrollment Systems: Fully Met (2.9 out of 3)</td></tr>
<tr><td>Hardware Systems: Fully Met (2.7 out of 3)</td><td>Vendor Data Integration: Fully Met (3 out of 3)</td></tr>
<tr><td>Security: Not Met (1.5 out of 3)</td><td>Provider Data: Fully Met (2.8 out of 3)</td></tr>
<tr><td>Strengths</td><td>Opportunities for Improvement</td></tr>
<tr><td>• Information Systems: TRSN and Netsmart provide ongoing annual training for programmers, report writers, and IS staff.
• Staffing: Outpatient authorizations are requested, processed, and housed in the same system as encounter data.
• Hardware Systems: Data center facilities and hardware systems are well designed and maintained.
• Security: TRSN’s contracted provider agencies maintain Business Continuity/Disaster Recovery plans.
• Administrative Data: TRSN performs automated edits and verification checks to ensure completeness and correctness of submitted encounter data, including provider identification, diagnosis and procedure codes, and service authorization.
• Enrollment Systems: TRSN performs eligibility checks before submitting encounters to DBHR.
• Vendor Data Integration: TRSN verifies encounters monthly. TRSN reported a high match rate between provider data and state data.
• Provider Data: TRSN maintains up-to-date provider profile information in an accessible repository, and can produce reports upon request.</td><td>Findings
Security: TRSN needs to ensure that all aspects of the DBHR contract (e.g., Exhibit C, Section 11: Management Information Systems and Data Security Requirements) are implemented at the RSN and provider agency levels. High-level items may include, but are not limited to:
• Update and test Business Continuity/Disaster Recovery plans at least annually (including plans for outsourced IT services).
• Encrypt all data that will be in transit outside the contractor’s internal network; encrypt all data storage on portable devices or media with a key length of at least 128 bits.
• Remove access to data immediately when an authorized person no longer requires access.
• Require password security to meet complexity and forced changes at least every 90 days.
• Implement process for frequent backup of systems data. TRSN and WSC need to work with Netsmart to schedule and complete restoration testing.
• Define monitoring responsibilities for outsourced IT services and review for adherence to DBHR contract requirements.</td></tr>
<tr><td colspan="2">TRSN, headquartered in Cathlamet, administers mental health services for Medicaid enrollees in Lewis, Pacific, and Wahkiakum counties. In 2012, TRSN had about 26,000 Medicaid enrollees in its service area.</td></tr>
<tr><td colspan="2">Data source: Timberlands RSN 2013 External Quality Review Report (Acumentra Health).</td></tr>
</table>

Timberlands Regional Support Network (continued)

Activity

Encounter Data Validation (n=49,610)

Completeness—Number of fields with data 100% complete

Outpatient encounter data	9 out of 10 fields	Demographic data	2 out of 11 fields

Accuracy—Percentage of charts with data matching state's electronic data

Procedure code (n=407)	89.7%	First name (n=99)	100.0%
Provider type (n=407)	95.8%	Last name (n=99)	100.0%
Minutes of service (n=407))	62.7%	Date of birth* (n=99)	100.0%
Service location (n=407)	95.6%	Ethnicity (n=99)	59.6%
Service date (n=407)	96.6%	Language (n=99)	62.6%

Golden Thread review—Percentage of charts meeting criteria (n=98)

	Children		Adults		Total	
	Yes	Partially	Yes	Partially	Yes	Partially
Assessment substantiates Category A diagnosis (if applicable)	90.9%	6.1%	98.3%	1.7%	95.6%	3.3%
Assessment substantiates Category B diagnosis (if applicable)	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Treatment plan includes interventions and goals consistent with issues identified in assessment	94.3%	0.0%	86.2%	0.0%	89.2%	0.0%
Treatment plan objectives are individualized	94.4%	0.0%	86.0%	0.0%	89.2%	0.0%
Progress notes address interventions in treatment plan and individual's progress toward stated goals	75.0%	8.3%	83.1%	3.4%	80.0%	5.3%

Clinical Record Review (n=36)

Assessment, treatment plan, and progress notes indicate adherence to principles of Children's Mental Health Redesign

Percentage of children's charts with completed assessment in the past year: 69.4%

Percentage of applicable assessments that include:

Living environment and safety needs	100.0%	Cultural issues that may affect treatment	87.0%
Documentation of current living situation	100.0%	Language needs taken into consideration	N/A
Child's/family's natural systems of support	100.0%	Child/family involvement in activities outside home	100.0%
Development/learning/sensory impairment	100.0%	Justification of diagnosis	91.7%

Percentage of treatment plans that include:

Strength-based activities and interventions	82.4%	Coordination/collaboration with other agencies identified in assessment	80.0%
Individualized treatment objectives	97.1%	Team-based services	56.3%
Documentation of family/guardian participation in developing treatment plan	96.7%	Interventions and goals consistent with issues identified in assessment	97.0%

Percentage of progress notes that include:

Interventions identified in treatment plan and progress toward meeting stated goals	76.5%	Care coordination with agencies and systems	80.0%
Unconditional treatment	97.1%	Outcome-based progress notes	60.6%
Delivery of strength-based services	91.2%		

Appendix B. MCO Profiles

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

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

Amerigroup B-3
Community Health Plan of Washington B-5
Coordinated Care Corp. B-7
Molina Healthcare of Washington B-9
UnitedHealthcare Community Plan B-11

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Amerigroup Washington (AMG)

Measure	Score		Measure	Score	
Service Utilization*					
Inpatient—general hospital/acute care	**Per 1000 MM[a]**			**ALOS[b]**	
Total inpatient discharges	6.97	▲		3.72	▲
Medical discharges	2.78	▲		3.67	
Surgical discharges	1.52	▲		5.60	
Maternity discharges	3.99			2.69	▲
Ambulatory care	**Per 1000 MM[a]**				
Outpatient visits	248.50	▼			
Emergency room visits	61.00	▲			
Regulatory and Contractual Standards—Percent of elements met**					
Availability of Services	20%		Emergency and Post-stabilization Services	50%	
Furnishing of Services (Timely Access)	50%		Enrollee Rights	47%	
Program Integrity	60%		Enrollment and Disenrollment	100%	
Claims Payment	100%		Grievance Systems	78%	
Continuity and Coordination of Care	80%		Practice Guidelines	66%	
Enrollees with Special Healthcare Needs	80%		Provider Selection (Credentialing)	50%	
Patient Review and Coordination	63%		QA/PI Program	25%	
Coverage and Authorization of Services	100%		Subcontractual Relationships/Delegation	50%	
Performance Improvement Projects (PIPs)**					
Clinical			**Nonclinical**		
Well-Child Visits During the First 15 Months of Life (5 or More Visits)	Not Met		Statewide Transitional Healthcare Services	n.a.***	
			Provider Denial Letters	Not reviewed	
Amerigroup Washington Inc. (AMG) began serving Medicaid members July 1, 2012, and currently serves over 30,000 members through Apple Health and Basic Health in 24 counties. Approximately one-third of AMG's Medicaid clients are 19 years of age or younger.					

[a] Per 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

[b] ALOS = average length of stay (in days).

▲▼ MCO percentage is significantly higher or lower than state average (p<0.05).

*Data source: 2013 Performance Measure Comparative Analysis Report.

**Data source: 2013 TEAMonitor report.

***PIP will be scored in 2014.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

Amerigroup Washington (continued)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards**	
Met 100% of elements for: • Claims Payment • Coverage and Authorization of Services • Enrollment and Disenrollment Met 60–80% of elements for: • Program Integrity • Continuity and Coordination of Care • Enrollees with Special Healthcare Needs • Patient Review and Coordination • Grievance Systems • Practice Guidelines	Met ≤50% of elements for: • Availability of Services • Furnishing of Services (Timely Access) • Emergency and Post-stabilization Services • Enrollee Rights • Provider Selection (Credentialing) • QA/PI Program • Subcontractual Relationships/Delegation
Performance Improvement Projects (PIPs)**	
	• TEAMonitor scored the clinical PIP "Not Met" because AMG did not demonstrate that it had undertaken an intervention to increase the infant WCC visit rate.

**Data source: 2013 TEAMonitor report.

Community Health Plan of Washington (CHP)

Measure	Score		Measure	Score	
Service Utilization*					
Inpatient—general hospital/acute care	**Per 1000 MM[a]**			**ALOS[b]**	
Total inpatient discharges	5.52			3.22	
Medical discharges	1.62			3.55	▲
Surgical discharges	0.96			5.20	
Maternity discharges	5.50			2.40	
Ambulatory care	**Per 1000 MM[a]**				
Outpatient visits	337.16	▲			
Emergency room visits	46.99	▼			
Regulatory and Contractual Standards—Percent of elements met**					
Availability of Services	40%		Emergency and Post-stabilization Services	50%	
Furnishing of Services (Timely Access)	100%		Enrollee Rights	53%	
Program Integrity	40%		Enrollment and Disenrollment	50%	
Claims Payment	0%		Grievance Systems	83%	
Continuity and Coordination of Care	40%		Practice Guidelines	33%	
Enrollees with Special Healthcare Needs	80%		Provider Selection (Credentialing)	50%	
Patient Review and Coordination	50%		QA/PI Program	50%	
Coverage and Authorization of Services	50%		Subcontractual Relationships/Delegation	75%	
Performance Improvement Projects (PIPs)**					
Clinical			**Nonclinical**		
Improving Use of Appropriate Medications for People with Asthma	Met		Statewide Transitional Healthcare Services	n.a.***	
Improving PHQ-9 Results for MCS Members	Partially Met		Improving CSR Handling of Benefit Calls	Partially Met	

Founded over 20 years ago by the state's community health centers, Community Health Plan of Washington (CHP) is the state's only local, nonprofit health plan. Since 2011, the plan has been accredited by NCQA for Medicaid and Medicare products. CHP now provides managed care for more than 350,000 individuals throughout Washington. The plan's network includes more than 540 primary care clinics, 2,365 primary care providers, 13,571 specialists, and over 100 hospitals. CHPW's innovative practices include programs that reward members for taking care of themselves, pay-for-performance models for network providers, and integrating clinical information across the care continuum.

[a] Per 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

[b] ALOS = average length of stay (in days).

▲▼ MCO percentage is significantly higher or lower than state average (p<0.05).

*Data source: 2013 Performance Measure Comparative Analysis Report.

**Data source: 2013 TEAMonitor report.

***PIP will be scored in 2014.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

Community Health Plan of Washington (continued)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards**	
Met 100% of elements for: • Furnishing of Services (Timely Access) Met 75–83% of elements for: • Enrollees with Special Healthcare Needs • Grievance Systems • Subcontractual Relationships/Delegation	Met ≤53% of elements for: • Availability of Services • Program Integrity • Claims Payment • Continuity and Coordination of Care • Patient Review and Coordination • Coverage and Authorization of Services • Emergency and Post-stabilization Services • Enrollee Rights • Enrollment and Disenrollment • Practice Guidelines • Provider Selection (Credentialing) • QA/PI Program
Performance Improvement Projects (PIPs)**	
• CHP's clinical PIP on asthma medications was generally well written and documented, featuring member education interventions and new provider feedback reports. • TEAMonitor called the clinical PIP on PHQ-9 results "a very promising project that seemed to yield interesting results." • TEAMonitor noted improvements in the design, data collection, and analysis of the nonclinical PIP.	• For the asthma medications PIP, CHP needs to improve its documentation to clarify that the MCO used hybrid data collection methods. • The mental health PIP needs improvement in overall documentation—definitions, data analysis plan, data collection methods, and analysis of results. • The nonclinical PIP failed to demonstrate that it adequately addressed the MCS population.

**Data source: 2013 TEAMonitor report.

Coordinated Care Corp. (CCC)

Measure	Score		Measure	Score
Service Utilization*				
Inpatient—general hospital/acute care	**Per 1000 MM[a]**			**ALOS[b]**
Total inpatient discharges	6.82	▲		3.24
Medical discharges	2.51	▲		3.17
Surgical discharges	1.35	▲		5.20
Maternity discharges	4.85			2.41
Ambulatory care	**Per 1000 MM[a]**			
Outpatient visits	283.15	▼		
Emergency room visits	60.10	▲		
Regulatory and Contractual Standards—Percent of elements met**				
Availability of Services	20%		Emergency and Post-stabilization Services	50%
Furnishing of Services (Timely Access)	0%		Enrollee Rights	87%
Program Integrity	20%		Enrollment and Disenrollment	100%
Claims Payment	100%		Grievance Systems	88%
Continuity and Coordination of Care	60%		Practice Guidelines	33%
Enrollees with Special Healthcare Needs	80%		Provider Selection (Credentialing)	25%
Patient Review and Coordination	63%		QA/PI Program	75%
Coverage and Authorization of Services	50%		Subcontractual Relationships/Delegation	0%
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
Increasing Compliance of Female Members Over Age 40 in Getting an Annual Screening Mammogram	Partially Met		Statewide Transitional Healthcare Services	n.a.***
Diabetes Compliance	Not reviewed			
Established to deliver quality health care in Washington through local, regional, and community-based resources, Coordinated Care (CCC) is a managed care organization and subsidiary of Centene Corp. CCC's mission is to improve the health of its beneficiaries through focused, compassionate, and coordinated care, based on the core belief that quality health care is best delivered locally.				

[a] Per 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

[b] ALOS = average length of stay (in days).

▲▼ MCO percentage is significantly higher or lower than state average (p<0.05).

*Data source: 2013 Performance Measure Comparative Analysis Report.

**Data source: 2013 TEAMonitor report.

***PIP will be scored in 2014.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

Coordinated Care Corp. (continued)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards**	
Met 100% of elements for: • Claims Payment • Enrollment and Disenrollment Met 60–88% of elements for: • Continuity and Coordination of Care • Enrollees with Special Healthcare Needs • Patient Review and Coordination • Enrollee Rights • Grievance Systems • QA/PI Program	Met ≤50% of elements for: • Availability of Services • Furnishing of Services (Timely Access) • Program Integrity • Coverage and Authorization of Services • Emergency and Post-stabilization Services • Practice Guidelines • Provider Selection (Credentialing) • Subcontractual Relationships/Delegation
Performance Improvement Projects (PIPs)**	
• TEAMonitor said CCC's clinical PIP on mammogram compliance appeared solid, using the HEDIS breast cancer screening measure.	• Documentation of the clinical PIP was too brief.

**Data source: 2013 TEAMonitor report.

Molina Healthcare of Washington (MHW)

Measure	Score		Measure	Score	
Service Utilization*					
Inpatient—general hospital/acute care	**Per 1000 MM[a]**			**ALOS[b]**	
Total inpatient discharges	5.37	▼		3.07	▼
Medical discharges	1.37	▼		3.19	▼
Surgical discharges	0.89	▼		5.70	
Maternity discharges	6.00			2.27	▼
Ambulatory care	**Per 1000 MM[a]**				
Outpatient visits	347.27	▲			
Emergency room visits	45.52	▼			
Regulatory and Contractual Standards—Percent of elements met**					
Availability of Services	100%		Emergency and Post-stabilization Services	0%	
Furnishing of Services (Timely Access)	100%		Enrollee Rights	53%	
Program Integrity	0%		Enrollment and Disenrollment	50%	
Claims Payment	100%		Grievance Systems	88%	
Continuity and Coordination of Care	40%		Practice Guidelines	100%	
Enrollees with Special Healthcare Needs	60%		Provider Selection (Credentialing)	25%	
Patient Review and Coordination	63%		QA/PI Program	100%	
Coverage and Authorization of Services	50%		Subcontractual Relationships/Delegation	25%	
Performance Improvement Projects (PIPs)**					
Clinical			**Nonclinical**		
Improving Breast Cancer Screening	Met		Statewide Transitional Healthcare Services	n.a.***	

Established in 1995, Molina Healthcare of Washington (MHW) provides coverage for Medicaid enrollees in 34 counties across Washington. MHW insures approximately 410,000 lives, 95% of whom are covered by Medicaid. About 80% of Medicaid clients are 18 years of age or younger. MHW is accredited by NCQA for its Medicaid product lines.

[a] Per 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

[b] ALOS = average length of stay (in days).

▲▼ MCO percentage is significantly higher or lower than state average (p<0.05).

*Data source: 2013 Performance Measure Comparative Analysis Report.

**Data source: 2013 TEAMonitor report.

***PIP will be scored in 2014.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

Molina Healthcare of Washington (continued)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Furnishing of Services (Timely Access) • Claims Payment • Practice Guidelines • QA/PI Program Met 60–88% of elements for: • Enrollees with Special Healthcare Needs • Patient Review and Coordination • Grievance Systems	Met ≤53% of elements for: • Program Integrity • Continuity and Coordination of Care • Coverage and Authorization of Services • Emergency and Post-stabilization Services • Enrollee Rights • Enrollment and Disenrollment • Provider Selection (Credentialing) • Subcontractual Relationships/Delegation
Performance Improvement Projects (PIPs)**	
• MHW's clinical PIP was generally well documented.	• MHW needs to describe its interventions for the clinical PIP in greater detail.

**Data source: 2013 TEAMonitor report.

UnitedHealthcare Community Plan (UHC)

Measure	Score		Measure	Score
Service Utilization*				
Inpatient—general hospital/acute care	**Per 1000 MM[a]**			**ALOS[b]**
Total inpatient discharges	6.47	▲		3.35
Medical discharges	2.36	▲		3.30
Surgical discharges	1.34	▲		5.23
Maternity discharges	4.42			2.47
Ambulatory care	**Per 1000 MM[a]**			
Outpatient visits	253.06	▼		
Emergency room visits	53.98	▲		
Regulatory and Contractual Standards—Percent of elements met**				
Availability of Services	100%		Emergency and Post-stabilization Services	50%
Furnishing of Services (Timely Access)	50%		Enrollee Rights	53%
Program Integrity	40%		Enrollment and Disenrollment	50%
Claims Payment	100%		Grievance Systems	94%
Continuity and Coordination of Care	60%		Practice Guidelines	33%
Enrollees with Special Healthcare Needs	80%		Provider Selection (Credentialing)	25%
Patient Review and Coordination	63%		QA/PI Program	100%
Coverage and Authorization of Services	75%		Subcontractual Relationships/Delegation	50%
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
Improving the Medical Home for Emergencies that are Avoidable and Readmissions from Transitions	Partially Met		Statewide Transitional Healthcare Services	n.a.***

UnitedHealthcare Community Plan (UHC) is the largest Medicaid managed care plan in the United States, with more than 25 years of experience helping low-income adults and children and people with disabilities get access to personalized healthcare benefits and services. In Washington, UHC provides Medicaid coverage through Apple Health (formerly Healthy Options) for more than 50,000 enrollees in 32 counties. UHC is also a lead entity for the Washington State Health Home Initiative and for the state's Medicare-Medicaid Eligible (MME) Demonstration Project in King and Snohomish Counties.

[a] Per 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

[b] ALOS = average length of stay (in days).

▲▼ MCO percentage is significantly higher or lower than state average (p<0.05).

*Data source: 2013 Performance Measure Comparative Analysis Report.

**Data source: 2013 TEAMonitor report.

***PIP will be scored in 2014.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

UnitedHealthcare Community Plan (continued)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Claims Payment • QA/PI Program Met 60–94% of elements for: • Continuity and Coordination of Care • Enrollee with Special Healthcare Needs • Patient Review and Coordination • Coverage and Authorization of Services • Grievance Systems	Met ≤53% of elements for: • Furnishing of Services (Timely Access) • Program Integrity • Emergency and Post-stabilization Services • Enrollee Rights • Enrollment and Disenrollment • Practice Guidelines • Provider Selection (Credentialing) • Subcontractual Relationships/Delegation
Performance Improvement Projects (PIPs)**	
• TEAMonitor called UHC's clinical PIP an important and promising new project with clear, measurable indicators, aimed at assessing how a positive discharge experience affects service utilization by enrollees following hospitalization.	• TEAMonitor cited "documentation challenges" that limited the clinical PIP to a score of Partially Met.

**Data source: 2013 TEAMonitor report.

Appendix C: DBHR Information Systems Capabilities Assessment

Acumentra Health conducted a full ISCA review of DBHR's Medicaid encounter data system in 2013, building on similar full reviews in 2011 and 2009. The purpose was to determine the extent to which DBHR's information systems and data processing and reporting procedures support the production of valid and reliable performance measures and the capacity to manage enrollees' mental health care.

Since 2010, DBHR has used the ProviderOne management information system to process Medicaid claims and encounter data. DBHR's Consumer Information System (CIS) houses demographic information for all mental health consumers and non-Medicaid mental health service data. The CIS is used to run crucial data reports such as those connected with statewide performance measures. DBHR contracts with Looking Glass Analytics (LGAN) to calculate the performance measures.

The full ISCA review in 2013 examined DBHR's information systems, data processing procedures, and oversight and monitoring of LGAN and RSN-contracted activities. The review found that DBHR *fully met* federal standards related to data processing procedures and personnel, and *fully met* the data acquisition capabilities standards (see Table C-1).

Table C-1. Weighted average scores and ratings on DBHR ISCA sections, 2013.

Review section/subsection	Score	Compliance rating
Section 1: Data Processing Procedures and Personnel		
A. Information Systems	2.6	Fully met
B. Staffing	2.9	Fully met
C. Hardware Systems	2.9	Fully met
D. Security	2.4	Partially met
Section 2: Data Acquisition Capabilities		
A. Administrative Data (claims and encounter data)	2.8	Fully met
B. Enrollment System (Medicaid eligibility)	2.8	Fully met
C. Performance Measure Repository	2.4	Partially met
D. Report Production	2.4	Partially met

ISCA Section 1: State Data Processing Procedures and Personnel

DBHR servers, ProviderOne production servers, and testing servers are interconnected by Global Crossing's Multiple Protocol Label Switching service, using an Internet connection with the State Governmental Network.

ACES eligibility data. The state's Automated Client Eligibility System (ACES) updates Medicaid enrollee eligibility data in ProviderOne nightly. ProviderOne uses these data when processing Medicaid claims and encounter data. ProviderOne assigns members to RSNs on the basis of demographic information.

ProviderOne. ProviderOne auto-adjudicates Medicaid encounter data. There are no manual adjudication processes.

CNSI hosts and provides all maintenance for ProviderOne hardware and software. In 2013, CNSI upgraded the hardware for its data warehouse. CNSI has experienced little staff turnover, although current staffing numbers were not available. Programmers receive professional training each year. Changes to the application are developed on testing servers located at the CNSI testing facility. Data from the production server are replicated to the testing servers in near real time. HCA must approve all changes to the application before implementation. Patches are also tested before implementation. CNSI uses ClearQuest version control software.

ProviderOne receives community hospital claims and RSN encounter data through a secure file transfer connection. ProviderOne also has a secure web portal that can be used to verify enrollee eligibility.

CNSI has not upgraded to a new version of the ProviderOne platform since implementation in 2010, although updates are available.

CNSI performs full backups of ProviderOne data weekly. Backup tapes are stored onsite in a closed tape library. CNSI also replicates ProviderOne data to the CNSI testing facility in near real time.

DBHR uses two data warehouses for reporting: one at the ProviderOne facility and the other in Boston. The test environment is located in San Jose, CA. DBHR exports data from ProviderOne to an Operational Data Store (ODS). CIS, DBHR's legacy information system, then pulls extracts of data from the ODS for loading. Currently, no validation occurs for the data being loaded into CIS.

CIS. CIS is a SQL data warehouse that uses data extracts from the reporting data warehouse, updated weekly. CIS has been preserved to maintain the customized mental health reports created before implementation of ProviderOne. CIS is housed at the DBHR data center.

Looking Glass Analytics. DBHR contracts with LGAN to calculate state performance measures and report the results. DBHR extracts data from ProviderOne that LGAN uses to calculate the performance measures.

LGAN reports the performance measures on a website. According to LGAN, the infrastructure for the web application includes secure Internet connections, a web server, a web report server (SAS software), and a SAS server for processing incoming data and preparing the data for the web servers. Source data are extracted from CIS and ProviderOne databases. It was not clear why LGAN requires both sets of data.

The virtual servers are fully backed up monthly or as major changes occur. Encrypted backup media are stored offsite.

Section 1A: Information Systems — Score: 2.7 (Fully met)

This subsection reviews the systems development life cycle (SDLC) and supporting environments, including database management systems and/or billing software, programming languages, and training for programmers.

HCA is responsible for oversight of CNSI, which includes communicating policy, enforcing SDLC practices, user acceptance testing, defect changes, and scheduling of production releases. HCA does not review CNSI coding changes.

DBHR receives daily reports from CNSI about the health and maintenance of the ProviderOne systems and network, including the list of implemented patches. However, neither DBHR nor HCA has formally audited CNSI.

DBHR expects internal IT staff members to progress within their field, but has no budget to support staff training.

The CIS facility in Olympia, managed by HCA IT staff, provides redundant power and HVAC, emergency response, 24-7 security staff, and surveillance monitoring. All equipment resides in locked cabinets.

HCA IT performs full backups of HCA data weekly. Backup tapes are stored onsite.

Strengths

- DBHR and CNSI use software configuration and source code (version control) management software.
- CNSI provides DBHR with daily reports on the health and maintenance of the ProviderOne systems and network.
- CNSI's SDLC practices suggest that accuracy and security are considered throughout the process.
- DBHR balances the ODS after each load from ProviderOne.

Recommendations

DBHR has no budget for training to keep programmers abreast of rapid changes in information technology.

- DBHR needs to develop a plan for programmer training during this period of budget austerity.

The ProviderOne/CIS file consolidation project was completed in 2011, but at the time of the 2013 ISCA review, project documentation was still not available.

- DBHR needs to fully document the process by which source data are extracted from CIS, aggregated and uploaded to DBHR's SAS server, and made available for LGAN to use.

CNSI has not upgraded its ProviderOne software since implementation in 2010.

- DBHR should develop a plan to upgrade the ProviderOne software and ensure that critical software remains supported.

ProviderOne data are replicated to the ODS in a format that differs from the CIS data format. Many changes to the files are applied before CIS extractions for loading. Extracted CIS data are moved into tables with varying formats. The many data changes between the ProviderOne, CIS, and LGAN systems throughout this process raise concerns about the accuracy and quality of the reported data.

- DBHR needs to develop a process to validate the quality, completeness, and accuracy of CIS data after each load.
- DBHR should develop a process to validate the quality, completeness, and accuracy of the entire system, ensuring that the same level of controls is used throughout the system to increase confidence in the data.

Section 1B: Staffing — Score: 2.9 (Fully met)

This subsection assesses physical access by DBHR staff to IT assets, as well as specific training requirements for programmers and claims processing staff.

HCA IT staff members with an average of seven years' experience maintain the CIS. No training budget exists for programmers because of state budget constraints.

DBHR employs limited staff to perform mental health data analysis and oversight of encounter data throughout the process.

Strengths

- DBHR's and CNSI's software programming, quality assurance, and IT staff are highly trained and experienced.
- CNSI's software programmers receive formal training annually.

Recommendations

More appropriate staffing levels would equip DBHR with backup for key IT functions, helping to minimize single points of failure and maintain anticipated turnaround times.

- DBHR should consider allocating more resources for staff to analyze and oversee the flow of mental health data.

Section 1C: Hardware Systems — Score: 2.9 (Fully met)

This subsection assesses DBHR's network infrastructure and hardware systems.

HCA, DBHR, CNSI, and LGAN maintain infrastructural support that includes maintenance and timely replacement of computer equipment and software, adequate training of support staff, and a secure computing environment.

The ProviderOne application resides in Virginia. CNSI upgraded the production servers in the summer of 2012. The testing servers in San Jose were scheduled to be upgraded in 2013.

Strengths

- DBHR's and CNSI's data center facilities and hardware systems are well designed and maintained.
- DBHR receives daily reports from CNSI on the health and maintenance of ProviderOne systems and network, including the list of implemented patches.

Recommendations

According to information supplied by HCA, DBHR's hardware may be approaching end of life or end of the support period. In some circumstances, support may be extended at a premium. In this period of budget austerity, it is essential to manage planned replacements well in advance to ensure that funds are set aside for such costly upgrades or service agreements (i.e., CIS systems).

- DBHR needs to pursue its plans to upgrade hardware that may be approaching end of life and/or end of support.

Section 1D: Security — Score: 2.4 (Partially met)

This subsection assesses DBHR's information systems for integrity and the ability to prevent data loss and corruption. A security walkthrough of the computer area and/or data center assesses the possibility of a breach in security measures.

DBHR tested its Business Continuity/Disaster Recovery (BC/DR) plan with CNSI in December 2012. However, the plan has not been updated since September 2009. DBHR submitted limited supporting documentation and recovery strategies for the CIS system.

DBHR uses full disk encryption strategies for all laptops and other portable devices.

CNSI has a process to remove access to ProviderOne immediately for an employee or contractor who no longer requires access.

DBHR has a policy to remove access within five days for an employee or contractor who no longer requires access to CIS.

Strengths

- CNSI replicates ProviderOne to the CNSI testing facility in near real time, providing quick and easy access to nearly complete backup data.
- DBHR, CNSI, and LGAN implement security measures that make it difficult for unauthorized users to gain access to data and other network resources.
- CNSI performs regular network scanning for potential vulnerabilities that may result from poor or improper system configuration.
- DBHR uses full disk encryption for all portable devices.
- LGAN performs full backups of its virtual server monthly. Encrypted backup media are transported to a secure offsite location.
- DBHR maintains password policies with appropriate complexity requirements and forced password changes that align with industry standards.

Findings

DBHR does not have a process in place to monitor contracted IT services, such as reviewing programming code and monitoring for adherence to contract requirements and deliverable expectations for CNSI and LGAN.

- DBHR needs to develop and implement a formal process for monitoring of outsourced IT services.

DBHR has a policy to remove access within five days for an employee or contractor who no longer requires access to state data systems. This policy does not align with current industry standards.

- DBHR needs to revise its access policy to ensure that access is removed immediately when a previously authorized person no longer requires access.

DBHR's BC/DR plan for the ProviderOne system was last updated in 2009.

- DBHR needs to review and/or update its BC/DR plan at least annually.
- DBHR and HCA need to ensure that they have integrated BC/DR plans for all of their significant information systems and outsourced IT services, including CNSI, CIS, LGAN, and other systems.

ISCA Section 2: Data Acquisition Capabilities

DBHR accepts encounter data from the RSNs in a HIPAA-compliant 837 electronic format only. At least monthly, the RSNs connect to ProviderOne via a secure service on the ProviderOne network to transmit batched encounter data. RSNs also may submit individual encounters through the ProviderOne web portal. Community hospitals submit claims directly to DBHR.

ProviderOne loads each batch and uses commercial software to confirm that the batch meets HIPAA format requirements. A batch that fails this screening is not processed further, and the RSN receives notice. If the batch passes the screening, the encounters are translated and loaded to ProviderOne data tables. ProviderOne processes these data nightly, marking each encounter "accepted" or "rejected." The submitting RSN receives a report showing the acceptance of each encounter or a detailed reason for its rejection. RSNs resubmit batches or encounters when they are corrected. DBHR manages and monitors RSN encounter data certifications for accuracy and completeness.

Auditing and monitoring of data processing. DBHR performs monthly reconciliation activities to verify provider credentials, eligibility files, member ID codes, and income source and program codes. DBHR uses monthly summaries of encounter data submissions, error reports, and certification reports for these reviews.

During processing, DBHR does not audit its encounter data to ensure the accuracy and completeness of electronic data interchange (EDI) and adjudication processes. HCA and ProviderOne have some activities in place to review reasonableness. However, those activities may not identify issues that were not anticipated when the EDI rules were developed, and may not be mental health-specific. Encounter data loaded into ProviderOne may not be verified to ensure adherence to DBHR's Service Encounter Reporting Instructions (SERI).

When data are transferred from ProviderOne to CIS, several file manipulation activities take place to convert the files to a format appropriate for CIS. Data elements in CIS are not verified for accuracy after this conversion.

Acumentra Health detected a significant number of duplicates and errors in the DBHR system. It is unclear why these errors are not being identified internally.

Submission of diagnoses. The RSNs submit demographic and periodic data about Medicaid enrollees (including diagnoses) to CIS via the State Governmental Network. RSNs report diagnosis fields on the 837 encounter data record to represent the specific diagnosis treated at the time of service. More than one diagnosis can be reported. Some RSNs reported that they submit only the primary diagnosis when submitting any data. This practice may introduce inaccuracy into the encounter data—i.e., a reported service may treat a condition other than the reported diagnosis. This exposes provider agencies to a significant risk of revenue take-backs.

RSN encounter data validation. DBHR requires the RSNs by contract to perform encounter data validation audits of contracted provider agencies, and to report the results of those audits to DBHR.

CIS data issues. The ProviderOne file format differs from the CIS file format. Data extraction and translation programs were developed to convert ProviderOne encounter data into the CIS format so that existing report programming could remain in use.

Following this conversion, LGAN aggregates the data using SAS routines, and uses the data to develop performance measure reports.

Section 2A: Administrative Data — Score: 2.8 (Fully met)

This subsection reviews DBHR's reporting of accurate data, process for verifying the accuracy of submitted claims, and data assessment and retention.

Strengths

- ProviderOne is a fully automated auto-adjudication application.
- DBHR provides exception reports to RSNs to help them examine possible encounter errors and to make corrections.
- The 837 record allows submission of up to 12 diagnoses per encounter.

Recommendations

DBHR performs only ad-hoc reviews of encounter data stored in the data warehouse. ProviderOne rules may be overly broad and may not flag issues that do not comply with the SERI.

- DBHR needs to perform routine audits of encounter data.
- DBHR needs to ensure that EDI rules are developed and implemented for mental health-specific encounters and that the rules are detailed enough to flag errors that do not comply with the SERI.

The 837 electronic format accepts multiple diagnoses. However, some RSNs report that they submit only the primary diagnosis. That diagnosis may come from the enrollee's original intake assessment and may be at least several years old. DBHR has no method in place to ensure that the diagnosis being treated at the time of service is reported on the 837.

- DBHR needs to develop a method to ensure that the diagnosis being treated at the time of service is reported on the 837, and that the reported diagnosis is current and reviewed regularly.
- DBHR needs to clarify its reporting rules to inform RSNs and provider agencies of the proper reporting of diagnoses.

Section 2B: Enrollment System — Score: 2.8 (Fully met)

This subsection assesses DBHR's systems pertaining to Medicaid enrollment and disenrollment, tracking of claims and encounter data, Medicaid enrollment data updates, enrollment code, and data verification.

ACES updates ProviderOne eligibility files every 15 minutes, and uploads a full eligibility file nightly. DBHR sends a full eligibility file to each RSN monthly and update files weekly.

DBHR has worked to improve the quality of eligibility data over the past few years. In 2013, RSNs reported improvement in the quality and accuracy of the eligibility data files received from the state, but some issues remain.

Eligibility data issues. (1) Many RSNs cannot upload eligibility files to their claims/encounter processing applications, limiting the completeness of adjudication. Several RSNs address this by using an MS Access application to compare DBHR eligibility files with a file of enrollees for whom encounters are submitted. Because this approach uses two data sets, it introduces risk of duplication or loss. A few RSNs rely solely on their contracted provider agencies to check enrollee eligibility on the ProviderOne web portal at the time of service; these RSNs do not verify enrollee eligibility independently. RSNs continue to struggle with issues of retroactive eligibility.

(2) RSNs and their provider agencies can verify enrollee eligibility by viewing eligibility data in ProviderOne, but neither the RSNs nor providers

can make changes to the data (e.g., address or name). Provider agencies reported that they lack processes to notify DBHR of potential errors in the eligibility data (particularly important in the case of change of address).

Strengths

- DBHR receives full eligibility data from ACES each night and updates daily.
- DBHR provides RSNs with full eligibility data files monthly and updates weekly.
- DBHR has significantly improved the quality and accuracy of the 834 eligibility data.

Recommendations

RSNs submit to the state all encounters paid for with RSN funds. Many RSNs are not tracking which services are paid for with Medicaid funds, since all encounters are included in the same file. DBHR provides no specification for RSNs to distinguish services paid by Medicaid from those paid by other sources, such as state-only or block grant funds. The funding source for individual services can be difficult to reconstruct, as some services for a Medicaid-eligible person may not be covered by Medicaid (e.g., jail services).

- DBHR needs to work with the RSNs to develop and/or clarify reporting rules to identify services and encounters that RSNs pay for with Medicaid funds.

ProviderOne accepts all encounters regardless of funding source. DBHR uses internal processes to determine if a person was Medicaid-eligible at the time of a service, and attaches a revenue code to the encounter. This practice may not account for all RSN funding sources and does not replicate RSN processing rules, such as ensuring that non-Medicaid-eligible services are excluded.

- DBHR needs to develop internal practices for tracking services paid for by Medicaid.

Although DBHR developed a process that RSNs can use to update eligibility data (e.g., change of address or name), RSNs are not sufficiently aware of this process to use it effectively.

- DBHR needs to clearly communicate the process that allows RSNs and/or provider agencies to notify DBHR of potential errors in demographic and eligibility data.

Although DBHR has improved the quality of 834 eligibility data, some issues remain.

- DBHR needs to continue to work with RSNs to resolve issues related to the quality of 834 eligibility data.

RSNs and provider agencies have varied policies on when to check member eligibility.

- DBHR needs to work with RSNs to define expectations for checking enrollee eligibility when submitting encounters.

Section 2C: Performance Measure Repository — Score: 2.4 (Partially met)

This subsection assesses DBHR's systems pertaining to functionality for archiving benchmark data; current and past performance measurement results; source data for each report or the ability to link to the source data; measure definitions, including numerators and denominators; and a copy of each report.

DBHR is proceeding with its plan to develop documentation of the process for compiling and calculating its performance measures.

DBHR facilitates the statewide Performance Indicator Workgroup, representing DBHR, RSNs, and provider agencies. Members work to improve methodology to clarify the interpretation of performance targets and results.

DBHR's repository is an organized set of files with functionality for archiving benchmark data; current and past performance measurement results; source data (e.g., through a unique key or claim number);

measurement definitions, including numerators and denominators; and a copy of each report.

Strengths

- DBHR produces performance measure reports quarterly and distributes them to the RSNs.
- DBHR has the infrastructure in place (through its contract with LGAN) to display performance measure data in a web-based format for RSNs.
- DBHR uses two data warehouses (the ProviderOne facility in Virginia and a flat file database in Boston) to produce management reports and ad-hoc reports.

Recommendations

Many changes to the data files are applied prior to CIS extractions, and many formatting changes occur when CIS data are pulled into individual tables for use by LGAN.

- DBHR needs to develop procedures to validate the integrity of data undergoing formatting changes in transition from ProviderOne to LGAN for performance measure reporting.

RSNs have expressed concerns about the quality of CIS data. The RSNs' data are received by ProviderOne and replicated to the ODS before being loaded into CIS. It is unclear whether the concerns relate to the quality of both ProviderOne and CIS data, or whether the issues stem from the transformation of CIS systems. RSN staff members do not have access to verify data or reporting from ProviderOne or the ODS. This factor may have contributed to several issues with RSN data quality.

- DBHR needs to work with RSNs to define appropriate reporting needs and solutions.
- DBHR needs to develop a method to verify the accuracy and quality of the CIS data to create more confidence in the performance measure results.

Many RSNs have reported that they lack access to reports that compare their performance measure results with those of other RSNs.

- DBHR needs to work with LGAN to provide reports to RSNs that will compare results at the RSN level.

There does not appear to be a clear process for RSNs to report and track issues regarding CIS data quality, accuracy, and completeness. Some RSNs were aware of issues but did not know whether DBHR had resolved the issues.

- DBHR needs to develop a process for RSNs to report CIS data issues, and for DBHR to report the resolution of those issues to the RSNs.

Section 2D: Report Production — Score: 2.4 (Partially met)

This subsection assesses how the state documents and tests its Medicaid report generation programs, applies quality control, makes data revisions, and ensures adequate backup for performance measure programming needs.

DBHR generates performance measure reports from encounter data in the warehouse and sends these reports to the RSNs. The reports review all encounters submitted each month. DBHR also develops ad-hoc reports to evaluate the accuracy and completeness of data in each field, based on samples of the encounter data.

Strengths

- DBHR distributes performance measure reports quarterly to the RSNs.
- DBHR has the infrastructure in place (through its contract with LGAN) to display performance measure data in a web-based format for RSNs.

Recommendations

Performance measure reporting code is managed by LGAN and has not changed in recent years. The performance measure results are largely driven by data stored in tables managed by DBHR. Within these tables, DBHR has made frequent changes to the data elements that determine the inclusion and exclusion criteria for the performance measure calculations. Therefore, CIS table changes can affect the performance measure results.

- DBHR needs to develop and implement a version control process related to changes in the CIS data elements that affect performance measure results.
- DBHR needs to develop a process to clearly communicate and document data table changes.

LGAN's staff member assigned to generate the DBHR performance measure has calculated the measure with little documentation or oversight.

- DBHR needs to work with LGAN to document the process used to calculate the performance measures.
- DBHR needs to develop and implement a formal process for monitoring of outsourced IT services. (See also under Security.)

DBHR uses an informal manual process to give RSNs access to the raw data for verifying the calculation of performance measure results.

- DBHR needs to develop a process to validate and test performance measure results.
- DBHR needs to formalize its process to give RSN access to raw data for verifying the performance measure results.

Appendix D: Elements of Regulatory and Contractual Standards

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

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

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

Contract provisions	Healthy Options or *RSN* contract section(s)
Access to care	
The MCO/RSN must provide enough information to enable enrollees to make informed decisions about enrollment and to understand benefit coverage and how to obtain care. For physical health care, written information must discuss how to choose and change PCPs and how to obtain emergency services, hospital care, and services outside the service area. The MCO must provide information on available specialists, informed consent guidelines, advance directives, grievance procedures, covered benefits, well-child care, translation and interpretation services, and how to obtain a second opinion. For mental health care, RSNs must use the DBHR-published benefits booklet to notify enrollees of their benefits, rights, and responsibilities.	3.2; *5.1*
The MCO/RSN must ensure ***equal access*** for enrollees and potential enrollees with communication barriers. For oral communication, the MCO/RSN must provide free interpreter services for those with a primary language other than English. The MCO/RSN must ensure that written materials are available in a form that can be understood by each enrollee and potential enrollee, and must translate generally available written materials into prevalent non-English languages.	3.3; *5.1.1.4–5.1.1.8*
The MCO/RSN must maintain and monitor a ***provider network*** sufficient to serve enrollee needs, including out-of-network services as medically necessary. The MCO/RSN must consider factors such as the expected service utilization by the Medicaid population, the number and types of providers required, the geographic locations of providers and enrollees, and enrollees' cultural, ethnic, racial, and language needs.	5.1–5.2; *7.12*
The MCO/RSN's provider network must meet ***distance standards*** in each service area. For physical health care, two PCPs must be available within 10 miles for 90% of enrollees in an urban service area, and one PCP must be available within 10 miles in a rural service area. Similar standards exist for obstetrics, pediatric or family practice, and hospital and pharmacy services. For mental health care, service sites must be available within a 30-minute drive in rural areas, within a 90-minute drive in large rural geographic areas, and within a 90-minute public transportation trip in urban areas.	5.9; *7.13*
Each MCO must provide all medically necessary ***specialty care*** for enrollees in its service area, whether within or outside the provider network. The MCO must help providers obtain timely referrals to specialty care.	5.12
Timeliness of care	
The MCO/RSN must meet state standards for ***timely access*** to care, including transitional care services. For physical health care, designated services must be available 24 hours a day, seven days a week by telephone. Preventive care office visits must be available from the enrollee's PCP or another provider within 30 calendar days; routine care visits, within 10 calendar days; urgent, symptomatic visits within 48 hours; and emergency care, 24 hours a day, seven days a week. For mental health care, the RSN must offer a routine intake evaluation appointment within 10 business days of an enrollee's request. Emergent mental health care must occur within 2 hours of a request, and urgent care must occur within 24 hours of a request. The time period from request to first routine services appointment may not exceed 28 calendar days.	5.3–5.7; *7.6*

Contract provisions	Healthy Options or *RSN* contract section(s)
Quality of care	
"Quality" means "the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 CFR 438.320)."	1.74
The MCO/RSN must adopt ***practice guidelines***, disseminate them to providers, and use them in decision making for utilization management, enrollee education, service coverage, and other areas. The guidelines must be evidence-based, consider enrollee needs, be adopted in consultation with contracting professionals, and be reviewed and updated regularly.	6.6; *7.11*
The MCO/RSN must guarantee ***enrollee rights***, including the right to be treated with respect and with consideration for dignity and privacy; to be informed of available treatment options and alternatives; to participate in decisions regarding their health care; to be free from unnecessary restraint or seclusion; and to request and receive copies of their medical records and ask that they be amended. RSN enrollees must have individual service plans, developed with the participation of enrollees and their families. Each RSN must provide an independent mental health Ombuds to inform enrollees of their rights and help them resolve complaints and grievances.	9.1; *10.1–10.5*
The MCO/RSN must maintain written policies and procedures for ***advance directives*** that meet state and federal requirements and must provide for staff and community education concerning these policies.	9.3; *10.6*
For physical health care, the MCO must ensure that each enrollee has an ***appropriate source of primary care*** and must allow each new enrollee to choose a PCP, to the extent possible and appropriate. For mental health care, the RSN must offer each enrollee a choice of providers.	9.4; *7.14*
The MCO/RSN must have and maintain a ***utilization management program*** that includes mechanisms for detecting both underutilization and overutilization of services furnished to enrollees.	10.1; *7.10*
The MCO/RSN must meet state and federal requirements for ***service authorization***, including consistent application of review criteria for authorization decisions and timely notification of providers and enrollees in the event that the contractor denies an authorization request. The notice must explain the reasons for denial and the procedures for filing an appeal or requesting expedited resolution.	10.3; *7.7–7.8*
MCO/RSN ***grievance systems*** must meet state and federal standards regarding procedures and time frames for grievances, appeals, and access to the hearing process.	12; *12*
MCOs must ensure ***continuity of care*** for enrollees in an active course of treatment for a chronic or acute medical condition and must prevent the interruption of medically necessary care. RSNs must ensure coordination with other service delivery systems responsible for meeting needs identified in the enrollee's individual service plan, including primary medical care and services such as education, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections, and juvenile justice.	13.1; *10.3.3*
MCOs must facilitate ***transitional care*** for enrollees through operational agreements with state and community hospitals, RSNs, long-term care facilities, and substance abuse treatment programs. Agreements must include completion of a standardized discharge screening tool with a risk assessment for reinstitutionalization, rehospitalization, or treatment recidivism, plus intervention plans to mitigate such risk for enrollees.	13.2

Contract provisions	Healthy Options or *RSN* contract section(s)
MCOs must ensure ***coordination of care*** for enrollees through their PCPs, including initiating and coordinating referrals for specialty care. MCOs must ensure that children with special healthcare needs (SHCN) receive individualized treatment plans that ensure integration of clinical and nonclinical disciplines and services. Specific coordination requirements apply when providing services for children in foster care. Each MCO must establish and conduct an Intensive Care Management program that includes identifying, assessing, and developing individualized treatment plans for enrollees with SHCN. The MCO must have mechanisms in place to assess and monitor compliance with care management requirements by qualified health home entities. MCOs must collaborate to develop and implement standardized screening tools to assess development in young children and mental health conditions and alcohol and substance use disorder in children, adolescents, and adults. Each RSN must help to coordinate mental health care for enrollees admitted for psychiatric inpatient services; provide follow-up care for enrollees treated in emergency rooms; facilitate communication between physical and mental health providers about Early Periodic Screening, Diagnosis, and Treatment for enrollees under age 21; and have a plan for coordinating services with chemical dependency and substance abuse, criminal justice, and other allied systems.	13.3–13.7; *13.8–13.11*
Each MCO must maintain a ***Quality Assessment and Performance Improvement*** program that meets federal regulatory requirements. The program must include a Quality Improvement Committee that oversees quality functions, an annual work plan, and an annual written program evaluation. Each RSN's quality management program must include an annual review of community mental health agencies within the network.	6.1; *8.1–8.2*
The MCO/RSN must conduct ***performance improvement projects*** (PIPs) designed to achieve significant sustained improvement in areas expected to have a favorable effect on health outcomes and enrollee satisfaction. Each MCO must collaborate with peer MCOs to conduct a nonclinical statewide PIP on Transitional Healthcare Services for SHCN or high-risk enrollees. If any of the MCO's HEDIS rates for well-child care fall below designated levels, the MCO must implement a clinical PIP designed to increase the rates. The RSN's PIPs may address topics identified by DBHR for statewide improvement or identified by the RSN for local improvement.	6.2; *8.2.5*
For physical health care, each MCO must report HEDIS and non-HEDIS ***performance measures*** according to NCQA specifications. The contract specifies measures to be submitted each year. Each RSN must show improvement on a set of performance measures specified and calculated by DBHR. If the RSN does not meet DBHR-defined improvement targets on any measure, the RSN must submit a performance improvement plan.	6.3; *8.3*

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

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

CFR section	Description
438.100 Enrollee Rights ***(a) General rule*** 438.100(a) General rule 438.10(b) Basic rule 438.10(c)(3) Language – non-English 438.10(c)(4) and (5) Language – oral interpretation 438.10(d)(1)(i) Format, easily understood 438.10(d)(1)(ii) and (2) Format, alternative formats 438.10(f) General information 438.10(g) Specific information 438.10(h) Basic rule 438.100(b)(2)(iii) Specific rights 438.100(b)(2)(iv) and (v) Specific rights 438.100(b)(3) Specific rights 438.100(d) Compliance with other federal/state laws	Federal regulations include comprehensive language governing enrollee rights; Healthy Options contract requirements address advance directives, enrollee choice of primary care provider, access to specialty care for enrollees with special healthcare needs, prohibition on charging enrollees for covered services, and affirmation of provider/enrollee right to communicate freely regarding needs and services.
438.226 Enrollment and Disenrollment 438.226 and 438.56(b)(1) - (3) Disenrollment requested by the MCO, PIHP 438.56(c) Disenrollment requested by the enrollee 438.56(d) Procedures for disenrollment 438.56(d)(5) MCO grievance procedures 438.56(e) Timeframe for disenrollment determinations	Establish policies, procedures, and mechanisms to ensure appropriate process for disenrollment.
438.228 Grievance Systems 438.228 Grievance systems 438.402(a) The grievance system 438.402(b)(1) Filing requirements - Authority to file 438.402(b)(2) Filing requirements - Timing 438.402(b)(3) Filing requirements - Procedures 438.404(a) Notice of action - Language and format 438.404(b) Notice of action - Content of notice 438.404(c) Notice of action - Timing of notice 438.406(a) Handling of grievances and appeals - General requirements 438.406(b) Handling of grievances and appeals - Special requirements for appeals 438.408(a) Resolution and notification: Grievances and appeals - Basic rule 438.408(b) and (c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes 438.408 (d) and (e) Resolution and notification: Grievances and appeals- Format of notice and Content of notice of appeal resolution 438.408(f) Resolution and notification: Grievances and appeals-Requirements for State fair hearings 438.410 Expedited resolution of appeals 438.414 Information about the grievance system to providers and subcontractors 438.416 Recordkeeping and reporting requirements 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending 438.424 Effectuation of reversed appeal resolutions	Meet requirements regarding a defined grievance and appeal process for enrollees, including access to the state Fair Hearing system; policies, procedures, and standard notices to enrollees; acknowledgement of grievances and investigation and resolution of all relevant issues.

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

Appendix E. PIP Review Procedures

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

TEAMonitor PIP Review Steps

ACTIVITY 1: Assess the Study Methodology
Step 1. Review the Selected Study Topic(s)
1.1. Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services? 1.2. Did the PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? 1.3. Did the PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees such as those with special healthcare needs?
Step 2: Review the Study Question(s)
2.1. Was/were the study question(s) stated clearly in writing?
Step 3: Review Selected Study Indicator(s)
3.1. Did the study use objective, clearly defined, measurable indicators? 3.2. Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?
Step 4: Review the Identified Study Population
4.1. Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant? 4.2. If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?
Step 5: Review Sampling Methods
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? 5.2. Did the sample contain a sufficient number of enrollees? 5.3. Did the MCO employ valid sampling techniques that protected against bias?
Step 6: Review Data Collection Procedures
6.1. Did the study design clearly specify the data to be collected? 6.2. Did the study design clearly specify the sources of data? 6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? 6.4. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? 6.5. Did the study design prospectively specify a data analysis plan? 6.6. Were qualified staff and personnel used to collect the data?
Step 7: Assess Improvement Strategies
7.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?

Step 8: Review Data Analysis and Interpretation of Study Results

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

8.2. Did the MCO present numerical PIP results and findings accurately and clearly?

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

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

Step 9: Assess Whether Improvement Is "Real" Improvement

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

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

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

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

Step 10: Assess Sustained Improvement

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

ACTIVITY 2. Verify Study Findings (Optional)

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

ACTIVITY 3. Evaluate Overall Validity and Reliability of Study Results

Check one:

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

PIP scoring

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

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

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

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

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

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

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

Acumentra Health PIP Review Steps

Assessing the PIP methodology consists of the following 10 steps.

Step 1: Review the study topic
Step 2: Review the study question
Step 3: Review the selected study indicator(s)
Step 4: Review the identified study population and sampling methods
Step 5: Review the data collection procedures
Step 6: Assess the improvement strategy
Step 7: Review the data analysis and interpretation of study results
Step 8: Assess the likelihood that reported improvement is "real" improvement
Step 9: Assess whether the RSN has documented additional interventions or modifications
Step 10: Assess whether the RSN has sustained the documented improvement

Each step addresses the extent to which the PIP complies with a particular standard in the CMS protocol. The specific criteria for assessing compliance with each standard are listed on the following pages.

Step 1. Review the study topic

To meet Standard 1, the RSN needs to establish the importance of the study topic in general and present local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population; and demonstrate that a systematic selection and prioritization process was used in choosing the topic.

Please explain:

1.1 The importance of the study topic in general.

1.2 How the study topic is relevant to your local Medicaid population.

1.3 How you identified the study topic (e.g., quality committee, focus group, grievances, QAPI activities, other sources).

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

1.5 How the study topic relates to enrollee outcomes, satisfaction, or quality of care.

Step 2: Review the study question

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

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

Step 3: Review the selected study indicator(s)

To meet Standard 3, the RSN needs to define the measure (numerator) and study population (denominator); define key terms; and discuss the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care.

Please define the following elements for each study indicator:

3.1 The denominator (study population), and continuous enrollment criteria if applicable.

3.2 The numerator (what is being measured), including the event or enrollee characteristics that qualify for the numerator.

3.3 All relevant terms, CPT codes, diagnosis codes, etc., associated with the study indicator.

3.4 Describe why you selected the study indicator. Your description should include a discussion of:

   a. The validity of the study indicator (i.e., HEDIS, commonly accepted measures, research literature, etc.).

   b. How the indicator measures enrollee outcomes, satisfaction, or quality of care either directly or indirectly through a process which is closely related to enrollee outcomes or satisfaction.

Step 4: Review the identified study population and sampling methods

To meet Standard 4, the RSN needs to list all inclusion and exclusion criteria for the study population; document all data sources, including fields, codes, and calculations; and describe data validation procedures. If a sample is selected, the RSN needs to describe the sampling methods.

Describe your data sources.

4.1 List the inclusion criteria for the denominator (study population) and name each data element and its source, table, field, calculation (if applicable), and relevant codes.

4.2 List all exclusion criteria for the denominator (study population) and name each data element and its source, table, field, calculation (if applicable), and relevant codes. You do not need to list the inverse of the inclusion criteria as exclusions.

4.3 Describe data validation procedures for each data element.

4.4 If you used a sample, describe the sampling methodology and a justification for the sample size.

Step 5: Review the data collection procedures

To meet Standard 5, the RSN needs to list all inclusion and exclusion criteria for the numerator (what is being measured); document all data sources, including fields, codes, and calculations; describe data validation procedures; and present a clear data analysis plan, including time frames for the measurement and intervention periods, and an appropriate statistical test to measure differences between the baseline and remeasurement periods.

Describe your data sources.

5.1 List the study inclusion criteria for the numerator (what is being measured) and name each data element and its source, table, field, calculation (if applicable), and relevant codes.

5.2 List all exclusion criteria for the numerator (what is being measured) and name each data element and its source, table, field, calculation (if applicable), and relevant codes. You do not need to list the inverse of the inclusion criteria as exclusions.

5.3 Describe data validation procedures for each data element.

5.4 Document clear study measurement periods. The baseline period should end before the start date of the intervention. The first remeasurement period should not begin before the start date of the intervention. The intervention and remeasurement periods may run concurrently.

5.5 Document a data analysis plan that includes an appropriate statistical test, rationale for selecting the test, and a probability level. If you have more than one study indicator, you should document a separate data analysis plan for each indicator.

Step 6: Assess the improvement strategy

To meet Standard 6, the RSN needs to select an improvement strategy that will affect a wide range of enrollees or a high-risk enrollee population, and that is reasonably expected to result in measurable improvement. The RSN needs to discuss the basis for adopting the intervention; document the implementation, including dates and locations of principal activities; discuss cultural competence; and track how effectively the intervention was implemented.

6.1 Describe the intervention strategy. Once intervention activities begin, please provide updated details, including dates and locations.

6.2 Describe why you selected this particular intervention; for example, because it is based on barriers identified in your system or because it is an evidence-based practice. It should be clear how the intervention strategy is expected to improve the study indicators.

6.3 Describe how you will track the implementation of the intervention (i.e., how you will know whether all aspects of the intervention were implemented successfully). If the intervention has already been implemented, report on the results of your tracking.

6.4 Discuss how intervention services and materials are culturally and linguistically appropriate.

Step 7: Review the data analysis and interpretation of study results

To meet Standard 7, the RSN needs to present results according to the data analysis plan, including the study indicator, the original data used to compute the indicator, and a statistical test to measure differences between the baseline and remeasurement periods; and discuss how the intervention influenced the results.

7.1 Present raw data for the numerator and denominator, as well as the calculated study indicator for the baseline and first remeasurement periods.

7.2 Present the results of your statistical analysis comparing baseline data to the first remeasurement data. Report the probability level to determine whether or not there is a statistically significant difference.

7.3 Discuss how the intervention influenced the study results.

Step 8: Assess the likelihood that reported improvement is "real" improvement

To meet Standard 8, the RSN needs to assess whether any reported improvement is "real" by documenting that baseline and remeasurement data were collected using the same methods and are comparable; discuss the statistical and clinical significance of the study results; address barriers to improvement and lessons learned during the PIP process; and identify confounding factors that may have affected the results.

Discuss the following:

8.1 Whether the PIP resulted in real statistical and clinical improvement.

8.2 Any barriers to improvement or lessons learned during the PIP process.

8.3 Whether there were any changes in methodology or inconsistencies in measurement periods and, if so, whether measurement periods are comparable.

8.4 Any confounding factors that may have affected the PIP results.

Step 9: Assess whether the RSN has documented ongoing or additional interventions or modifications

To meet Standard 9, the RSN needs to document modifications to the intervention, or added interventions, planned or implemented after the first remeasurement period; and discuss changes in other aspects of the PIP based on lessons learned from data analysis or barrier analysis.

9.1 Discuss how you addressed the identified barriers and describe any other modifications you made to the PIP after the first remeasurement period.

Step 10: Assess whether the RSN has sustained the documented improvement

To meet Standard 10, the RSN needs to report complete study results for two or more measurement periods, including the study indicator, original data used to compute the indicator, and a statistical test of group differences; and interpret the statistical and clinical significance of the overall results, discuss lessons learned, and determine if goals were met and sustained improvement was achieved.

10.1 Present raw data for the numerator (what you are measuring) and denominator (study population), and the calculated study indicator for the baseline and the second remeasurement.

10.2 Present the results of a statistical analysis comparing baseline data to the second remeasurement data. Report the probability level to determine whether or not there is a statistically significant difference.

10.3 Interpret whether the PIP resulted in sustained statistical and clinical improvement over multiple remeasurement periods.

10.4 Draw a conclusion about whether the PIP was successful overall. Discuss lessons learned during the PIP process, whether you met your goals for this PIP overall, and the factors that contributed to whether the PIP achieved sustained improvement.

PIP scoring

Each compliance standard has a potential score of 100 points for full compliance, with lower scores for lower levels of compliance. The scores for each standard are weighted and combined to determine the overall PIP score, as shown in Table E-1.

Table E-1. Weighting of individual standard scores in overall PIP score.

Standard	Scoring weight
Demonstrable Improvement	
1 Selected study topic is relevant and prioritized	20%
2 Study question is clearly defined	10%
3 Study indicator is objective and measurable	10%
4 Study population is clearly defined and, if sample is used, appropriate methodology is used	10%
5 Data collection process ensures that data are valid and reliable	10%
6 Improvement strategy is designed to change performance based on the quality indicator	10%
7 Data are analyzed and results interpreted according to generally accepted methods	10%
8 Reported improvement represents “real” change	10%
Demonstrable Improvement Score	**90%**
Sustained Improvement	
9 RSN has documented additional or ongoing interventions or modifications	5%
10 RSN has sustained the documented improvement	5%
Sustained Improvement Score	**10%**
Overall PIP Score	**100%**

The overall score is weighted 90% for demonstrable improvement in the first year (Standards 1–8) and 10% for sustained improvement in later years (Standards 9–10). Thus, for a PIP that has completed one remeasurement, the maximum overall score is 90 points (90% x 100 points for full compliance). If the PIP has progressed to a second remeasurement, enabling reviewers to assess sustained improvement, the maximum score is 100 points.

Table E-2 on the following page shows a scoring calculation for a PIP with both demonstrable and sustained improvement.

Table E-2. Example scoring worksheet.

Standard	Compliance rating	Assigned points	Weight	Points score
Demonstrable Improvement				
1	Fully met	100	20%	20.0
2	Fully met	100	10%	10.0
3	Partially met	50	10%	5.0
4	Partially met	50	10%	5.0
5	Fully met	100	10%	10.0
6	Minimally met	25	10%	2.5
7	Partially met	50	10%	5.0
8	Partially met	50	10%	5.0
			Demonstrable Improvement Score	**62.5**
Sustained Improvement				
9	Substantially met	80	5%	4.0
10	Partially met	50	5%	2.5
			Sustained Improvement Score	**6.5**
			Overall PIP Score	**69.0**

If graded on the 90-point scale (i.e., before a second remeasurement), this PIP would earn an overall rating of Substantially Met. If graded on the 100-point scale (following a second remeasurement), the PIP would earn the same overall rating.