State of Washington

Department of Social and Health Services
Mental Health Division

2006 External Quality Review Statewide Technical Report for Prepaid Inpatient Health Plans

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I. EXECUTIVE SUMMARY

BACKGROUND

This report presents the third-year findings of an external quality review of the mental health prepaid inpatient health plans (PIHPs) serving the Medicaid population in the state of Washington. The review was conducted by a division of APS Healthcare (APS): the Washington External Quality Review Organization (WAEQRO), under contract with the State of Washington Mental Health Division (MHD).

The WAEQRO reviewed thirteen PIHPs in 2006-2007, a decrease of one, the result of a State request for qualifications/request for proposals (RFQ/RFP). At the conclusion of this process, North Central Regional Support Network (NCRSN) absorbed the population and providers formerly constituting Northeast RSN (NEWRSN). Most of the information in this report reflects the larger NCRSN entity. To provide the most current information to MHD and the Center for Medicare and Medicaid Services (CMS), the review period for each PIHP covered the year immediately preceding their document submission date – about six weeks prior to each site visit. Activities occurring between the end of the last review period and the beginning of this were considered in this year's review.

Purpose of the 2006 Review

The WAEQRO has conducted its annual reviews within a framework of continuous quality improvement. Thus, for those areas previously reviewed, the 2006 review was designed to focus on the extent to which the PIHPs had achieved improvement in review elements defined as not meeting minimum standards in 2005, or for which a baseline had been previously established. In addition, MHD requested intensified review for part of one CMS-required activity and a change in focus for one optional activity.

The 2006 review was designed to:

- Review and measure improvement in operational and clinical practices, defined in Balanced Budget Act (BBA) Standards, that in 2005 continued to be scored below minimal acceptable levels;
- Evaluate the status of performance improvement projects (PIPs) without applying a formal scoring system;
- Validate performance measure calculations specified by the State.

New or re-designed reviews included:

- Evaluation of PIHP encounter validation activities, using CMS protocols as a guide; and an

- In-depth review of PIHP Quality Assurance and Improvement plans and activities, with particular focus on clinical oversight and incorporation of grievance and appeal information into the quality management program.

PROCESS

For each of the 13 PIHPs, APS completed a Subpart Review, Performance Improvement Project review, Performance Measure/System update review, an Encounter Validation process review, and a Quality Assurance and Improvement review. Upon completion of the review and feedback process, a report was provided to each PIHP and the Mental Health Division. In conducting the reviews, APS followed guidelines set forth in the CMS protocols for each review activity, with some modifications defined by the Mental Health Division. The methods for data collection, review, scoring, and analysis were the same for all PIHPs.

In addition to the PIHP reviews, APS evaluated the State's performance measure calculation methodology and related code as well as their data management system, to assess confidence in the data used to calculate performance measures.

The 2006 review was conducted in two phases: an initial desk review of policies, procedures, and other supporting documentation provided by the PIHPs, followed by site visits to all PIHPs and two network providers contracted with each. Samples of all relevant communication materials are included in the attachments to this report.

APS Healthcare staff and consultants participating in the 2006 review and report development included:

- Harriet Markell, MA: Washington External Quality Review Executive Director
- Brad Babayan: Systems Analyst
- Marty Driggs, MA, LMHC: Administrative/Clinical Reviewer
- Irene Finley, MA: Administrative/Clinical Reviewer
- Joanne Jerabek, Office Manager/Report Production
- James Andrianos, MBA: Data Analysis Consultant
- Stephan Magcosta: Editor

RESULTS

This report provides results from the five review activities conducted by the WAEQRO for each of the 13 PIHPs in the state of Washington. Data is analyzed for all PIHPs, providing individual PIHP and statewide results. Included at the end of the report are recommended improvements related to PIHP operations and quality of services provided to Medicaid enrollees, some of which relate directly to federal and state regulations and requirements and others which would generally support the PIHPs and/or the State in meeting those requirements. Detailed information can be found in the full Statewide report following this Executive Summary and in reports compiled for each PIHP, which are included here as attachments.

Evaluation and scoring methodologies vary across review topics and were developed by APS in

consultation with MHD. Of note in the Subparts and Encounter Validation is the use of enrollment-weighted scores or averages. "Simple", PIHP-specific scores/averages reflect the performance of each PIHP and are useful for comparisons of PIHPs one to another. Enrollment-weighted scores, by contrast, provide a picture of the experience of the "average" consumer as they access and receive services, i.e., the quality of care and services a given consumer is likely to experience or the quality of the related data. For example, about 20% of consumers state-wide reside in King County; therefore, King's performance impacts a much greater number of consumers (and their data) than does that of Gray's Harbor, the smallest PIHP in the state. Because the intent of the external quality review is the ongoing improvement in services and care provided to consumers, it is important to understand the implications of these results as they affect consumers state-wide and the quality of data state-wide that informs financial, operational, and quality indicators.

Subparts

The WAEQRO reviewed BBA standards using a tool and set of scoring guidelines developed by MHD. Throughout the scoring and analysis, the concept of an "Expected" performance recurs. This standard of Expected, a score of 3 on a 0-5 scale, was established as an initial performance goal in 2004 for all BBA standards and, as such, became the basis for determining which Subpart review items would be re-scored in 2005 and 2006. MHD requested that the Subpart review focus on those elements that continued to reflect scores below Expected (score 3).

System-wide, performance of PIHPs in 2006 improved by approximately 20% over 2005. All 13 PIHPs evidence attention paid to External Quality Review results and State-requested corrective actions of prior review years. Attaining minimum Expected performance requires that policies and procedures consistently meet BBA and State requirements. Performance above the minimum expected signifies effective dissemination, training, and implementation of those P&Ps. Progress being made toward outstanding performance continuously improves the provision of clinical care in a manner that supports consumer rights and consumer-driven service delivery.

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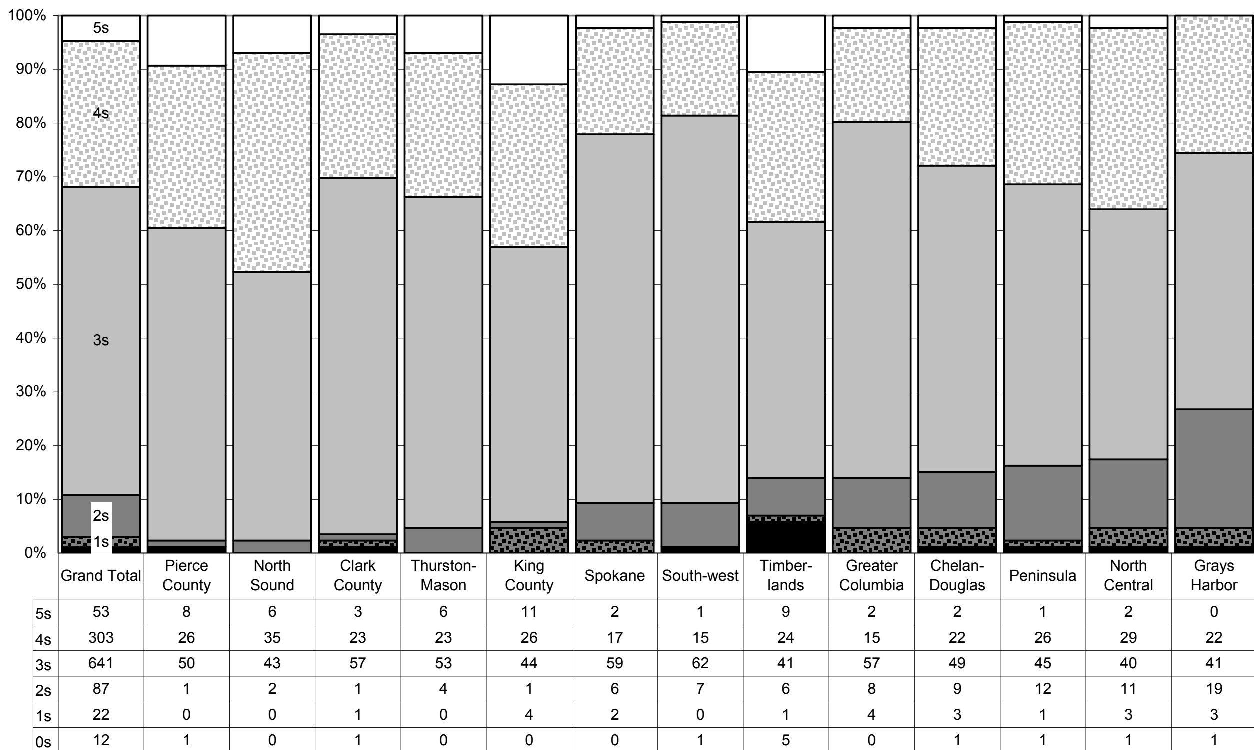
Presented here is a graphical review of Subpart results and measures of improvement for all 13 PIHPs. To provide a comprehensive set of scores, the 2006 Subpart results include a roll-up of 2004 and 2005 scores at Expected or higher and 2006 scores for all remaining items.

ES Figure 1

All Subpart Scores
2006 Distribution by PIHP

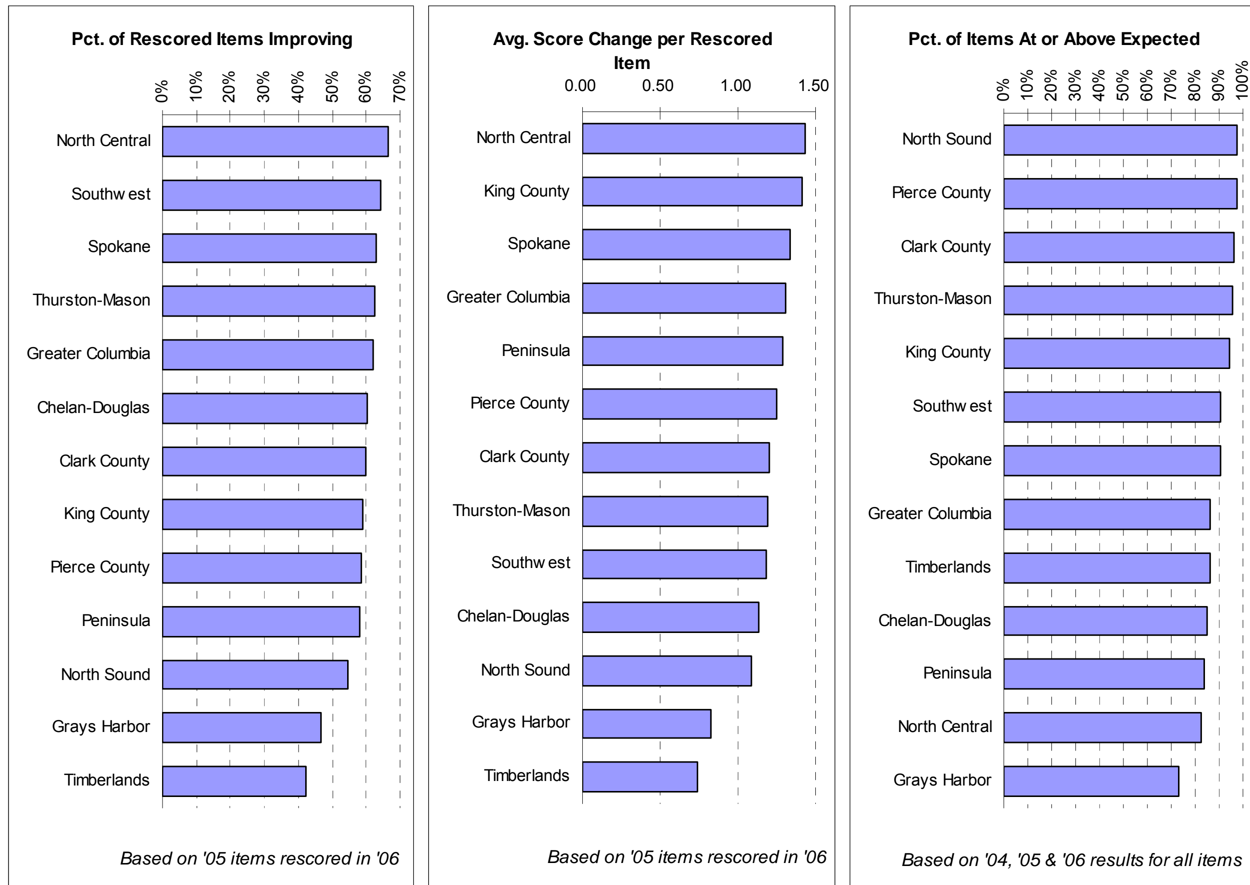


	Grand Total	Pierce County	North Sound	Clark County	Thurston-Mason	King County	Spokane	South-west	Timber-lands	Greater Columbia	Chelan-Douglas	Peninsula	North Central	Grays Harbor
5s	53	8	6	3	6	11	2	1	9	2	2	1	2	0
4s	303	26	35	23	23	26	17	15	24	15	22	26	29	22
3s	641	50	43	57	53	44	59	62	41	57	49	45	40	41
2s	87	1	2	1	4	1	6	7	6	8	9	12	11	19
1s	22	0	0	1	0	4	2	0	1	4	3	1	3	3
0s	12	1	0	1	0	0	0	1	5	0	1	1	1	1

* Data reflects combined NEWRSN and NCRSN

Close to 90% of 2006 scores on all Subparts statewide were at or above the Expected level of performance, compared to 70% in 2005. Over half of the PIHPs (7 of 13) achieved that performance or better. Also noteworthy, scores of 0 and 1 decreased to .03% of total scores in 2006, from 12% of total scores in 2005.

ES Figure 2: Measures of Improvement



* Data reflects combined NEWRSN and NCRSN

The first chart recognizes the most improved PIHPs. Top ranking goes to the PIHP showing the greatest percentage of rescored elements with higher scores in 2006 than in 2005. In order to facilitate comparison, the calculation used in this ranking method equalizes the actual number of rescored elements for all PIHPs. For example a PIHP that had 8 elements rescored has the same opportunity to rank as high as or higher than a PIHP with 35 elements rescored.

The second chart displays the average score increase for each PIHP, based on all elements that were rescored in 2006. PIHPs are ranked by average increase in scores, from greatest to least. Average PIHP improvement is calculated by summing the total amount of movement between points on the scoring scale from 2005 to 2006, and dividing that result by the number of rescored items accounting for that change. Note that this ranking method also equalizes the number of rescored elements for all PIHPs.

The third chart recognizes PIHPs with the best overall performance at the end of the 2006 review year. Overall performance is defined as the greatest percentage of scores at or above the Expected performance level (3, 4, or 5) on all elements.

Quality Assurance and Improvement

As an optional activity for 2006, MHD contracted with WAEQRO to conduct an expanded review of the PIHPs' Quality Assurance and Improvement (QAI) processes, focusing specifically on scope and usefulness of the Quality Management Plan, and on effectiveness of PIHP oversight with respect to the quality of clinical care. This year's review is intended to establish a baseline for each PIHP, including provision of specific information and recommendations to support ongoing enhancements of their system and processes.

The WAEQRO and MHD developed a review tool to assess performance in four areas of contractually-defined, quality assurance and improvement activities. (see **Attachment B: Communications**) A completed review tool, including a summary and recommendations, were included in the individual PIHP reports.

Four global performance standards included multiple contributory elements (17 total). Highlights of findings for each standard follow.

Standard 1 – QAI Plan: the degree to which it addresses all elements of a complete and effective QAI process

- Overall, more than half the QAI Plans contain most elements of a comprehensive plan, which are implemented sufficiently to consider the QAI Plan as shaping the quality management system. Consistent implementation of the plans varies widely across PIHPs.
- A significant strength of this element is the degree to which providers and consumers are integrated into the quality improvement system.
- Performance indicators vary widely in the degree to which they are defined (including measurement methods), the specification of desired targets, schedule and venues for reporting, assignment of responsibility, and thresholds for taking action.

Standard 2 – Evaluates and Ensures Improvement: sufficiency, accuracy, and reliability of clinical chart review tool to measure performance as well as the consistency of the review process

- Most PIHPs use some version of the chart review tool employed by MHD licensing staff, and most have some type of reviewer interpretive guide (criteria for applying scores).
- Most PIHPs do not, however, have formal methods and/or documentation to ensure inter-rater reliability across reviews and reviewers.
- With some notable exceptions, chart review scoring methods are generally insufficient to identify agency and system outliers and trends; scoring and analysis methodology documentation is sparse or non-existent.

Standard 3 – Review Results Acted Upon: the degree to which results were data-driven, analyzed, and communicated

- Provider-specific and system-wide data analysis is significantly missing from all but a

few PIHPs. Methods of data collection and reporting are not well supported by documentation.

- As evidenced by the frequency and quality of reports, content of meeting minutes, and provider and PIHP assertions, communication and discussion of results of oversight activities was inconsistent across the state, particularly related to identifying and analyzing aggregated and trended data.

Standard 4 – Grievance, Appeals, and Fair Hearings: the degree to which the complaint and grievance process was effectively incorporated into the QAI system

- Knowledge of requirements and facilitation of consumer access to the complaints and grievance system is a significant strength across the PIHP system. This score is enhanced in almost all cases by the quality of Ombuds participation.
- Few PIHPs document evidence of incorporating grievance and appeal data into quality oversight and improvement activities.
- Few PIHPs have systematic procedures for tracking compliance with requirements for managing complaints, grievances, and fair hearings.

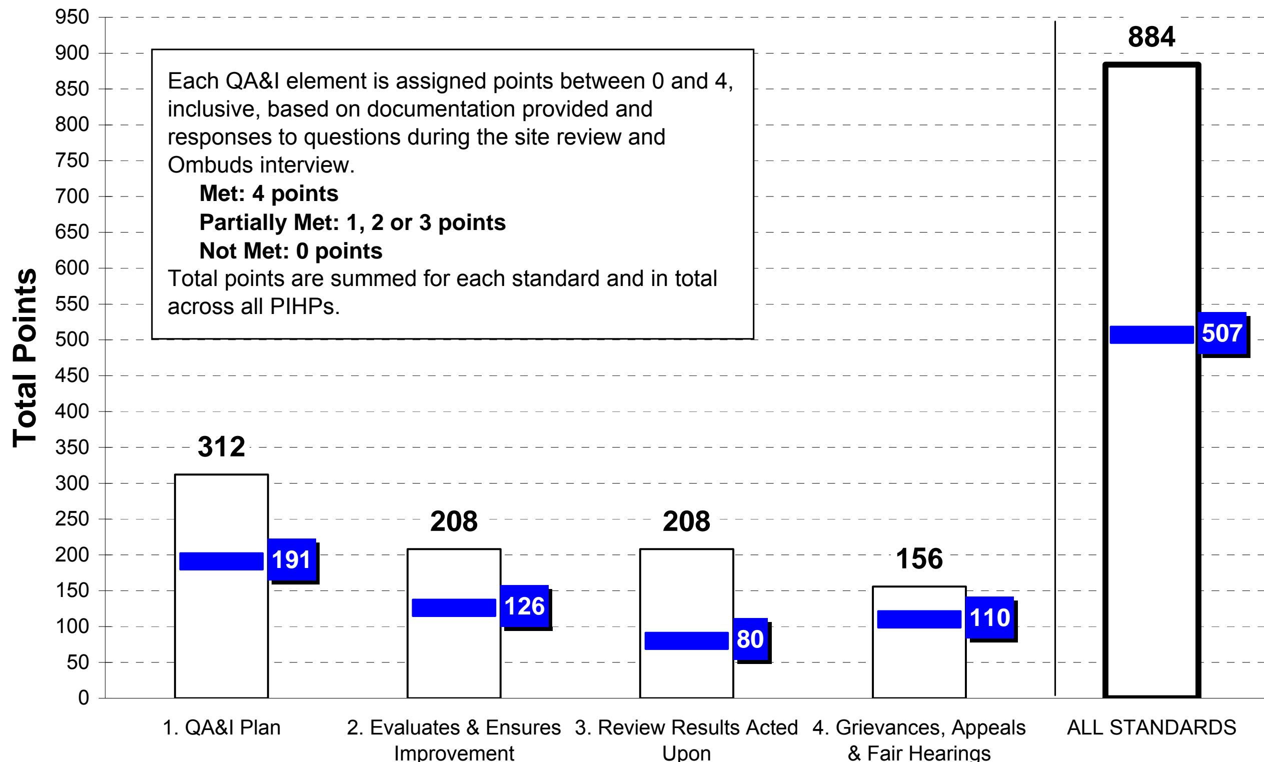
Scoring

Each of the seventeen elements in the tool (see **Attachment B: Communications)** was scored on a 5-point scale: zero to four, and designations of Met, Partially Met, and Not Met were assigned to the numerical values. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully Met; and Not Met indicates that the element is not present, or is very inconsistent or incomplete.

Each standard was scored by total points attained and number of Met/Partial/Not Met items for each. Overall scores were calculated by dividing total number of points achieved by the total number possible. Scores greater than 80% are considered an overall Met score; 65% to 79% is Partially Met, and those below 65% are considered overall as Not Met. In addition, the number of Met items was compared to the total possible, the ultimate goal being the achievement of all elements as Met.

The chart below displays the cumulative points achieved by all PIHPs on each standard, providing a system-wide view of performance on those QAI activities reviewed for 2006.

ES Figure 3



The bars in the chart above represent the four standards of the QAI tool, with the maximum number of points possible indicated above each bar. The heavy line represents the cumulative points achieved by all PIHPs combined on each standard and overall.

Overall, slightly more than half of all points possible were achieved. Of the four standards, the most points achieved were for Standard 4, Grievance and Appeal system, 110/156 (70.5%). This was followed by the QAI Plan with 191/312 (61.2%). The total points achieved for the chart review tool was 126 of a possible 208 (60.5%). The least number of cumulative points were achieved in the standard measuring use of data for quality improvement activity, with only 80 of a total possible 208 points achieved (38.4%). These results indicate that the system-wide strength is in effective support of the grievance and appeal process, and the greatest opportunity for improvement lies in an improvement in PIHP capacity to consistently review and analyze data for quality assurance and improvement purposes.

Performance Improvement Projects

Complete review of PIPs, according to CMS protocol, entails three sets of activities: 1) assessment of methodology for conducting the PIP, 2) verification of results, and 3) evaluation of overall validity and reliability of study results. Because the PIHPs in Washington State have been unfamiliar with the protocols for conducting PIPs, no PIHPs have completed a PIP, and most do not have fully developed plans and methodologies. Therefore, WAEQRO review has focused on assessment of methodology, intending to provide technical assistance and an informal assessment of reliability and validity of the methodology for informational purposes. While t he WAEQRO review tool and process reflect the CMS evaluation protocol, formal, or "official" scoring has been deferred.

The WAEQRO reviewed in detail one of two PIPs submitted by each PIHP. When possible, the CMS validation tool was used to assess methodology and provide feedback on previously developed (or new) PIPs. Ratings of Met, Partially Met, Not Met, and N/A were applied to each step in the PIP methodology process, reflecting the extent to which they approached the level of soundness required for a reliable and valid PIP. The tool was enhanced for 2006 by adding highlights of those activities for each step which are "critical" for producing valid, reliable results, and for demonstrating confidence in the PIP findings. A summary of findings was provided at the end of the validation tool, along with an overall, Met/Partially Met/Not Met, summarizing the quality of the entire methodology. Where they could be helpful, comments and suggestions were included in each step and in the summary. Final PIHP reports included completed validation tools and/or a performance summary with recommendations for improvement based on the current status of PIP activity.

All PIHPs were under contractual obligation to have two PIPs in process, one clinical and one non-clinical, either of their own choosing or continuing a state-defined topic from 2004 or 2005. The WAEQRO expected that PIP quality would improve in 2006 based on site visit discussions in 2005, and as PIHPs were able to make use of MHD-sponsored training in September 2006 and February 2007. While PIHPs whose review years ended before the training were at some disadvantage relative to those whose review years encompassed the training, results indicate that some PIHPs made significant progress without the training, and others did not appear to make any progress despite having several months post-training to revise their PIP plans.

The table below provides an overview of methodology review results for all PIHPs.

2006 Results

ES Figure 4: 2006 PIP Methodology Assessment

PIHP	Plan Assessed *	Overall Performance
Pierce County	X	Met
King County	X	Met
Southwest	X	Not met
Chelan-Douglas	X	Not met
Thurston-Mason	X	Not met
Clark County	X	Partial
Timberlands	X	Partial
North Sound	X	Partial
Greater Columbia		
Peninsula		
North Central		
Spokane County		
Grays Harbor		

*** Validation Tool used**

Met = high confidence in methodology
Paritally Met = low confidence in methodology
Not Met = methodology unreliable

* Data reflects combined NEWRSN and NCRSN

With few notable exceptions, PIPs in 2006 had not progressed appreciably over 2005. Many PIHPs did little more than create a document to submit for APS review, which included meeting minutes indicating that the subject was mentioned, irrespective of context. Anticipation of a State-defined PIP and/or the training was most often cited as the reason for lack of activity. In sharp contrast were those PIHPs (all Met and Partial) that had carefully applied the CMS protocols to new study topics, or had refined existing studies to reflect increased understanding of the PIP process.

Improvements over 2005 by those PIHPs achieving Met and Partially Met performance included the following:

1. Structure of study questions to incorporate impact of an intervention on baseline data;
2. Definition of study indicators that allow for the question to be answered or proven, and established numerators and denominators;
3. Detailed and appropriate data analysis plans; and
4. Selection and detailed description of planned interventions, based on discussions about possible barriers to achieving desired results.

Performance Measurement

As part of the performance measure validation process, the WAEQRO examines the PIHPs and the State to gain perspective on the reliability of results published by the State. Accuracy of data submitted by the PIHPs is assessed through the Encounter Validation Review activity. Validation of MHD calculation methodologies and procedures and procedures consists of interviews with key MHD personnel and reviews of their calculation and measurement processes. Specific topics related to data system capabilities and data submission were discussed at the site visit with PIHP Information Technology (IT) staff as a follow-up to the 2005 report.

In the state of Washington, Performance Measures are State-defined. The 2006 measures evaluated by the WAEQRO are:

- **Crisis Only Utilization Rates** – for Medicaid Population;
- **Expenditures per Consumer** – for Community Outpatient Services; and
- **Outpatient Employment Change Over Time** – Working Age Adults (18-64 yrs)**.**

PIHPs are responsible for submitting timely, accurate, and complete data that drives the performance measures. During the 2006 review period, PIHPs engaged in their own encounter validations. Results varied, but positive steps in continuous quality improvement are taking place system-wide. This progress and momentum has had a positive effect on improving the timeliness, accuracy, and completeness of data used for performance measure calculation.

Validation Results

Crisis Only Utilization Rates – for Medicaid Population
Finding: Valid
Significant progress has been made in the overall system controls used to ensure data accuracy and completeness. The PIHPs implemented audits similar to those used by WAEQRO in the 2005 Encounter Validation. These efforts have yielded positive results. The more such reviews are conducted, the more accurate the State's data.

Expenditures per Consumer – for Community Outpatient Services
Finding: Valid
Again, overall system control improvements have had a positive impact on accuracy of the data used to generate the denominator for this measure. The numerator is derived from the fiscal side of MHD's operations. The fiscal controls used in state government follow GAAP (generally accepted accounting principles), the gold standard for the accounting world. The employment of GAAP controls and methods combined with yearly audits from State's Auditor help to ensure validity of the numbers used in the numerator.

Outpatient Employment Change Over Time – Working Age Adults (18-64 yrs)
Finding: Questionable
The employment change measure appears reliable on its face, in that re-measurement tends to produce similar results. Whether it is valid remains an open question; i.e., whether it actually

measures employment status changes. This uncertainty relates to the exact "counting rules" used in constructing the measure. For example, for clients with two employment status readings, it is clear that the cohorts to which they are assigned depend entirely on these two readings. However, for clients with 3 or more employment status readings, it is not clear how intervening readings are handled.

The Performance Indicator Calculation System

During the 2005 review period, the Mental Health Division contracted with an external entity, Looking Glass Analytics (LGAN), for calculation and web publication of their performance measures. A new system has been implemented during the 2006 review period, which includes many desirable enhancements that increase the reliability and validity of the performance measures. Improvements include:

- Many of the processes used to generate the measures have been automated, which reduces the chance for error.
- The code has been re-written and appropriately documented.
- The original code used for extracting data has been redesigned and streamlined, and the code has been enhanced by in-line documentation.
- The contracted entity has a disaster recovery system that protects this data and related code.
- As a function of process redesign, data files created from encounter data and summarized into analysis files used in the production of the performance measures are kept until the monthly update of the performance data. In addition, the process used to summarize encounter data is documented. While not creating a frozen data set, this system keeps the data secure and allows for increasingly more accurate results. However, data re-evaluation at another time is limited, due to its dynamic nature, and third party use of the data for independent calculation and verification is unlikely.

Encounter Validation

In 2006, MHD requested that the WAEQRO review encounter validations conducted by the PIHPs during the review period, a request reflecting focus on continuous improvement in the quality of reported data. The evaluation was designed to determine compliance with requirements specified in the contract between the State of Washington and the PIHPs, and to evaluate the full process used to conduct the encounter validations.

The Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to a PIHP's particular environment. APS reviewed the following elements/activities related to PIHP conduct of an encounter validation:

- PIHPs contract with the State and with their providers – language and requirements related to data management;
- PIHP efforts to evaluate the capability of their providers to produce timely, accurate, and

complete encounter data;

- PIHP efforts to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness;
- PIHP documentation of encounter/matching exercise (data/medical record comparison)
- PIHP submission of findings to the State; and
- PIHP documentation of follow-up activities.

A total of 14 elements were assessed as Met, Partially Met, Not Met, and NA.

PIHP EV Compliance

The review tool includes a subset of activities required by PIHPs to meet state contract terms (referred to as "compliance"). The specific contract requirements include:

1. Analysis of data for accuracy and completeness;
2. A review of 1% of all encounters or 250 encounters, whichever is less during the first 6 months of the Agreement period, verifying that the service reported actually occurred; and
3. A report submitted to MHD 30 days prior to the end of the Agreement.

To receive an overall Met on the compliance part of the review, PIHP review of records and submission of findings both need to be Met (items 2 and 3, above), with a minimum of Partially Met required for the analysis of the data (item 1, above).

Only one PIHP received an overall Met for their encounter validation efforts in the compliance portion of the review; seven received Partially Met, and five were rated Not Met. While specific contract requirements were minimally met by all but one PIHP, the review process encompassed more detail than the steps outlined in the contract. The tool required the process to be adequately documented and, in many cases, it was not. The tool evaluated the type of analysis conducted on the data, which, if conducted at all, was not the type of review that would meet the CMS definition for an encounter validation. Finally, every PIHP submitted an EV activities report to the MHD; however, the included information and conclusions (when drawn) did not adequately describe processes and results obtained from employing them.

EV Process Review

The EV Review tool was designed to evaluate in detail the necessary procedures (based on CMS protocol) related to validating encounters. The procedures evaluated include:

- Adequately documented and communicated data requirements and completeness standards;
- Assessment of PIHP provider network capability to collect, secure, and transmit accurate and completed data in a timely fashion;
- Development of tools to analyze data under review for accuracy and completeness, including freezing data for future use;

- Thorough documentation of the EV process;
- Routine check of additional data elements;
- Effective reporting to MHD and other stakeholders; and
- Reliable and effective follow-up on identified improvement needs.

The following summarizes the results of the encounter validation process review.

ES Figure 5

2006 PIHP EV Review Results		
	Average	
King County	1.86	Met
Clark County	1.46	Partially Met
Greater Columbia	1.29	Partially Met
Pierce County	1.14	Partially Met
Spokane County	1.08	Partially Met
Peninsula	1.00	Partially Met
Thurston-Mason	1.00	Partially Met
North Sound	0.77	Not Met
Southwest	0.77	Not Met
Chelan-Douglas	0.54	Not Met
Timberlands	0.50	Not Met
North Central	0.46	Not Met
Grays Harbor	0.43	Not Met

Score Range:
Greater then 1.7 = Met
Between .08 and 1.7 = Partially Met
Less than .08 = Not Met

* Data reflects combined NEWRSN and NCRSN

ES Figure 5 reflects the performance of each PIHP on each activity and calculates an overall average for the PIHP. On the full tool, counting all PIHPs at Met and those above the mid range of Partially Met (1.25), it is evident that 3 out of 13 PIHPs are conducting encounter validations in a reasonable manner, albeit with some opportunities for improvement. Ten PIHPs are performing at a level requiring significantly more effort to achieve an adequate encounter validation.

ES Figure 6

Item	2006 Enrollment-Weighted Statewide EV Review Results	Average	
1a	PIHP documents data requirements	1.4	Partially Met
1b	PIHP communicates data requirements	1.8	Met
2a	Network Capability	0.9	Partially Met
3a	Data analysis	0.9	Partially Met
3b	Data analysis tools	0.8	Partially Met
3c	Data is frozen	0.0	Not Met
4a	Review of medical records (EV process)	1.5	Partially Met
4b	Includes additional data elements	1.0	Partially Met
4c	Adequate tools for EV process	1.1	Partially Met
5a	EV Report to State	1.5	Partially Met
5b	Reports to provider agencies	1.5	Partially Met
5c	Reports internally for QI activities	1.4	Partially Met
6a	PIHP documents corrective action process	1.1	Partially Met
6b	Evidence of follow-up activites	1.9	Met

The chart above provides the Medicaid enrollee-weighted average for all encounter validation activities across the system, and by inference, reflects confidence in the handling of each consumer's data. These weighted averages provide a mechanism for evaluating scrutiny applied to the State data set as a whole and are somewhat higher than the simple averages (displayed in full report), owing to the influence of King County's size and performance. Because King County serves the largest number of consumers (about 20% of the total) and has the largest data set in the state, the influence of its scores is greater than that of any other PIHP individually. It therefore follows that 1) more of the data statewide receives better scrutiny than would be implied looking only at the simple averages, and 2) confidence in the typical consumer's data statewide (as a result of this scrutiny) is commensurately increased.

Averaging all weighted totals for each review item yielded a 1.2 overall statewide rating on EV activities, demonstrating that, on a weighted basis, the quality of the EV reviews was just above Partially Met. Based on these results, confidence in data quality across the state lies just above "fair" (using the terms "fair" and "good" as general measures, with "poor" being the worst, i.e., low confidence in the data, "fair" reflecting mid-level confidence, and "good" reflecting high confidence).

Based on three years of data quality review results, it is evident that processes undertaken by the PIHPs have become progressively more refined and effective with respect to increasing accountability, error follow-up, and the screening of data prior to submission to MHD. Discussions at site visits revealed that PIHPs continue to identify and address opportunities for improving the quality of their data.

2006 RECOMMENDATIONS

Recommendations here are based on those most frequently included in individual PIHP reports, thereby reflecting improvements that would be beneficial system-wide. Again, while some reflect required improvements relative to the BBA, others are suggestions for general strengthening of operations and/or service delivery. Consistent in almost all reports was an emphasis on the importance of enhancing data reporting and analysis capabilities. With few exceptions, PIHPs struggle to devise meaningful reports and to maintain a consistent reporting process and schedule. Accordingly, site visit discussions emphasized the importance of maintaining focus and ensuring attention to those issues most critical to PIHP operation and the consumer service delivery system.

Subparts

1. PIHP procedures relative to detecting internal fraud and abuse remain underdeveloped. Recommend that PIHPs review their policy and procedures and implement necessary changes to ensure adequate oversight of associated risks.
2. Access to care and exercise of client rights are key aspects of a consumer-oriented service system. PIHPs (and consumers) would benefit from clearly defined and consistently implemented procedures with respect to tracking and monitoring initial requests for service, intake, authorizations, denials, and grievance system junctures.
3. Most PIHPs would benefit from developing procedures to officially adopt and approve new and revised policies and procedures, including a method for ensuring documentation of such approvals.

Quality Assurance and Performance Improvement

1. Many PIHPs would benefit from more consistent application of their quality improvement plans and processes. Fidelity to meeting and reporting schedules, follow-up on issues raised in quality oversight forums, and ensuring meaningful participation of all stakeholders are important to ensuring a well-functioning QAI system.
2. As the performance evaluation and improvement roadmap, matrices of indicators would be enhanced by the addition of detailed definitions, methods of measurement, targets for achievement, thresholds for considering/taking action, and reporting responsibilities and schedules.
3. Most PIHPs would benefit from improving the clinical chart review scoring methodology to support a more useful analysis of individual provider and network performance over time. Identifying strengths and improvement opportunities at both levels, as well as observing performance changes over time, help the PIHP more specifically identify the appropriate level and types of interventions required and evaluate the results of those interventions.

Performance Improvement Projects

1. The WAEQRO recommends that, by formal contract and meetings with PIHPs, MHD clarify expectations related to the number and type of PIPs required.
2. PIP design and implementation would benefit from PIHPs assigning appropriate staff

and/or committees to analyze existing data and develop study topics and methodology. A mechanism to ensure dedicated focus on ongoing implementation, including routine reporting responsibility, would improve reliability and usefulness of improvement projects.

3. The entire system would benefit from ongoing technical assistance related to PIP development, including cross-PIHP sharing of resources and knowledge.

Performance Measures

1. WAEQRO continues to stress the need for reproducible performance measure calculations. To enable this functionality, processes and procedures must be sufficiently documented so as to allow another entity to successfully reproduce results without guidance.
2. Those PIHPs not calculating and using member months should begin doing so. The WAEQRO continues to recommend the use of member month calculations, as the level of granularity available by calculating member months facilitates comparison among PIHPs and between the State and other entities.

Encounter Validation

1. Most PIHPs have not developed, documented, and communicated data completeness standards; doing so would greatly increase their confidence in the reliability of network provider data.
2. Develop tools and begin assessing network provider capabilities.
3. Freeze and analyze data under review.
4. Develop methods for incorporating other data elements in the review process. The ultimate goal is to have a level of scrutiny for all data collected.
5. Ensure that reports to the state, providers, and for internal use have adequate information appropriate to the intended audience.
6. PIHPs would benefit from training related to the entire EV process or, at a minimum, assessing network capability, data analysis, sampling procedures, and effective reporting.
7. The WAEQRO recommends that the State continue a phased-in approach to implementing PIHP encounter validation requirements until consistent and comprehensive processes are in place state-wide.

II. INTRODUCTION

The state of Washington's Mental Health Division (MHD) is charged with responsibility to arrange for an external evaluation of the quality of specialty mental health services, pursuant to requirements of the Code of Federal Regulations, Title 42 (42 CFR), provided to beneficiaries enrolled in the Medicaid-managed mental health care program. This report presents the third-year findings of an external quality review conducted by a division of APS Healthcare: the Washington External Quality Review Organization (WAEQRO), under contract with MHD.

The WAEQRO reviewed thirteen Prepaid Inpatient Health Plans (PIHPs) in 2006-2007, a decrease of one, the result of a statewide RFQ/RFP. At the conclusion of this process, North Central Regional Support Network (NCRSN) absorbed the population and providers formerly constituting Northeast RSN (NEWRSN). Most of the information in this report reflects the larger NCRSN entity. To provide the most current information to MHD and the Centers for Medicare and Medicaid Services (CMS), the review period for each PIHP covered the year immediately preceding their document submission date – about six weeks prior to each site visit. Activities occurring between the end of the last review period and the beginning of this were considered in this year's review.

BACKGROUND

State of Washington Mental Health System

The Mental Health Division in the state of Washington is part of the Health and Recovery Service Administration (HRSA) of the Department of Social and Health Services (DSHS). The Division is responsible for ensuring the provision of clinically necessary mental health and mental health-related services to all Medicaid enrollees, as well as providing a set of emergency and priority services to all state citizens.

The Mental Health Division began delivering outpatient mental health services under a 1915(b) waiver in 1993. The capitated, managed mental health system gave the county or multi-county based Regional Support Networks (RSNs) the ability to design an integrated system of care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing high quality, required mental health services. Services covered under the waiver included the full range of community mental health rehabilitation services offered under the Medicaid State Plan. In 1997, an amendment to the existing waiver was approved which incorporated into the capitated RSN contracts community psychiatric inpatient services for Medicaid-eligible adults, older persons, and children. The entities within the RSNs responsible for the managed care portion of the mental health delivery system are now called PIHPs.

Each RSN is responsible for ensuring that all Medicaid-eligible persons in their service area receive needed mental health care. In addition, each must make emergency services available to all citizens.

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Demographics

The state of Washington is varied geographically, economically, and ethnically. According to the Office of Fiscal Management, the 2006 state census is estimated to be 6,375,600. The highest percentage of the state's population resides on the west side of the Cascade mountain range, which spans the entire length of the state, creating a one third/two thirds divide. The most heavily populated urban center is greater Seattle. Most of the remaining urban population resides in smaller cities along the I-5 corridor from Vancouver, near the Oregon state line, north to the Seattle city limits. One exception is Spokane, which is east of the mountains and boasts a population of about 500,000.

Medicaid enrollment and numbers served by the mental health system in FY 2006 are shown below.*

Figure 1: Medicaid Enrollment and Penetration

PIHP	Medicaid Enrollees	Number Served	Penetration Rate
Grays Harbor	16,630	1,797	10.8%
Timberlands	21,592	2,239	10.4%
Southwest	21,643	2,619	12.1%
Chelan-Douglas	21,610	1,489	6.9%
North Central	59,454	3,309	11.5%
Thurston-Mason	43,164	4,060	9.4%
Clark County	65,516	5,724	8.7%
Peninsula	47,132	4,972	10.5%
Spokane County	90,138	7,129	7.9%
Greater Columbia	155,822	11,249	7.2%
Pierce County	123,975	8,798	7.1%
North Sound	149,310	11,331	7.6%
King County	217,863	26,473	12.2%
Statewide	**1,037,606**	**89,755**	**8.7%**

*Based on data published in the 2006 Performance Indicator Report – Northeast values are combined with North Central reflecting that North Central absorbed North East Medicaid enrollees in September 2006.

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2006 REVIEW OBJECTIVES

History

The first review year spanned July 2004 through June 2005. During that review, conducted August 2004 - March 2005, APS reviewed all PIHPs relative to all Balanced Budget Act (BBA) Standards, performed an Information Systems Capability Assessment (ISCA) review for all PIHPs, and validated a set of performance measures (PMs) calculated and specified by the State. The individual and statewide final reports contained recommendations intended for review during the next review cycle. In addition, MHD issued corrective actions based on requirements that staff felt to be the most essential for public sector managed care organizations.

For the 2005 review, the WAEQRO again reviewed all BBA standards not meeting State-defined minimum standards, validated performance measure calculations, updated information related to PIHP system capabilities, implemented the CMS Performance Improvement Project Validation protocol (without formal scoring), and conducted an encounter validation of data submitted to MHD by the PIHPs. To the degree possible, the 2005 report focused on improvements reflected in PIHP performance.

Purpose of the 2006 Review

The WAEQRO has conducted its annual reviews within a framework of continuous quality improvement. Thus, for those areas previously reviewed, the 2006 review was designed to focus on the extent to which the PIHPs had achieved improvement in review elements defined as not meeting minimum standards in 2005, or for which a baseline had been previously established. In addition, MHD requested intensified review for part of one CMS-required activity and a change in focus for one optional activity.

Based on the 2005 findings, the 2006 review was designed to:

- Review and measure improvement in operational and clinical practices (BBA Standards) that in 2005 continued to be scored below minimal acceptable levels;
- Evaluate the status of performance improvement projects (PIPs) without applying a formal scoring system;
- Validate performance measure calculations specified by the State.

New or re-designed reviews included:

- Evaluation of PIHP encounter validation activities, using CMS protocols as a guide; and
- In-depth review of PIHP Quality Assurance and Improvement plans and activities, with particular focus on clinical oversight and incorporation of grievance and appeal information into the quality management program.

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2006 REVIEW ACTIVITIES

For each of the 13 PIHPs, APS completed a Subpart Review, Performance Improvement Project Validation (PIP), Performance Measure/System update review, an Encounter Validation Process review (EV), and a Quality Assurance and Improvement (QAI) review. Upon completion of each PIHP review and feedback process, a report was provided to the PIHP and to the Mental Health Division. In conducting the reviews, APS followed guidelines set forth in the CMS protocols for each review activity, with some modifications defined by the Mental Health Division. The methods for data collection, review, scoring, and analysis were the same for all PIHPs and are described below.

In addition to the PIHP reviews, APS evaluated the State's performance measure calculation methodology and related code as well as their data management system, to assess confidence in the data used to calculate performance measures.

The 2006 review was conducted in two phases: an initial desk review of policies, procedures, and other supporting documentation provided by the PIHPs, followed by site visits to all PIHPs and two network providers contracted with each. The following table outlines activities involved in this year's review, including a description of the reporting and feedback process. Samples of all relevant communication materials are included in Attachment B.

Figure 2: 2006 EQRO Activities

Activity	Timeline	Documents/Content
Pre-onsite		
1. Communication re: 2006 review	August 1, 2006 to all PIHP Administrators and MHD	Email and memo with general information about 2006 review; site visit schedule for all PIHPs
2. Document request	To each PIHP approx 6 weeks prior to site visit	Email with instructions for submission of documents for all review areas
3. Site visit agenda; instructions re: orientation call with EQRO Executive Director	One month prior to scheduled site visit for each PIHP	Email/agenda with names of network providers to be visited and instructions for orientation call
4. Site visit orientation call	With each PIHP administrator, 2 weeks prior to visit	Review logistics, answer questions, discuss attendance and agenda
Onsite Review		
1. PIHP visit	Between September 25, 2006 and April 10, 2007	Interview management team re: changes in operations/service delivery, specific questions about Subparts, QAI; review PIPs;

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Activity	Timeline	Documents/Content
		update on IS capabilities
2. Network provider visit	Between September 25, 2006 and April 11, 2007	Interview management and direct service staff at each of 2 providers re: PIHP oversight, training, and communication; assess knowledge and implementation of relevant BBA and contract requirements
Post Onsite		
1. Review additional documents and finalize review results	Period immediately following each site visit	The WAEQRO requested specific supplemental documentation at the conclusion of each site visit.
2. Draft report	Submitted to PIHP Administrator approximately thirty days after site visit	Included instructions for submitting feedback about results/ requests for changes
3. PIHP response	Due to WAEQRO approximately 5 days after draft	PIHPs could request scoring or other changes with specified documentation
4. Debrief conference calls	2-4 days after response submitted to WAEQRO	Review results; highlight strengths and recommendations for improvement; answer questions; discuss and decide changes requested
5. Final PIHP reports	3-5 days after Debrief	Submitted to PIHP and MHD
6. Performance measure validation	May 2007	Review of State PM-related processes; e.g., data capture and storage and data reliability
7. Draft Statewide report	To MHD May 24, 2007	For MHD review and comment
8. Final Statewide report	To MHD, CMS June 12, 2007	

CONTENT AND ORGANIZATION OF THE REPORT

This report provides:

1. For each review activity, an overview of 2005 results (where applicable) as baseline for 2006 performance, and analysis where comparable reviews were conducted;
2. A description of how data for all 2006 review activities were captured, aggregated, and analyzed, and conclusions as to the quality, timeliness, and access to care furnished by the PIHPs;
3. A summary of findings from the EQR activities for all PIHPs;
4. An assessment of PIHP and statewide strengths and weaknesses with respect to provision of health care services furnished to Medicaid recipients; and
5. Recommendations for improving the quality of health care services provided by the PIHPs, some of which relate directly to federal and state regulations and requirements and others that would generally support the PIHPs and/or the State in meeting those requirements.

This report meets the federal requirement for preparation of an annual EQR report, as set forth in the Balanced Budget Act (BBA) of 1997 (42 CFR 438.364).

Evaluation and scoring methodologies vary across review topics and were developed by APS in consultation with MHD. Of note in the Subparts and Encounter Validation is the use of enrollment-weighted scores or averages. “Simple”, PIHP-specific scores/averages reflect the performance of each PIHP and are useful for comparisons of PIHPs one to another. Enrollment-weighted scores, by contrast, provide a picture of the experience of the “average” consumer as they access and receive services, i.e., the quality of care and services a given consumer is likely to experience or the quality of the related data. For example, about 20% of consumers state-wide reside in King County; therefore, King’s performance impacts a much greater number of consumers (and their data) than does that of Gray’s Harbor, the smallest PIHP in the state. Because the intent of the external quality review is the ongoing improvement in services and care provided to consumers, it is important to understand the implications of these results as they affect consumers state-wide and the quality of data state-wide that informs financial, operational, and quality indicators.

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PROFILE OF REVIEWERS

Harriet Markell, MA: Washington External Quality Review Executive Director
Harriet is responsible for the overall operation of the Washington EQRO and is the primary point of contact for the Mental Health Division and the PIHPs. She reviews PIHP Performance Improvement Projects, assists with evaluation of the Subparts, and oversees data analysis processes. Harriet has a varied background in direct clinical care, program development and management, managed behavioral healthcare operations, and non-profit social service operations.

Brad Babayan: Systems Analyst
Brad is a senior computer systems analyst for APS Healthcare's WAEQRO. As a member of the WAEQRO team, Brad evaluates system capabilities of the PIHPs and the Mental Health Division, and also validates the system of performance measures used for quality and performance improvement efforts. Brad also serves on the APS corporate HIPAA implementation team. Brad has twenty-five (25) years of varied experience working in the information technology field. He began programming while in the military and has since gained experience in hardware, networking, and enterprise management.

Marty Driggs, MA, LMHC: Administrative/Clinical Reviewer
As an Administrative/Clinical Reviewer for the Washington EQRO, Marty holds primary responsibility for evaluating PIHP compliance with BBA standards. Marty has worked in the state of Washington's mental health system for over 25 years in various capacities, including the provision of direct care, clinical supervision program management, and as an RSN Administrator. In addition, Marty has a private consulting business that includes (in part) development of policies and procedures related to management and direct service functions, facilitation of stakeholder forums, mediation and conflict resolution, and facilitation of contract negotiations.

Irene Finley, MA, LMHC/LPC: Administrative/Clinical Reviewer
As an Administrative/Clinical Reviewer for the Washington EQRO, Irene assists with evaluating PIHP Quality Assurance and Improvement plans and activities, including clinical oversight and incorporation of grievance and appeal information into the quality management program. Irene worked in the state of Oregon's mental health system for over 14 years in various capacities, including the provision of direct care, intensive care coordination, contract and evaluations and as a program manager for utilization review of residential services. In addition, Irene worked in the state of Washington as an outpatient mental health therapist for several years.

James Andrianos, MBA: Data Analysis Consultant
Jim has assisted the WAEQRO with evaluating the results of the subpart reviews and developing methods for presenting and discussing PIHP performance, both individually and as comparisons. Jim has an extensive background in measurement and evaluation of clinical quality and efficiency from claim repositories, financial modeling, cost accounting and rate-setting for healthcare and social services, and design and implementation of management reporting systems.

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III. 2005 – 2006 REVIEW RESULTS

This report provides results from the four review activities conducted by the WAEQRO for each of 13 PIHPs in the state of Washington. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. The data is analyzed for all PIHPs, providing individual PIHP and statewide results; included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees. Detailed information can be found in the reports compiled for each PIHP and provided to MHD (see, **Attachment A – PIHP Reports**).

SUBPARTS

Using a tool and set of scoring guidelines developed by MHD, the WAEQRO reviewed BBA standards initially in 2004, conducting a comprehensive review of Subparts C, D, F, and H for all PIHPs. That review and scoring methodology was intended to provide baseline performance information relative to BBA standards and MHD contract requirements that MHD and individual PIHPs could use in a continuous quality improvement process.

Throughout the scoring and analysis, the concept of an "Expected" performance recurs. This standard was established as an initial performance goal and as such, became the basis for determining which Subpart review items would be re-scored in 2005 and 2006. MHD requested that the 2005 Subpart review focus on those elements that were scored below Expected in 2004; the 2006 review replicates this focus with respect to 2005.

In conducting the Subpart reviews, the WAEQRO followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each PIHP (see **Figure 2: 2006 EQRO Activities**, and **Attachment B, Communication/Document Submission Instructions**). Common elements involved use of the MHD standardized data collection tool, extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks. Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following.

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Subparts Scoring

The review tool and scoring guidelines, adapted from the CMS protocols, were designed to identify degree of compliance with Balanced Budget Act (BBA) standards and specific MHD contract requirements and priorities, as well as strengths and areas of needed (or recommended) improvement.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 was used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), as follows:

0 = No Compliance (no documentation/processes);
1 = Insufficient Compliance (documentation/processes exist);
2 = Partial Compliance (documentation processes available/distributed to personnel);
3 = Moderate Compliance (personnel trained, aware of documentation/processes);
4 = Substantial Compliance (provision articulated, implemented locally);
5 = Maximum Compliance (provision thoroughly/consistently implemented).

Subpart H was scored differently in that it was based on a 2-point scale, zero to one (0-1), as follows:

0 = No Compliance (insufficient evidence)
1 = Compliance (sufficient evidence exists)

A score of Expected denotes either of the following:

A score of 3 or better for Subparts C, D, and F
A score of 1 for Subpart H

It is important to note that in 2004, three different scoring methodologies were used in Subpart H. To create a consistent scoring methodology for 2005, scoring was simplified throughout Subpart H to a two (2) point scale, zero to one (0-1). To achieve data comparability across all Subparts, scores of one (1) were then converted to three (3). In addition, all elements of Subpart H were combined into 3 scored items in 2004; in 2005, a score was applied to each individual element, resulting in a total of 12 scored items. In 2006, Subpart H was scored by the same method used in 2005.

Items not reviewed in 2006 include the following:

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year);
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted

this year;

- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year; and
- All items associated with the Performance Improvement Projects (PIPs), as PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

The following sections present a graphical and narrative review of Subpart results for all 13 PIHPs. First is a recap of recommendations from the statewide 2005 PIHP review; this provides a basis for the 2006 performance and results analysis. To provide a comprehensive set of scores, the 2006 Subpart results include a roll-up of 2004 and 2005 scores of 3 or higher in Subparts C, D, F,[1] or a score of 1 in Subpart H, and 2006 scores for all remaining items. The 2006 results exhibit statewide and PIHP-specific distribution of scores, common areas of strength and improvement, and percentage of change/improvement per PIHP. Measures of statewide improvement over time are also displayed, as are system-wide observations of strengths and recommendations for quality improvement.

2005 Subpart Results Overview

2005 Distribution of Scores

The following chart identifies each PIHP's 2005 score distribution (0, 1, 2, 3, 4, or 5) for all Subparts. The total column height accounts for 100% of item responses. The PIHPs are arrayed by performance from best to worst, moving from left to right across the horizontal axis. *This ranking is based on the greatest number of scores at or above the Expected performance level (3, 4, or 5).* Below the chart, a data table displays the actual score count for each PIHP. These numbers drive the percentages in the stacked column chart.

For statewide comparison, the first column displays scores for all 14 PIHPs, providing a statewide overall distribution. Of note is that 72% of all scores are at Expected and above (3, 4, and 5), and 28% are in the below Expected range (2, 1, and 0). Also noteworthy is that, compared to 7 in 2004, 13 PIHPs reflect a greater number of scores in the Expected category, and only 1 PIHP has a greater number of scores that fall below Expected. While the vast majority of scores were 3s, the top 6 PIHPs had significantly more 4s and 5s and fewer 0s and 1s. On the other end of the spectrum, lower-performing PIHPs had scores of 1 and 2 in much higher percentages. In summary, system-wide performance of PIHPs is squarely in the mid-range, as measured by their 2005 performance on the Subparts.

[1]Some exceptions apply due to changes in scoring tools, and score conversions to adequately compare scores year to year.

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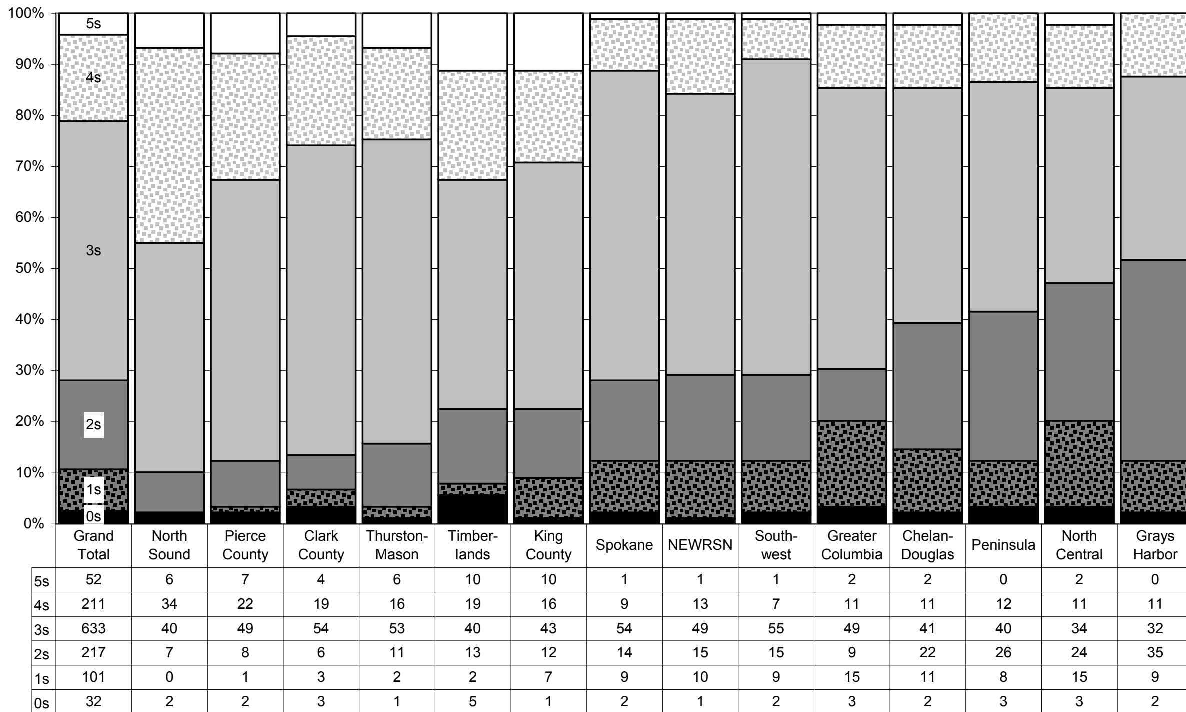
Figure 3



	Grand Total	North Sound	Pierce County	Clark County	Thurston-Mason	Timber-lands	King County	Spokane	NEWRSN	South-west	Greater Columbia	Chelan-Douglas	Peninsula	North Central	Grays Harbor
5s	52	6	7	4	6	10	10	1	1	1	2	2	0	2	0
4s	211	34	22	19	16	19	16	9	13	7	11	11	12	11	11
3s	633	40	49	54	53	40	43	54	49	55	49	41	40	34	32
2s	217	7	8	6	11	13	12	14	15	15	9	22	26	24	35
1s	101	0	1	3	2	2	7	9	10	9	15	11	8	15	9
0s	32	2	2	3	1	5	1	2	1	2	3	2	3	3	2

Based on the statewide overall distribution of scores and the Scoring Guidelines (see, **Attachment D**), this chart indicates that for 28% of the elements scored, two issues contributed to the low scores: (1) policies and procedures were underdeveloped and/or missing key requirements, and (2) key PIHP and Network Provider personnel need training to increase knowledge and application of related policies and procedures.

2005 Subpart Results and Recommendations

The following recommendations describe opportunities for improvement that the WAEQRO team identified as priorities during the 2005 EQR process. WAEQRO recommended that:

- MHD clarify the standard regarding posting of enrollee rights and translation of particular client materials, including specifics of language requirements, via written policy and procedure.
- PIHPs include in policies and procedures BBA requirements for authorization decision timeframes, and ensure that the PIHPs effectively implement these requirements.
- PIHPs develop and implement processes for sub-delegation that include all BBA

requirements; including pre-delegation assessment, contracting, and monitoring activities which ensure that subdelegated functions are being reliably conducted.

- To reduce duplicative efforts and increase effective resources, PIHPs collaborate in developing practice guidelines and provide training to provider network staff regarding their application.

- MHD clarify the operational definition of a denial for inpatient and outpatient services, and standardize processes for issuing, tracking, and monitoring Notice of Actions. In addition, recommend PIHPs increase their oversight of provider network screening and intake procedures to ensure that denials are not occurring without their knowledge and involvement.

- PIHPs implement formal procedures to prevent and detect internal fraud and abuse.

- PIHPs create procedures to officially adopt and approve new and revised policies and procedures. Each policy should contain all required provisions referenced in the Code of Federal Regulations (CFR), and include dated signatures of PIHP officials or designees, date(s) of revisions, and effective date.

- Prioritize PIHP-provided training for provider network direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

2006 Subpart Results

To provide a complete set of scores for the current review period, the 2006 Subpart results reflect the 2004 and 2005 item scores that were not rescored in 2006, and (new) 2006 scores for all items rescored during this review period. The 2006 results exhibit the overall distribution of scores by PIHP, their common areas of strength and improvement, and the percentage of change/improvement per PIHP. These results also reflect statewide improvement over time and system-wide observations of strengths and recommendations for quality improvement.

Three graphics are presented for each Subpart:

- **Pie Chart:** compares 2005 and 2006 scoring frequency for all PIHPs combined. Black wedges represent scores below 3, and white wedges represent scores at or above Expected (3 or above) performance. Annotations on each wedge specify the score level and frequency of that score within the Subpart.

- **Stacked Column Chart:** identifies each PIHP's distribution of scores (0, 1, 2, 3, 4, or 5). The total column height accounts for 100% of item responses. The PIHPs are arrayed by performance from best to worst, moving from left to right across the chart. This ranking is based on the greatest number of scores at or above the Expected performance level. Below the chart, a data table displays the actual score count for each PIHP. These numbers drive the percentages in the stacked column chart.

- **Enrollment-weighted Table:** three perspectives of the 2006 statewide Subpart scores are represented in this table: (1) comparison of a standard average and an enrollment-weighted average; (2) identification of strong and weak areas, based on weighted averages and a defined set of criteria; and (3) a comparison of those strengths and weaknesses with elements selected in 2004 by MHD and WAEQRO, respectively, for possible corrective action, and as opportunities for improvement. Flagged elements in this analysis form the basis of WAEQRO's recommendations for improvement in 2006.

  Enrollment-weighted scores
  Each PIHP's scores were weighted based on actual enrollment during the review period. For example, if PIHP "A" has 12% of the statewide enrollment, its element scores will receive a 0.12 weight. For each element, the PIHP score is multiplied by its respective weight, and 13 results are summed to obtain the "WA State Weighted Average". This enrollment-weighted score more accurately reflects statewide performance because an exceptional score in a large PIHP will affect more members than it would in a small PIHP.

  Strengths and Weaknesses
  To qualify as strength, the statewide, enrollment-weighted score must be at or above a specified level (3.7), *and* a certain number of PIHPs (9) must have individual scores at or above this level. Elements with scoring profiles meeting both criteria receive a strength "star." An inverted approach is used for assigning weakness "flags." These designate elements having low statewide scores (below 3.0) along with underperformance by 7 or more PIHPs. The two criteria for each category capture not only aggregate statewide performance, but also variation among PIHPs that can be masked when focusing strictly on statewide performance, even when weighted for enrollment.

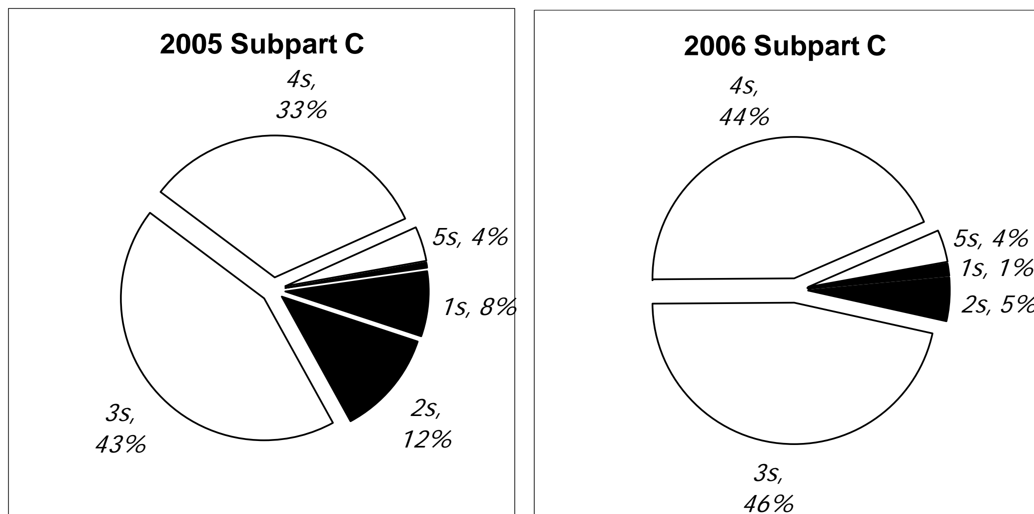
  As points of comparison, those elements identified by MHD for corrective action, if the PIHP scored below 3 (Expected), are indicated by gray shading. Those Elements reflected in the 2005 EQR report recommendations are underlined.

  The information displayed in these tables is supported by more detailed data that includes scores for each PIHP on each Subpart element (see, **Appendix 1(C – H) – Detailed Enrollment-Weighted Averages** for the complete dataset).

Subpart C – Enrollee Rights and Protections

This section of the EQR included the determination of PIHP compliance with Federal and State regulations related to enrollee rights and protections, as well as verification that these requirements had been incorporated into policies and procedures. Additionally, PIHP processes were assessed with respect to ensuring that staff and network providers take these rights and protections into account when furnishing services to enrollees.

Figure 4: Subpart C 2005 – 2006 Score Comparison



The increased white area in the 2006 chart shows statewide PIHP improvement with respect to meeting the requirements of Subpart C. The diminishing size of the wedges for scores 0, 1, and 2 also indicates improvement. At the end of the 2005 review, 80% of Subpart C scores were at or above the Expected level of performance. After the 2006 review, 94% of the items meet that level, a 14% improvement from 2005. The percentage of Subpart C elements that remain below the Expected level is 6%.

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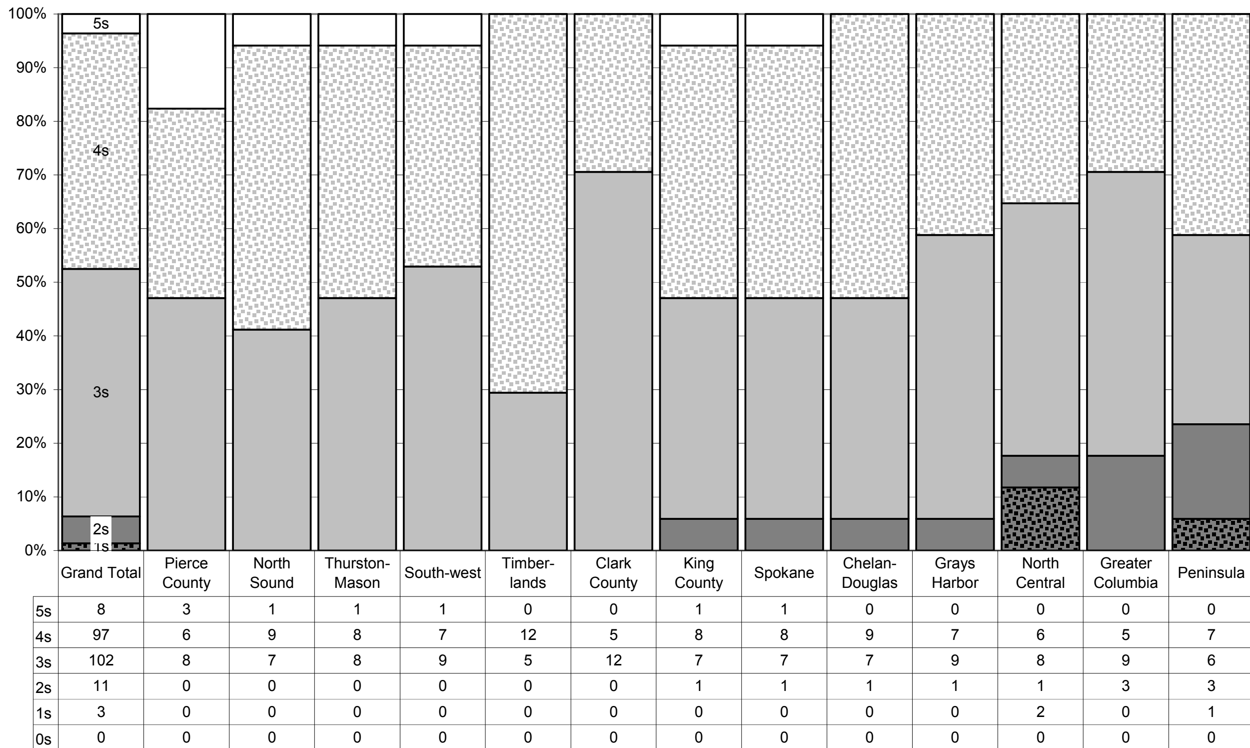
Figure 5

Subpart C
2006 Score Distribution by PIHP



	Grand Total	Pierce County	North Sound	Thurston-Mason	South-west	Timber-lands	Clark County	King County	Spokane	Chelan-Douglas	Grays Harbor	North Central	Greater Columbia	Peninsula
5s	8	3	1	1	1	0	0	1	1	0	0	0	0	0
4s	97	6	9	8	7	12	5	8	8	9	7	6	5	7
3s	102	8	7	8	9	5	12	7	7	7	9	8	9	6
2s	11	0	0	0	0	0	0	1	1	1	1	1	3	3
1s	3	0	0	0	0	0	0	0	0	0	0	2	0	1
0s	0	0	0	0	0	0	0	0	0	0	0	0	0	0

As in the 2006 pie chart, this view of the scores shows that 94% of all Subpart C scores are at Expected, with 6% in the below Expected range. Also noteworthy is that there are more PIHPs with 100% of their scores at Expected or above in Subpart C than any other Subpart. One hundred percent of 6 PIHPs' Subpart C scores are at Expected or above compared to 3 PIHPs in 2005. Also, while in 2005, 40% of the scores for 3 PIHPs were below Expected, in 2006 there is only 1 PIHP with more than 20% of scores below Expected, and there are no scores of zero. According to these results, PIHPs achieved the highest combined statewide Subpart score in Subpart C-Enrollee Rights and Protections.

It is evident by these results that the PIHPs continue to prioritize quality improvements relative to enrollee rights and protections. Based on the scoring guidelines (see, **Attachment D**), results indicate that PIHPs have relevant policies and procedures in place; they also indicate that PIHP and provider network staff have received formal or informal training on 94% of enrollee rights and protections elements. For the 6% of elements scored below Expected, various issues contributed to low scores: (1) policies and procedures were underdeveloped and/or missing key requirements, (2) key PIHP and Network Provider personnel need training to increase knowledge and improve application of related policies and procedures, and (3) related monitoring, analysis, and quality assurance and

improvement activities are underdeveloped.

Figure 6: 2006 Enrollment-Weighted Statewide Averages – Subpart C

<< Shading indicates 2004 Corrective Action Item
text << Underlining shows 2005 EQRO improvement recommendation

				Strength Stars			Weakness Flags		
				Q(s1)	Q(s2)	Stars	Q(w1)	Q(w2)	Flags
		WA State Simple Average	WA State Weighted Average	Is State Wtd Average at least 3.7?	Did more than 9 PIHPs score at least 3.7?	Items satis-fying both Q(s1) & Q(s2)	Is State Wtd Average less than 3?	Did more than 7 PIHPs score under 3?	Items satis-fying both Q(w1) & Q(w2)
Item	Description			3.7	9	0 stars	3.0	7	0 flags
Q01	Accessible written information requirements P&P	3.5	3.6						
Q02	Policy guaranteeing enrollee rights	3.4	3.2						
Q03	Subcontracts require advising enrollees of rights	3.7	3.7						
Q04	Subcontractors publicly post rights in req languages	3.6	3.5						
Q05	Subcontractors assure client rights understanding	3.6	3.7						
Q06	Subcontractors protect exercising of client rights	3.3	3.5						
Q07	Policy re: other Federal/State law compliance	3.2	2.9				•		
Q08	Subcontracts include Federal/State law compliance	3.8	3.8	•					
Q09	Policies ensure specific rights compliance	3.4	3.4						
Q10	Subcontracts reference specific rights compliance	3.5	3.6						
Q11	PIHP monitors provider compliance with laws/rights	2.9	3.2						
Q12	PIHP P&P against prohibitions re: advising enrollees	3.5	3.6						
Q13	Enrollee payment liability protections	3.5	3.7						
Q14	PIHP P&P re: Mental Health Advance Directives (MHAD)	3.5	3.6		•				
Q15	Prompt law updates to MHAD P&P	3.5	3.5						
Q16	Subcontractors req to have MHAD P&P	3.5	3.4						
Q17	Document clients informed of MHAD & choice	3.1	2.8				•		

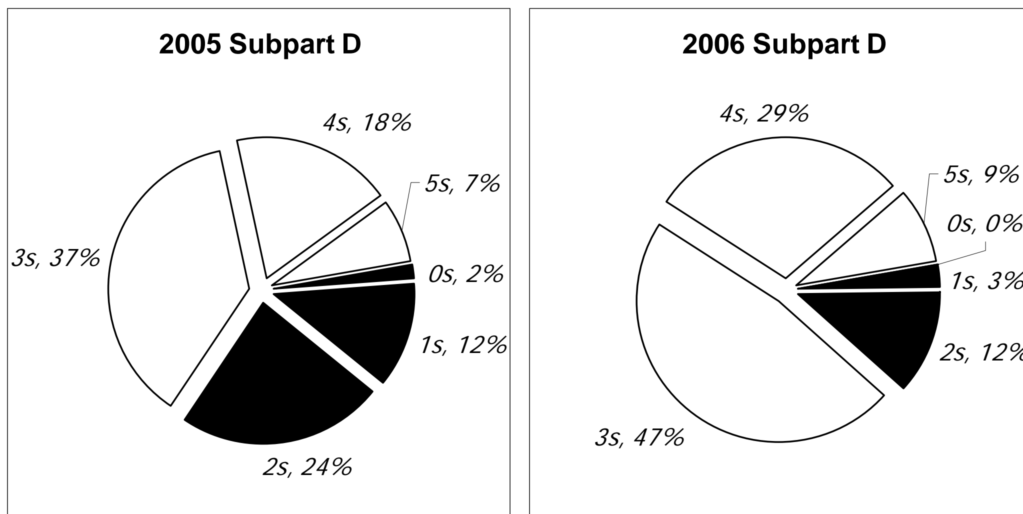
** as of June 2005, calculated April 2006*

The Subpart C enrollment-weighted average scores in the above table range from a low of 2.8 to a high of 3.8. Four elements have a State weighted average of at least 3.7. Weighted average scores for two elements remain below Expected. There are no elements in this Subpart that meet the criteria of strength (star); however, there are also no elements that qualify as a weakness (flag). By the end of the 2006 review all 13 PIHP scored Expected or better for Q04—Subcontractors publicly post rights in required languages, which was a 2005 WAEQRO improvement recommendation. As discussed previously, in 2006, the PIHPs continued to prioritize quality improvements related to enrollee rights and protections, thereby increasing state-wide scores and, more importantly, improving the quality of care provided to Medicaid enrollees.

Subpart D – Quality Assessment and Performance Improvement

The Subpart D protocol sets forth specifications for Quality Assessment and Performance Improvement strategies that must be implemented to ensure the delivery of quality mental healthcare. PIHPs were reviewed to determine their compliance with respect to Federal and State requirements related to the implementation of Access Standards, Structure and Operation Standards, and Measurement and Improvement Standards.

Figure 7: Subpart D 2005 – 2006 Score Comparison



The increased white area in the 2006 chart depicts a 23% increase statewide in scores achieving 85% at Expected or above. Fifteen percent of the elements in Subpart D remain below the Expected level.

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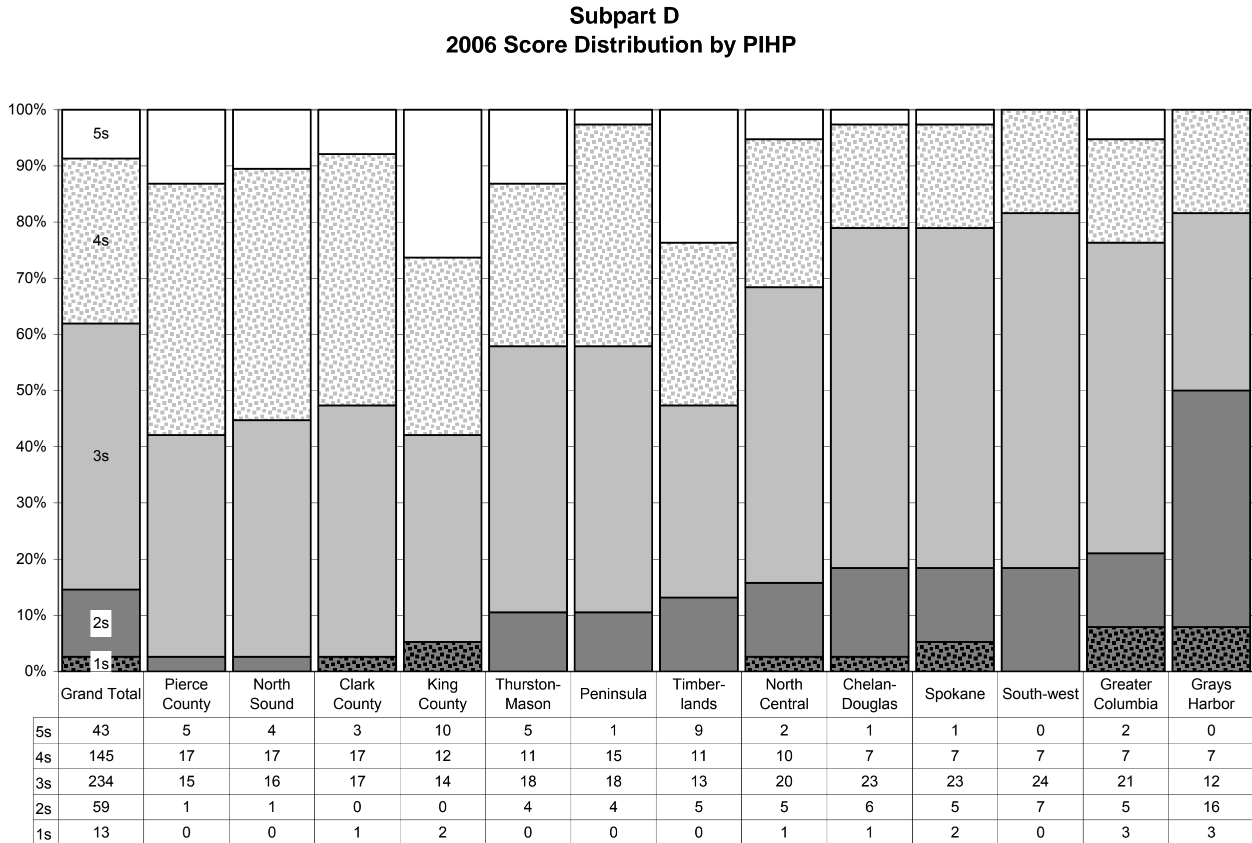
Figure 8: Subpart D 2006 Score Distribution by PIHP



	Grand Total	Pierce County	North Sound	Clark County	King County	Thurston-Mason	Peninsula	Timber-lands	North Central	Chelan-Douglas	Spokane	South-west	Greater Columbia	Grays Harbor
5s	43	5	4	3	10	5	1	9	2	1	1	0	2	0
4s	145	17	17	17	12	11	15	11	10	7	7	7	7	7
3s	234	15	16	17	14	18	18	13	20	23	23	24	21	12
2s	59	1	1	0	0	4	4	5	5	6	5	7	5	16
1s	13	0	0	1	2	0	0	0	1	1	2	0	3	3

As in the 2006 pie chart, this view shows that 85% of all Subpart D scores are at Expected or above, with 15% in the below Expected range. Also of note is that no PIHP achieved 100% of scores at or above Expected; however, 4 PIHPs achieved 95% of scores at or above Expected compared with 2005, when no PIHPs scored above 88%. Also, while in 2005, 40% of 8 PIHP Subpart D scores were below Expected, in 2006, only 1 PIHP showed 40% of their scores below Expected. Although these results confirm that Subpart D remains a challenge, it is evident in 2006 that the PIHPs have made considerable progress toward meeting requirements and have implemented quality improvements that directly enhance the care and services provided to Medicaid enrollees.

Based on the statewide overall distribution of Subpart D scores and the scoring guidelines (see, **Attachment D**), this chart indicates that for 15% of the elements scored, three factors contributed to low scores: (1) policies and procedures were underdeveloped and/or missing key requirements; (2) key PIHP and Network Provider personnel need training to increase knowledge and application of related policies and procedures; and (3) related monitoring, analysis, and quality assurance and improvement activities are underdeveloped.

Figure 9: 2006 Enrollment-Weighted Statewide Averages – Subpart D

	<< Shading indicates 2004 Corrective Action Item			Strength Stars			Weakness Flags		
text	<< Underlining shows 2005 EQRO improvement recommendation			Q(s1)	Q(s2)	Stars	Q(w1)	Q(w2)	Flags
		WA State Simple Average	WA State Weighted Average	Is State Wtd Average at least 3.7?	Did more than 9 PIHPs score at least 3.7?	Items satis-fying both Q(s1) & Q(s2)	Is State Wtd Average less than 3?	Did more than 7 PIHPs score under 3?	Items satis-fying both Q(w1) & Q(w2)
Item	Description			3.7	9	0 stars	3.0	7	0 flags
Q18	PIHP monitors access and service availability	3.3	3.2						
Q19	PIHP monitors & reports network sufficiency changes	3.2	3.1						
Q20	PIHP manages network adequacy	3.1	2.9				•		
Q21	Second opinion mechanism	3.5	3.3						
Q22	PIHP has out-of-network P&P	3.0	3.1						
Q23	PIHP P&P re: out-of-network payment coordination	3.2	3.5						
Q24	PIHP P&P re: out-of-network cost to enrollee	3.2	3.4						
Q25	Ensures compliance with timely access standards	3.8	3.8	•					
Q26	Timely access standards in subcontracts	3.6	3.5						
Q27	PIHP oversight of provider timely access compliance	3.3	3.3						
Q28	Culturally competent services by MH Specialists	3.9	4.0	•					
Q29	Written & oral translation of client materials	3.2	3.3						
Q30	Ensure Interpreter availability	3.4	3.4						
Q31	Culturally competent subcontractor specialists	3.8	4.1	•					
Q32	Written and oral translation by subcontractors	3.0	3.2						
Q33	Monitoring of culturally competent services	3.2	3.3						
Q34	Sufficiency of provider network to meet need	3.1	3.0						
Q35	Changes in capacity and services reported to State	3.5	3.6						
Q39	Consistent authorization standards	3.5	3.8	•					
Q40	Authorization conducted by MHPs	3.1	3.2						
Q41	Monitoring of consistent authorization practices	3.2	3.3						
Q42	Adverse action notices meet requirements	2.8	2.7				•		
Q43	Standard authorization requirements	3.3	3.2						
Q44	Expedited authorization requirements	3.3	3.4						
Q45	Extension of expedited authorization request	3.2	3.2						
Q47	Protection against provider discrimination	3.4	3.7	•					
Q48	Policy re: excluded providers	3.7	3.5						
Q49	Confidentiality compliance	4.2	4.6	•					
Q50	Privacy compliance by subcontractors	3.7	3.8	•					
Q51	Privacy compliance subcontractor audits	3.1	3.4						
Q52	Pre-subdelegation evaluation	2.9	3.5						
Q53	Written subdelegation agreement	3.1	3.6						
Q54	Annual subcontractor subdelegation performance review	2.9	3.5						
Q55	Corrective actions re: subdelegation deficiencies	3.2	3.8	•					
Q56	Adoption of evidenced based practice guidelines	3.5	3.5						
Q57	Dissemination of practice guidelines	3.5	3.4						
Q58	Application of practice guidelines	2.5	2.7				•		
Q61	Detection of over & under utilization	3.1	3.4						

** as of June 2005, calculated April 2006*

Figure 9, above, shows that in 2006, weighted average scores range from a low of 2.7 to a high of 4.6, a reduction in score deviation compared to the variation of 2005 scores that ranged from 1.5 to 4.5. Subpart D has the largest number of elements and the most diversified subject matter of all the Subparts, which may account for this deviation. In addition, some subject areas and/or specific requirements may be more difficult to accomplish.

There are no elements in Subpart D that qualify as strengths (stars) compared to 2005, in

which there were 2. The loss of 2 stars in Subpart D from 2005 to 2006 is linked to the consolidation of Northeast PIHP and North Central PIHP. In 2005, Northeast was one of the necessary 10 PIHPs with scores exceeding a "3" for Q25 and Q28, the starred elements. In 2006, these scores were replaced with North Central's performance, which did not exceed a "3". As a result, in 2006, only 9 PIHPs had scores greater than "3", falling short of the star requirement.

Note that in 2006, North Central inherited Northeast's enrollment base; therefore, the North Central contribution to the enrollment-weighted score has increased over 2005 in a relative sense. Even with the replacement of Northeast's higher scores on elements Q25 and Q28, the 2006 system-wide weighted score for both elements remains above 3.7, as it was in 2005.

Also of note in 2006, there are no elements that qualify as a weakness (flag), a considerable improvement over 2005 in which there were 12. Most of those low-scoring items were clustered under related requirements and included elements related to these factors:

- Authorization Timeframes
- Sub-delegation of PIHP Functions
- Practice Guidelines
- Data Submission

Additional flagged elements included Adverse Action Notice Requirements, Out-of-Network Payment Coordination, and Written and Oral Translation of Client Materials. Ten of these 12 elements were identified as 2004 and 2005 WAEQRO improvement recommendations, indicating that the PIHPs have focused their efforts in these areas. Additional elements identified by 2004 MHD corrective actions (highlighted in gray), also generated focused efforts of improvement by the PIHPs. According to the 2006 results, PIHPs made their greatest improvement in Subpart D-Quality Assessment and Performance Improvement.

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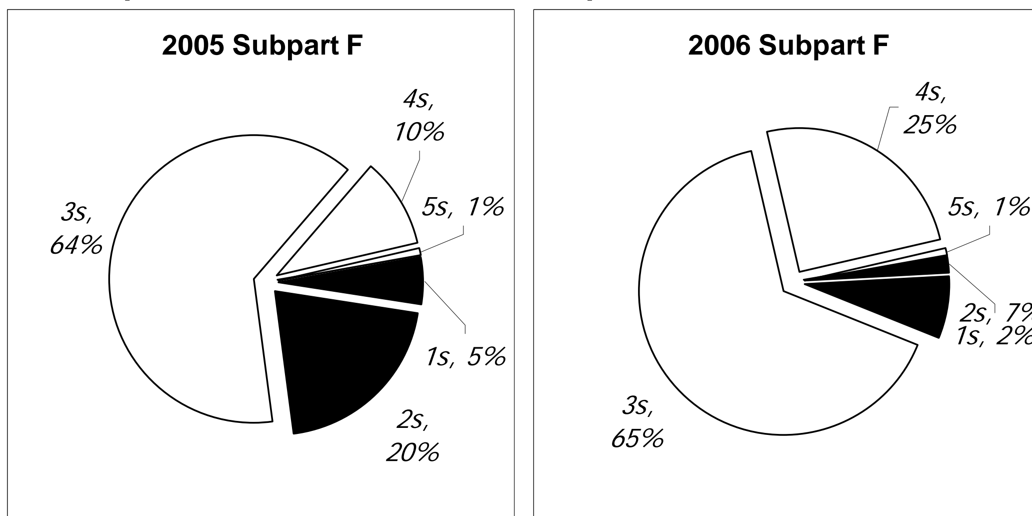
Subpart F – Grievance System

The Subpart F protocol requires that each PIHP have in place an enrollee grievance system which includes a grievance process, an appeal process, and access to the State's fair hearing system. Accordingly, PIHP written grievance system policies and procedures were reviewed to determine whether required provisions and timeframes were accurately included. In addition, PIHP and selected provider network staff were interviewed to determine their knowledge and application of grievance system policies and procedures, and the extent to which they have been integrated into the region-wide system of care.

Figure 10: Subpart F 2005 – 2006 Score Comparison



After the 2006 review, 91% of the elements meet the Expected level of performance, a 17% increase statewide from the 2005 scores. The percentage of Subpart F scores that remain below Expected is 9%, compared to 25% in 2005.

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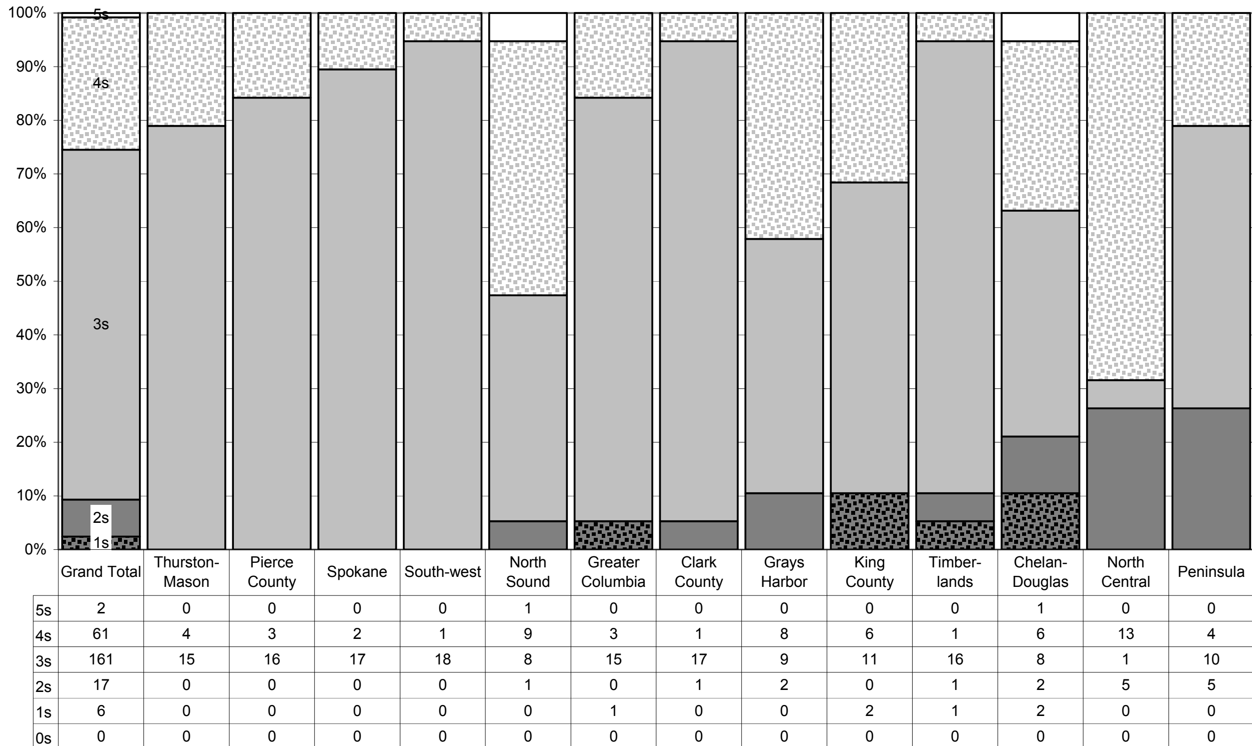
Figure 11



	Grand Total	Thurston-Mason	Pierce County	Spokane	South-west	North Sound	Greater Columbia	Clark County	Grays Harbor	King County	Timber-lands	Chelan-Douglas	North Central	Peninsula
5s	2	0	0	0	0	1	0	0	0	0	0	1	0	0
4s	61	4	3	2	1	9	3	1	8	6	1	6	13	4
3s	161	15	16	17	18	8	15	17	9	11	16	8	1	10
2s	17	0	0	0	0	1	0	1	2	0	1	2	5	5
1s	6	0	0	0	0	0	1	0	0	2	1	2	0	0
0s	0	0	0	0	0	0	0	0	0	0	0	0	0	0

As in the 2006 pie chart, this view shows that 91% of all Subpart F scores are at Expected and above, with 9% in the below Expected range. Four PIHPs scored at or above Expected on all items. Less than 12% of scores are below Expected for an additional 6 PIHPs, and there are no scores of zero.

These results show that PIHPs continued to improve their grievance systems in 2006. In particular, they prioritized formal and informal training of PIHP and provider network staff. Based on the scoring guidelines (see, **Attachment D**), results indicate that additional training for key personnel is needed to increase knowledge and application of policies, procedures, and related State and Federal requirements. In addition, related monitoring, analysis, and quality assurance and improvement activities need to be undertaken.

Figure 12: 2006 Enrollment-Weighted Statewide Averages – Subpart F

<< Shading indicates 2004 Corrective Action Item
text << Underlining shows 2005 EQRO improvement recommendation

Item	Description	WA State Simple Average	WA State Weighted Average	Strength Stars Q(s1)	Q(s2)	Stars	Weakness Flags Q(w1)	Q(w2)	Flags
				Is State Wtd Average at least 3.7?	Did more than 9 PIHPs score at least 3.7?	Items satis-fying both Q(s1) & Q(s2)	Is State Wtd Average less than 3?	Did more than 7 PIHPs score under 3?	Items satis-fying both Q(w1) & Q(w2)
				3.7	9	0 stars	3.0	7	0 flags
Q71	Authority to file grievance	3.5	3.5						
Q72	Timing and Procedures for filing	3.2	3.2						
Q73	Timing of notice	2.7	2.4				•		
Q74	Administrative assitance for enrollees	3.5	3.7	•					
Q75	Grievance acknowledgement	2.9	3.0				•		
Q76	Appropriate grievance review personnel	3.2	3.1						
Q77	Special requirements for appeals	3.5	3.6						
Q78	Enrollee access to case file	3.4	3.3						
Q79	Included appeal parties	3.2	3.0						
Q80	Resolution and notification of grievances & appeals	3.1	3.1						
Q81	Content of Notice of Appeal Resolution	3.2	3.2						
Q82	State fair hearings requirements	3.2	3.2						
Q83	Expedied appeal resolution/prohibition against punitive action	3.2	3.3						
Q84	Denial of expedited resolution	2.9	3.0				•		
Q85	Use of State developed description in subcontracts	2.8	3.1						
Q86	Record keeping	3.1	3.3						
Q87	Review and quality improvement	3.2	3.5						
Q88	Rights upheld during pended appeal	3.2	3.1						
Q89	Rights upheld regarding disputed services	3.2	3.2						

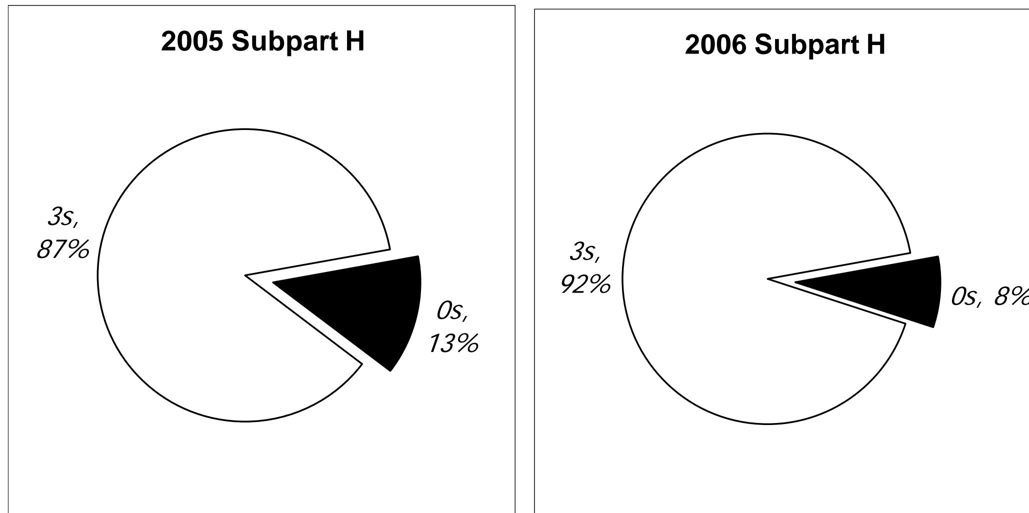
** as of June 2005, calculated April 2006*

The Subpart F enrollment-weighted average scores in Figure 12, above, range from a low of 2.4 to a high of 3.7. The Weighted average score for 1 element remains below Expected, compared to 11 elements below Expected in 2005. There are no elements in this Subpart that meet criteria for a starred strength. In 2005, there was 1 flagged weakness, Q73—Timing of Notice, identified by the WAEQRO as an improvement recommendation. In 2006, this element is no longer flagged as a weakness; however, it remains the only element in Subpart F with a weighted average score below Expected. As discussed previously, PIHPs continued to improve their grievance systems, which ensure the opportunity for Medicaid enrollees to exercise their rights. Quality Improvement efforts must be on-going, especially with respect to the timing of Notice of Actions.

Subpart H – Certification and Program Integrity

The Subpart H-Certification and Program Integrity protocol requires that, as a condition for receiving payment under the Medicaid managed care program, a PIHP must comply with applicable certification, program integrity, and prohibited affiliation requirements. To determine compliance, WAEQRO reviewed PIHP Data Certifications, Fraud and Abuse Compliance Plans, and other relevant documentation.

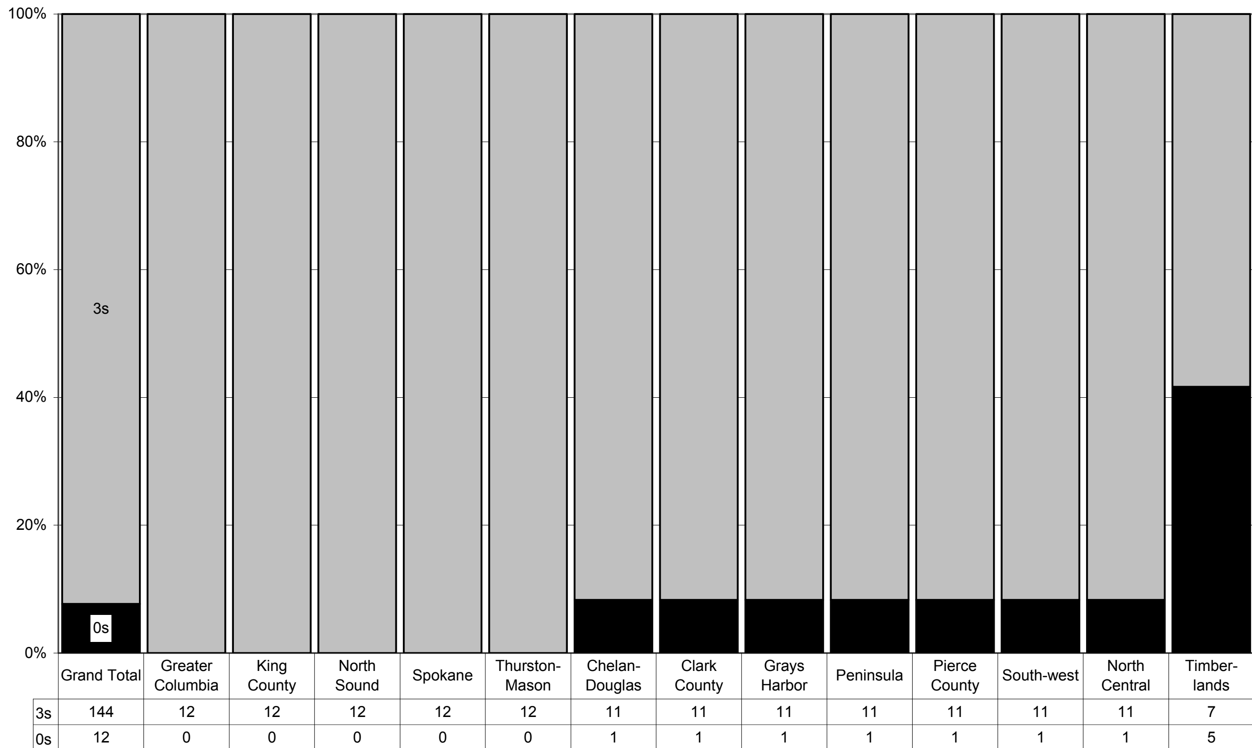
Figure 13: Subpart H 2005 – 2006 Score Comparison



The increased white area in the 2006 chart depicts a 5% increase statewide in scores above Expected, to a total of 92%.

Figure 14

Subpart H
2006 Score Distribution by Subpart



	Grand Total	Greater Columbia	King County	North Sound	Spokane	Thurston-Mason	Chelan-Douglas	Clark County	Grays Harbor	Peninsula	Pierce County	South-west	North Central	Timber-lands
3s	144	12	12	12	12	12	11	11	11	11	11	11	11	7
0s	12	0	0	0	0	0	1	1	1	1	1	1	1	5

* See page 26 for Subpart H scoring method description.

As in the 2006 pie chart, this view shows that 92% of all Subpart H scores are at Expected, with 8% below. In addition, 5 PIHPs scored at Expected on 100% of Subpart H items, up from 3 in 2005. Also noteworthy, 7 additional PIHPs scored zero (0) on only one element. One PIHP received zeros in all elements related to Data Certifications, which accounts for their variation in scores compared to other PIHPs. Overall, PIHPs continue to excel in meeting the requirements of this Subpart.

Figure 15: 2006 Enrollment-Weighted Statewide Averages – Subpart H

	<< Shading indicates 2004 Corrective Action Item			Strength Stars			Weakness Flags		
text	<< Underlining shows 2005 EQRO improvement recommendation			Q(s1)	Q(s2)	Stars	Q(w1)	Q(w2)	Flags
		WA State Simple Average	WA State Weighted Average	Is State Wtd Average at least 3?	Did more than 9 PIHPs score at least 3?	Items satis-fying both Q(s1) & Q(s2)	Is State Wtd Average less than 3?	Did more than 7 PIHPs score under 3?	Items satis-fying both Q(w1) & Q(w2)
Item	Description			3.0	9	6 stars	3.0	7	0 flags
Q90.a	Source of certification	2.8	2.9		•		•		
Q90.b1	Data content certification	2.8	2.9		•		•		
Q90.b2	Certification content requirements	2.8	2.9		•		•		
Q90.b3	Certification timing	2.5	2.8		•		•		
Q91.b1	Written fraud & abuse p&ps/compliance plan	3.0	3.0	•	•	*star*			
Q91.b2	Accountable compliance officer/committee	3.0	3.0	•	•	*star*			
Q91.b3	Effective Compliance training and education	3.0	3.0	•	•	*star*			
Q91.b4	Effective compliance communication	2.8	2.6		•		•		
Q91.b5	Well publicized disciplinary guidelines	3.0	3.0	•	•	*star*			
Q91.b6	Internal audit provisions	1.6	2.4				•		
Q91.b7	Prompt response to offenses	3.0	3.0	•	•	*star*			
Q92	Prohibited affiliations with the Federally debarred	3.0	3.0	•	•	*star*			

** as of June 2005, calculated April 2006*

Because the maximum attainable score for this Subpart is 3.0, thresholds for stars were set differently than for other Subparts. The enrollment-weighted averages in Figure 15, above, chart range from a low of 2.4 to a high of 3.0. In 2006, the PIHPs attained starred strengths only in Subpart H. In 2005, 3 elements were designated as starred strengths; in 2006, that number doubled to 6. All starred items are in Program Integrity, which includes elements required in PIHP fraud and abuse compliance plans. In 2005, there was 1 flagged weakness, Q91.b6—Internal Audit Provisions, also a component of Program Integrity, and identified by the WAEQRO as an improvement recommendation. In 2006, this element is no longer flagged as a weakness; however, it remains 1 of 6 elements in Subpart H with a weighted average score below Expected. As previously stated, Certifications and Program Integrity are areas in which the PIHPs generally do well.

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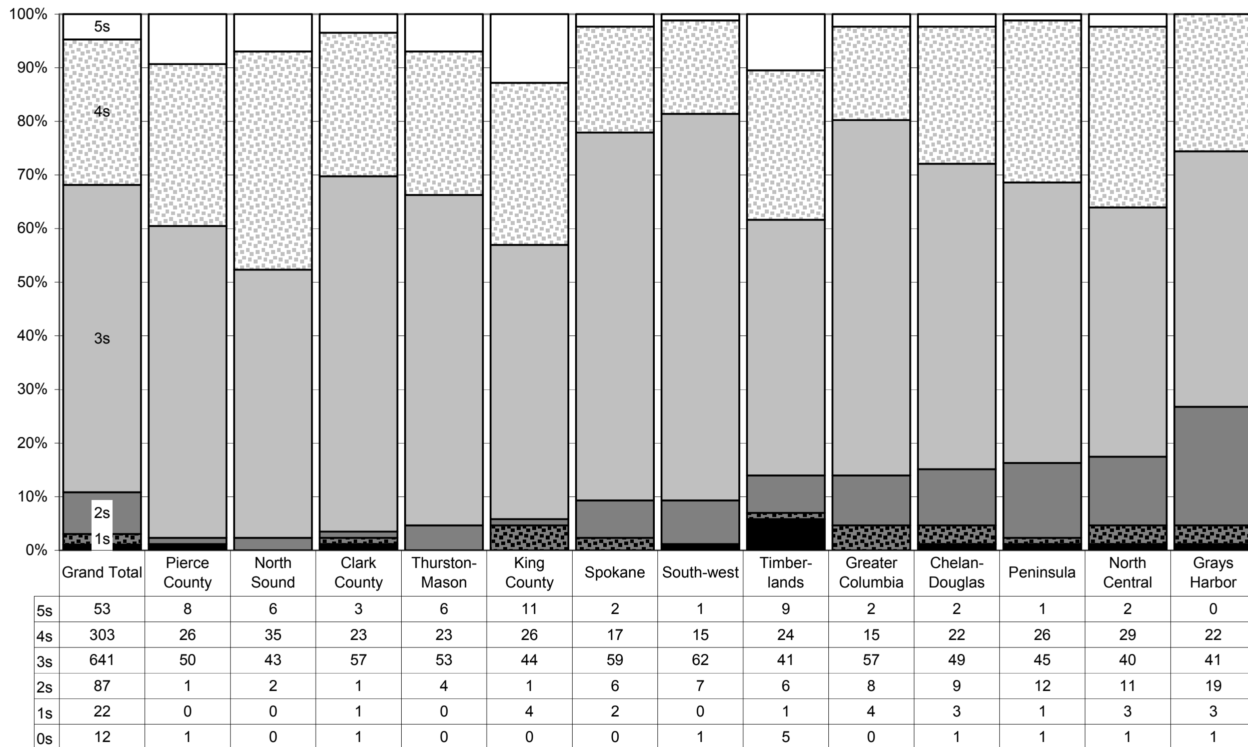
2006 - All Subparts

Figure 16



	Grand Total	Pierce County	North Sound	Clark County	Thurston-Mason	King County	Spokane	South-west	Timber-lands	Greater Columbia	Chelan-Douglas	Peninsula	North Central	Grays Harbor
5s	53	8	6	3	6	11	2	1	9	2	2	1	2	0
4s	303	26	35	23	23	26	17	15	24	15	22	26	29	22
3s	641	50	43	57	53	44	59	62	41	57	49	45	40	41
2s	87	1	2	1	4	1	6	7	6	8	9	12	11	19
1s	22	0	0	1	0	4	2	0	1	4	3	1	3	3
0s	12	1	0	1	0	0	0	1	5	0	1	1	1	1

Close to 90% of 2006 scores on all Subparts statewide were at or above the Expected level of performance, compared to 70% in 2005. Over half of the PIHPs (7 of 13) achieved that performance or better. While the vast majority of scores were 3s, in 2006, there was considerable increase in scores of 4, indicating increased training, as well as improved PIHP and provider staff ability to articulate the purpose of required provisions and how related policies and procedures are implemented in the local setting. As in 2005, the majority of scores that fall below Expected in 2006 are scores of 2. This signifies that PIHP policies and procedures and/or subcontract language contain the scope and intent of the BBA provision for the majority of elements with scores below Expected. Also noteworthy, scores of 0 and 1 decreased to .03% of total scores in 2006, from 12% of total scores in 2005.

In summary, system-wide performance of PIHPs in 2006 improved by approximately 20% over 2005. All 13 PIHPs evidence attention paid to External Quality Review results and State-requested corrective actions of prior review years. Attaining minimum Expected performance requires that policies and procedures consistently meet BBA and State requirements. Performance above the minimum expected signifies effective dissemination,

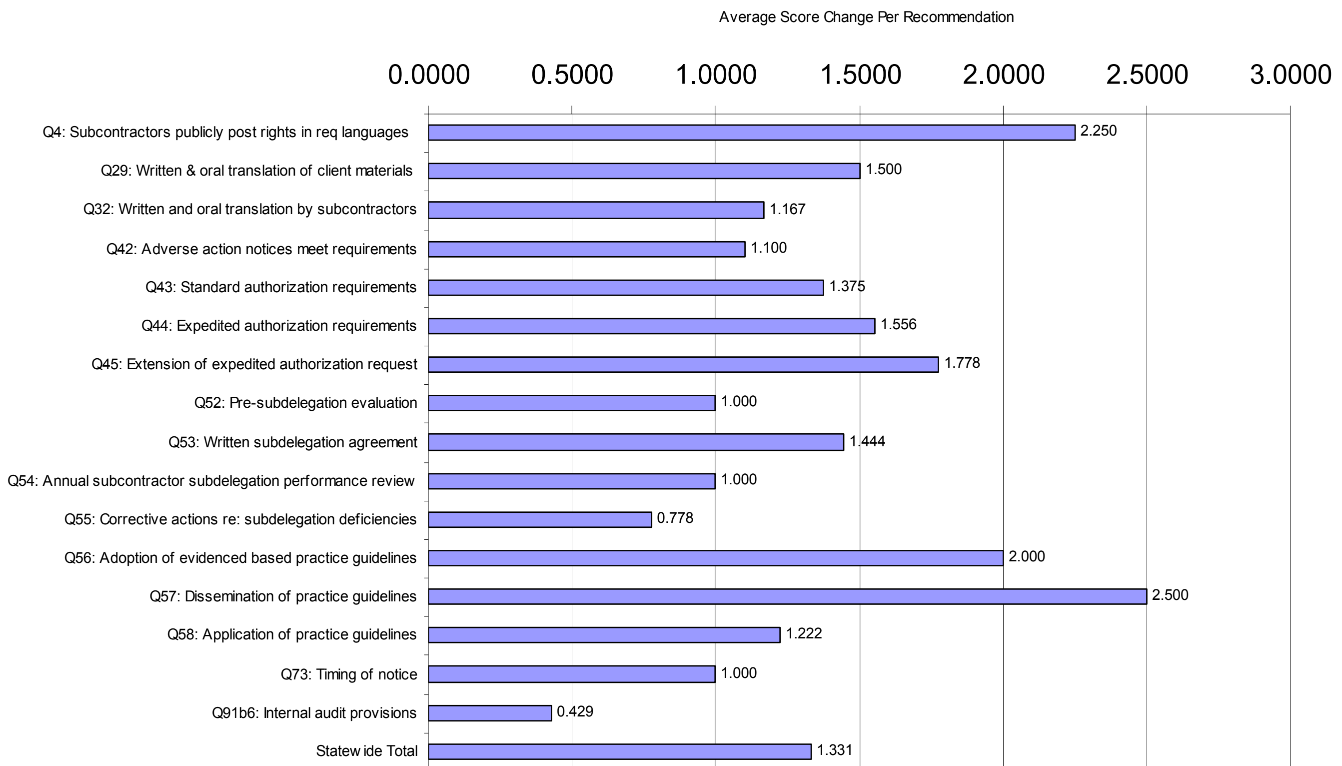
training, and implementation of those P&Ps. Progress being made toward outstanding performance continuously improves the provision of clinical care in a manner that supports consumer rights and consumer-driven service delivery. Specific strengths and improvement recommendations are addressed later in the report.

Figure 17, below, displays the average increase in score points for each 2005 WAEQRO improvement recommendation. The scale at the top of the chart represents increments of point changes; the starting point for all PIHPs (at zero) represents their 2005 score on the item. PIHPs improved from a minimum of 0.43 to a maximum of 2.50 on all elements. For instance, element Q04—Subcontractors publicly post rights in required languages - increased a combined average of 2.25 points over the 2005 scores on the six-point scoring scale. Those elements with the highest average increase include:

- Subcontractors publicly post client rights in required languages
- Adoption of evidenced-based practice guidelines
- Dissemination of practice guidelines.

The notable improvement on these 2005 recommendations demonstrates PIHP focus on provision of high quality care and ensuring consumer awareness of their rights.

Figure 17



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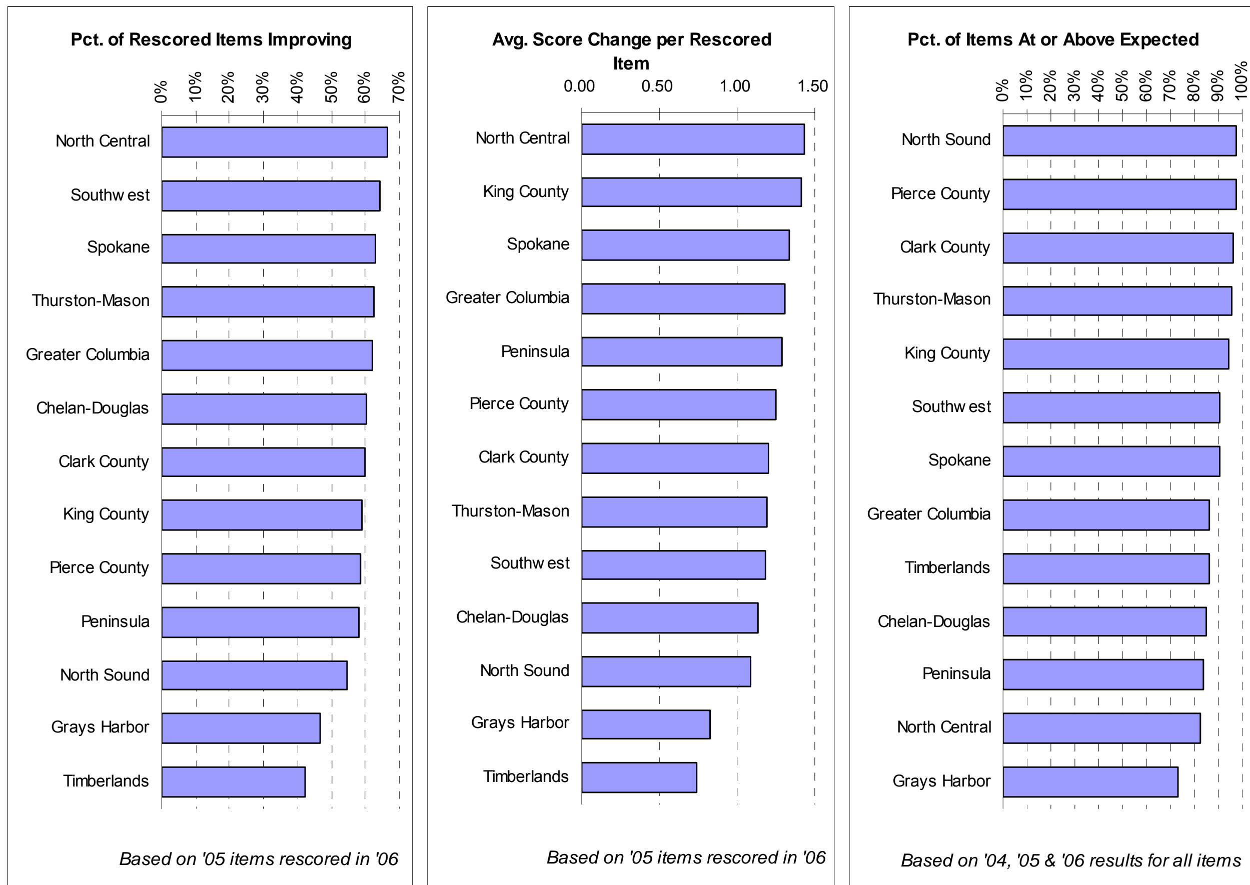
2006 – Performance Rankings

The following charts display three different approaches to understanding PIHP performance.

Figure 18: Measures of Improvement



The first chart recognizes the most improved PIHPs. Top ranking goes to the PIHP showing the greatest percentage of rescored elements with higher scores in 2006 than in 2005. In order to facilitate comparison, the calculation used in this ranking method equalizes the actual number of rescored elements for all PIHPs. For example a PIHP that had 8 elements rescored has the same opportunity to rank as high as or higher than a PIHP that had 35 elements rescored.

The second chart displays the average score increase for each PIHP, based on all elements that were rescored in 2006. PIHPs are ranked from greatest to least average increase in scores. For instance, North Central's average score change was 1.43 points per element rescored, using the 0-5 Subpart scoring scale. Average PIHP improvement is calculated by summing the total amount of movement from 2005 to 2006 between points on the scoring scale, and dividing that result by the number of rescored items accounting for that change. Note that this ranking method also equalizes the number of rescored elements for all PIHPs.

The third chart recognizes PIHPs with the best overall performance at the end of the 2006 review year. Overall performance is defined as the greatest percentage of scores at or above the Expected performance level (3, 4, or 5). This approach includes all element scores for each PIHP and is unique in its "snapshot" perspective, contrasted with the "trend" viewpoint presented in the first two methods.

In brief, these charts collectively reflect that each PIHP's performance continues to improve, contributing to an overall improvement in the mental health system statewide.

2006 Subpart Summary and Recommendations

Strengths

- PIHPs have maintained a steady level of continuous quality improvement. At least 90% of all Subpart C, F, and H scores are at the Expected level of performance, with Subpart D scores close at 85%.
- Evidence of many new and revised policies and procedures pertaining to the Subpart requirements demonstrates PIHP efforts to document, standardize, and operationally define processes to effectively manage care throughout the region. Notably, specific step-by-step procedures related to policy implementation have improved.
- Overall, PIHP and provider staff are committed to ensuring that Medicaid enrollees understand their rights and are able to freely exercise them without fear of retaliation or compromising their services.
- PIHPs generally have standardized and improved their authorization and utilization management procedures and mechanisms since separating these functions from the direct service providers.
- PIHP and provider staff have increased knowledge and understanding of their local grievance systems and are able to articulate pertinent steps to assist Medicaid enrollees in effectively maneuvering through the process.
- At least 2 Practice Guidelines and/or Evidence Based Practices (EBPs) have been adopted by all PIHPs. The majority of PIHPs have moved beyond locally developed guidelines to nationally validated guidelines and EBPs.
- The PIHPs have an increased commitment to integrating consumer voice and participation in decision-making throughout all levels of managed care operations and service delivery.
- Creative service options, based on fundamental values of recovery and normalization, are being developed to meet diverse enrollee needs and to reduce inpatient hospitalizations.

Recommendations

When selecting recommendations, the WAEQRO takes into account both the simple and enrollment-weighted state-wide average scores. The following recommendations describe

opportunities for PIHP improvements that the WAEQRO identified during the 2006 review process. The first 7 are related to the 2005 WAEQRO recommendations that remain relevant.

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.
2. To ensure that all required timeframes are met, establish procedures to track and monitor initial requests for service, intake, authorizations, denials, and grievance system junctures. WAEQRO also recommends that PIHPs continue their oversight of provider network screening and intake procedures to ensure that denials are not occurring without PIHP knowledge and involvement.
3. Develop and implement processes for sub-delegation that include all BBA requirements. Recommend that the State specify in contract which PIHP functions require the application of formal delegation protocols.
4. Delineate standards of application for the adopted practice guidelines. Develop strategies and mechanisms to monitor fidelity of the practice guidelines and provide oversight to ensure their full utilization in clinical services.
5. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.
6. Most PIHPs would benefit from development of procedures to officially adopt and approve new and revised policies and procedures, including a method for ensuring the documentation of such approvals.
7. Many PIHPs would benefit from review and enhancement of monitoring mechanisms that incorporate BBA requirements, State standards, and PIHP locally-determined operational standards.
8. PIHPs would benefit from increasing capacity for analyzing and trending aggregate data to identify improvement needs related to system management and provision of care and services.

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QUALITY ASSURANCE AND IMPROVEMENT

2006 QA&I Review

Section 438.240 of the CFR requires that each PIHP have an ongoing quality assessment and performance improvement program for services offered. As an optional activity for 2006, MHD contracted with WAEQRO to conduct an expanded review of PIHP Quality Assurance and Improvement (QAI) processes, focusing specifically on scope and usefulness of the Quality Management Plan, and on effectiveness of PIHP oversight with respect to the quality of clinical care. Essential elements for effectiveness in both arenas are:

- the extent to which the PIHP's quality management system is structured to ensure useful collection and reporting of data related to system management, service delivery process and quality, and consumer satisfaction;
- the extent to which the quality assurance and improvement process is fully integrated into the PIHP's overall management and service delivery system;
- the extent to which the PIHP follows its plan to monitor clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and
- the extent to which the PIHP uses the resulting information (data) to analyze agency and system strengths and challenges and takes appropriate action.

The Review Process

A desk review was conducted of relevant PIHP documentation (see **Attachment B: Communications**) and on-site interviews conducted with PIHP and provider staff. A phone interview with the PIHP Ombuds assessed the degree to which they receive information and cooperation needed to effectively facilitate and advocate with consumers in the complaints, appeals, grievance, and fair hearing system.

The WAEQRO and MHD developed a review tool to assess performance in four areas of contractually-defined, quality assurance and improvement activities (see **Attachment B: Communications**). The four global performance standards are described below and included multiple contributory elements (17 in all).

- Evaluation of the Quality Management Plan was based on the degree to which it addresses all elements of a complete QAI process, reflects a structure that could ensure this process, defines a data-driven reporting process, incorporates provider and consumer involvement, and describes the degree to which the Quality Management Plan is implemented.
- The PIHPs' clinical chart review evaluation included four elements: conduct of clinical chart reviews according to the QAI Plan and/or related policies and procedures; the sufficiency, accuracy, and reliability of the review tool to measure performance; a system for ensuring consistency of review results; and the degree to

which clinical chart review data generated quality improvement activity.

- Incorporation of review results in QA and I activities was measured using indicators related to the degree to which results were data-driven, aggregated, analyzed, and communicated to providers and consumers in forums charged with identifying and monitoring quality improvement opportunities.
- Three elements assessed the degree to which the complaint and grievance process was effectively incorporated into the quality assurance and improvement system. Included in this assessment was the role of the Ombuds in providing information that was analyzed and acted upon.

Scoring

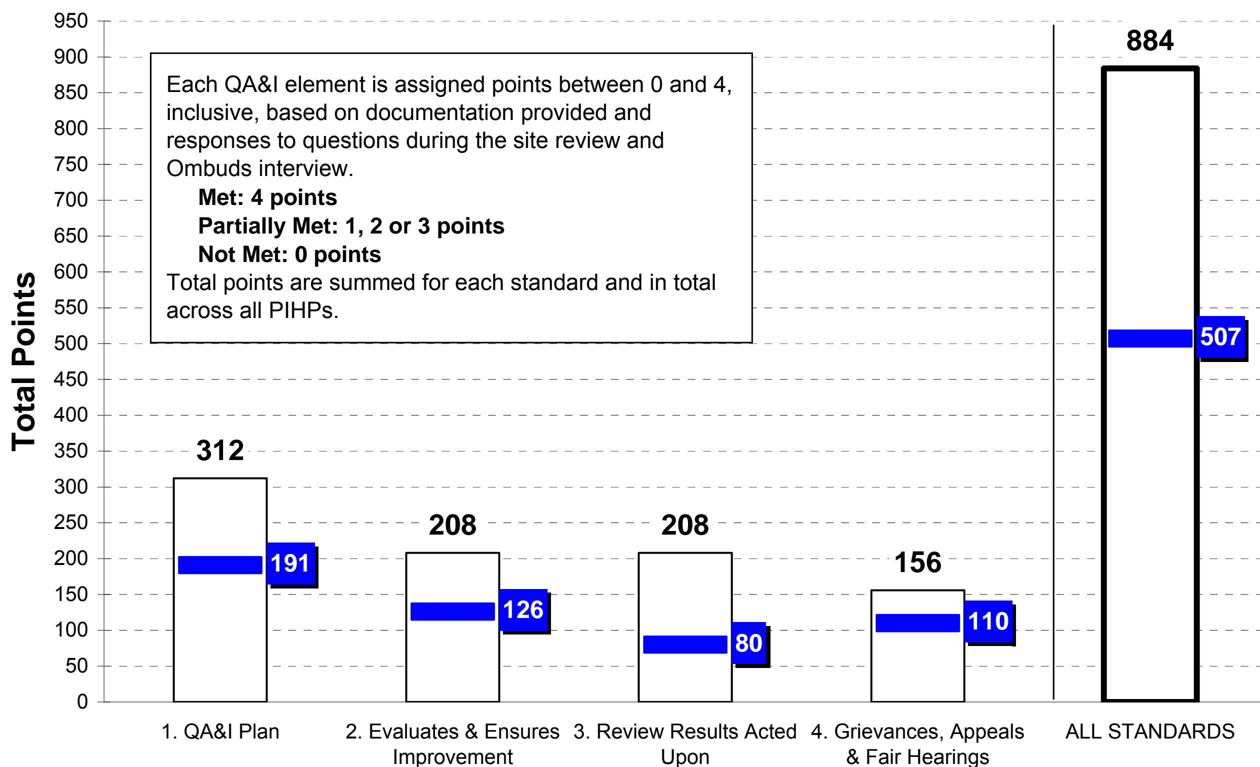
The scoring process provides a baseline measure of PIHP performance and was conducted along two parameters. Each of the seventeen elements in the tool (see **Attachment B: Communications)** was scored on a 5-point scale: zero to four, and designations of Met, Partially Met, and Not Met were assigned to the numerical values. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully Met; and Not Met indicates that the element is not present, or is very inconsistent or incomplete.

Each standard was scored by total points attained and number of Met/Partial/Not Met items for each. Overall scores were calculated by dividing total number of points achieved by the total number possible. Scores greater than 80% are considered an overall Met score; 65% to 79% is Partially Met, and those below 65% are considered overall as Not Met. In addition, the count of the number of Met items was provided and compared to the total possible, the goal ultimately being the achievement of all elements as Met.

The chart below displays the cumulative points achieved by all PIHPs on each standard, providing a system-wide view of performance on those QAI activities reviewed for 2006.

2006 QA&I Review Results

Figure 19



The bars in the chart above represent the four standards of the QAI tool, with the maximum number of points possible indicated above each bar. The heavy line represents the cumulative points achieved by all PIHPs combined on each standard and overall.

Overall, slightly more than half of all points possible were achieved. Of the four standards, the most points achieved were for Standard 4, Grievance and Appeal system, 110/156 (70.5%). This was followed by the QAI Plan with 191/312 (61.2%). The total points achieved for the chart review tool was 126 of a possible 208 (60.5%). The least number of cumulative points were achieved in the standard measuring use of data for quality improvement activity, with only 80 of a total possible 208 points achieved (38.4%). These results indicate that the system-wide strength is in effective support of the grievance and appeal process, and the greatest opportunity for improvement lies in an improvement in PIHP capacity to consistently review and analyze data for quality assurance and improvement purposes.

Figure 20

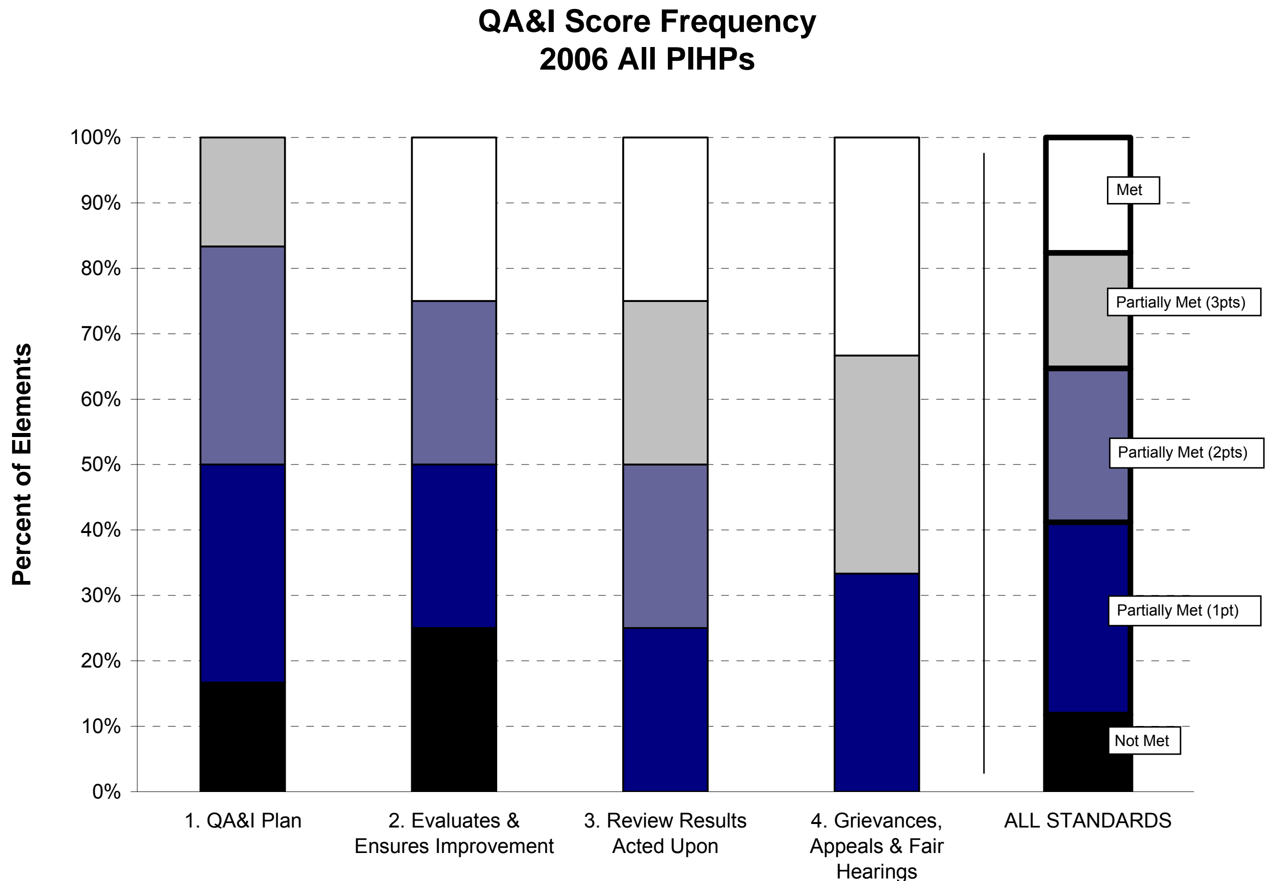


Figure 20, above, reflects the detail of the combined PIHP scores on the Met – Not Met Scale. Because achievement of Met on all standards is the ultimate goal, this chart graphically demonstrates the distance on each standard from fully Met as well as the relative need for improvement in each area. The far right bar demonstrates that system-wide slightly less than 20% of all review elements are fully Met in 2006 and that slightly more than 10% of review elements are fully Not Met. Thirty-four percent Met in Standard 4 reflects PIHP and provider knowledge and implementation of grievance and appeal requirements. The 25% Not Met in Standard 2 reflects the challenges most PIHPs experience related to data analysis and reporting, described in more detail below.

Figure 21: 2006 QA&I Enrollment-Weighted Statewide Averages

					Strength Stars			Weakness Flags		
		Chelan-Douglas	WA State Simple Average	WA State Weighted Average	Q(s1) Is State Wtd Average at least 2.5?	Q(s2) Did more than 9 PIHPs score at least 2.5?	Stars Items satisfying both Q(s1) & Q(s2)	Q(w1) Is State Wtd Average less than 2.5?	Q(w2) Did more than 9 PIHPs score under 2.5?	Flags Items satisfying both Q(w1) & Q(w2)
Item	Description				2.5	9	2 stars	2.5	9	3 flags
E.01	PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		2.2	2.4				•		
E.02	Plan includes annual review of PIHP Quality Assurance and Improvement program.		2.8	2.5	•					
E.03	Plan includes annual work plan and process for review of associated activities and progress.		1.2	1.2				•	•	*flag*
E.04	Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		2.5	2.4				•		
E.05	Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.		3.4	3.3	•	•	*star*			
E.06	PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		2.6	2.7	•					
E.07	Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis		3.1	3.3	•					
E.08	Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review		2.4	2.8	•					
E.09	Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		1.6	2.1				•	•	*flag*
E.10	PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		2.6	2.9	•					
E.11	QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		1.6	1.9				•		
E.12	PIHP analyzes and trends individual provider performance		1.6	2.2				•		
E.13	PIHP analyzes and trends system-wide performance		1.2	1.8				•	•	*flag*
E.14	PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		1.7	2.2				•		
E.15	IHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		2.2	2.4				•		
E.16	B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.		2.7	3.2	•					
E.17	C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.		3.5	3.7	•	•	*star*			

** as of June 2006, calculated May 2007*

Figure 21, above, provides a comparison between the raw average score for each of the 17 items on the QAI tool with the weighted average based on each PIHP's enrolled population. Each PIHP score was weighted based on Medicaid enrollment during the review period. This enrollment-weighted score more accurately reflects statewide performance because an exceptional score in a large PIHP affects more members than it would in a small PIHP.

To qualify as a strength, the statewide enrollment-weighted score must be at or above a specified level (2.5), and a certain number of PIHPs (9) must have individual scores at or above this level. Items with scoring profiles meeting both criteria receive a strength "star." An inverted approach is used for assigning weakness "flags." These designate items having low statewide

scores (below 2.5) along with underperformance by 9 or more PIHPs. The two criteria for each category capture not only aggregate statewide performance, but also variation among PIHPs that can be masked when focusing strictly on statewide performance, even when weighted for enrollment.

The enrollment-weighted averages range from a low of 1.2 to a high of 3.7. Two elements are starred as system-wide strengths, indicating that the most well-developed QAI processes include the involvement of providers and consumers in quality improvement activities and provider and Ombuds support of the appeal and grievance process. Three elements are flagged as the weakest areas of the QAI system, pointing to critical areas in need of improvement:

- creation of annual work plans;
- documentation of chart review scoring criteria;
- including processes for ensuring inter-rater reliability; and
- analysis of performance data for use in prioritizing QI activities.

Highlights of findings for each standard follow.

Standard 1 – QAI Plan: the degree to which it addresses all elements of a complete and effective QAI process:

- Overall, more than half the QAI Plans contain most elements of a comprehensive plan, which are implemented sufficiently to consider the QAI Plan as shaping the quality management system. Consistent implementation of the plans varies widely across PIHPs.
- A significant strength in this element is the degree to which providers and consumers are integrated into the quality improvement system.
- The most frequent element missing is an annual work plan; PIHPs generally identify their performance indicators as their work plan and fail to select a few important improvement initiatives to formally implement and track.
- Performance indicators vary widely in the degree to which they are defined (including measurement methods), the specification of desired targets, schedule and venues for reporting, assignment of responsibility, and thresholds for taking action.
- Most plans identify representation from the IT department as an important contributor to the QAI process and structure key committees accordingly; fiscal staff, however, are not consistently represented. Routine involvement of both departments is necessary to ensure a comprehensive, data-driven QAI process that incorporates reliable data analysis.
- Increased staffing for quality assurance and improvement functions was recommended for more than half of the PIHPs, including designation of a specific Quality Manager position that operates as part of the senior management team.

Standard 2 – Evaluates and Ensures Improvement: sufficiency, accuracy, and reliability of clinical chart review tool to measure performance as well as the consistency of the review process

- Chart reviews are conducted by all providers, and most occur routinely, according to plan.
- Most PIHPs tend to use some version of the chart review tool employed by the MHD licensing staff, and most have some type of reviewer interpretive guide (criteria for applying scores).
- Most PIHPs, however, do not have formal methods and/or documentation to ensure inter-rater reliability across reviews and reviewers.
- With some notable exceptions, chart review scoring methods are generally insufficient to identify agency and system outliers and trends over time; methodology documentation is sparse or non-existent.
- Thresholds for corrective actions are generally not defined or well-communicated by most PIHPs.

Standard 3 – Review Results Acted Upon: the degree to which results were data-driven, analyzed, and communicated

- While most PIHPs calculate scores of chart reviews for individual providers, only some calculate and analyze scores across the system to identify system-wide trends and improvement needs. Only 1 PIHP provided analysis of possible outliers as a source of quality improvement focus.
- As evidenced by the frequency and quality of reports, content of meeting minutes, and provider and PIHP assertions, communication and discussion of results of oversight activities was inconsistent across the state, particularly related to identifying and analyzing aggregated and trended data.

Standard 4 – Grievance, Appeals, and Fair Hearings: the degree to which the complaint and grievance process was effectively incorporated into the QAI system

- Knowledge of requirements and facilitation of consumer access to the complaints and grievance system is a significant strength across the PIHP system. The strength of this score is enhanced in almost all cases by the quality of Ombuds participation.
- Few PIHPs document evidence of incorporating grievance and appeal data into quality oversight and improvement activities.
- Few PIHPs offer training to provider staff and consumers concerning the purpose and value of quality improvement, an important element in the successful implementation of a system-wide QAI process.
- Few PIHPs have systematic procedures for tracking compliance with requirements for managing complaints, grievances, and fair hearings.

2006 QA&I Summary and Recommendations

Strengths

- Most PIHPs include IT representation on key QAI committees, enhancing the probability that use of data forms the basis of quality assurance and improvement activities.
- Clinical chart reviews are conducted routinely, and findings are shared with providers, verbally and in writing, thus increasing consistent opportunity for improvement across the provider system.
- Most PIHPs have at least a partially developed matrix of performance indicators that provides a roadmap for understanding all aspects of system performance and helps determine critical areas on which to focus.
- Providers and consumers are regularly included in the QAI process and provide meaningful input to a consumer-driven, recovery-oriented quality strategy.
- Almost all Ombuds evidence considerable knowledge relative to QAI matters and appropriately facilitate consumer access to the complaint and grievance system.

Recommendations

The following recommendations describe opportunities for PIHP improvements that WAEQRO identified during the review process.

1. Many PIHPs would benefit from more consistent application of their quality improvement plans and processes. In particular, maintaining regular meeting schedules, ensuring review of key indicators on scheduled basis, and following up on agreed-upon research and/or improvement activities, would enhance the effectiveness of their process and ensure that they maintain their desired focus.

2. Matrices of indicators, as the performance evaluation roadmap, would be enhanced by the addition of detailed definitions, methods of measurement, targets for achievement, thresholds for considering/taking action, and reporting responsibilities and schedules.

3. Selection of 2-4 well-defined improvement projects (in addition to PIPs) as an annual work plan, generated from results of the previous year's performance indicators, would help PIHPs ensure that QI activities are appropriately prioritized and consistently implemented.

4. Development of data analysis capabilities and consistent reporting and discussion would support effective use of the considerable data already available and bring statistical rigor to all aspects of the QAI process.

5. Most PIHPs would benefit from improving the clinical chart review scoring methodology to support a more useful analysis of individual provider and network performance over time. Identification of strengths and improvement opportunities at both levels, as well as observation of performance changes over time, help the PIHP identify more specifically

the appropriate level and types of interventions required and evaluate the results of those interventions.

PERFORMANCE IMPROVEMENT PROJECTS

Complete review of PIPs, according to CMS protocol, entails three sets of activities: 1) assessment of methodology for conducting the PIP, 2) verification of results, and 3) evaluation of overall validity and reliability of study results. Because the PIHPs in Washington State have been unfamiliar with the protocols for conducting PIPs, no PIHPs have completed a PIP, and most do not have fully developed plans and methodologies. Therefore, WAEQRO review has focused on assessment of methodology, intending to provide technical assistance and an informal assessment of reliability and validity of the methodology for informational purposes. While the WAEQRO review tool and process reflect the CMS evaluation protocol, formal, or "official" scoring has been deferred.

2005 PIP Overview

Recognizing that the CMS protocol was new or unfamiliar to the PIHPs, 2005 was the first year a CMS validation tool was used to conduct the PIP review. An informal "scoring" system calibrated to "Yes/No/Partial" was adopted to indicate the extent to which each step in the methodology assessment approached CMS standards for a sound performance improvement project. In both the PIHP reports and site visit discussions, the WAEQRO emphasized provision of technical assistance related to the PIP process; in particular, the selection of a study topic and indicators, and the importance of a well-defined intervention and data analysis plan to enhance confidence in project results.

Highlights of the 2005 review included:

1. Most PIHPs did not select study topics based on analysis of their ongoing data review; some chose interventions (clinical and process) in which they had interest, then looked for a problem to which that intervention would relate.
2. Questions were typically not structured as scientific inquiry, but rather stated as, "How can we accomplish ___?"
3. Indicators were generally vague, overly broad, or not directly related to the study question.
4. With few exceptions, data collection was brief, lacked detail, and did not address the extent to which the data would be reliable.
5. Many PIPs attempted to implement multiple "solutions", but without a system for identifying their individual impact.
6. Data analysis plans were vague or nonexistent; instead, submitted statements typically indicated, "The X Committee will review the information regularly and make recommendations".

2006 PIP Review

All PIHPs were under contractual obligation to have two PIPs in process, one clinical and one non-clinical, either of their own choosing or continuing a state-defined topic from 2004 or 2005.

The WAEQRO expected that PIP quality would improve in 2006 based on site visit discussions in 2005, and as PIHPs were able to make use of MHD-sponsored training in September 2006 and February 2007. While PIHPs whose review years ended before the training were at some disadvantage relative to those whose review years encompassed the training, results indicate that some PIHPs made significant progress without the training, and others did not appear to make any progress despite having several months post-training to revise their PIP plans.

The WAEQRO reviewed in detail one of two PIPs submitted by each PIHP. When possible, the CMS validation tool was used to assess methodology and provide feedback on previously developed (or new) PIPs. Ratings of Met, Partially Met, Not Met, and N/A were applied to each step in the PIP methodology process, reflecting the extent to which they approached the level of soundness required for a reliable and valid PIP. The tool was enhanced for 2006 by adding highlights of those activities for each step which are "critical" for producing valid, reliable results, and for demonstrating confidence in the PIP findings. A summary of findings was provided at the end of the validation tool, along with an overall, Met/Partially Met/Not Met, summarizing the quality of the entire methodology. Where they could be helpful, comments and suggestions were included in each step and in the summary. Final PIHP reports included completed validation tools and/or a performance summary with recommendations for improvement based on the current status of PIP activity.

The Review Process

Instructions for PIP document submission were included in the document request to all PIHPs. These instructions focused on compiling supporting documentation and included a copy of the validation tool, as well as a request for PIHPs to conduct a self-evaluation as a technical assistance exercise to increase understanding of process steps and performance evaluation. The WAEQRO suggested documentation such as the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for its improvement or the development of new PIPs based on what was learned in training provided by MHD.

2006 Results

Quality of 2006 PIPs varied widely across the state. Some were new and well-developed, reflecting focused effort to accomplish a meaningful improvement project. Others displayed little or no new activity, with PIHPs acknowledging that they either had done very little work on them and/or had not developed new study topics.

Of the thirteen PIPs reviewed, 8 were sufficiently developed to be evaluated using the CMS tool. The 5 not validated either submitted no documentation, or their submissions reflected little or no true PIP activity. Two PIPs were of very high quality, achieving a Met status; three demonstrated significant effort and achieved a Partially Met; and the remaining three achieved Not Met status, indicating significant shortcomings in key steps of the process. Figure 21, below, details the status of each PIP.

The table below provides an overview of methodology review results for all PIHPs.

Figure 22: Statewide PIP Summary

PIHP	Plan Assessed *	Overall Performance
Pierce County	X	Met
King County	X	Met
Southwest	X	Not met
Chelan-Douglas	X	Not met
Thurston-Mason	X	Not met
Clark County	X	Partial
Timberlands	X	Partial
North Sound	X	Partial
Greater Columbia		
Peninsula		
North Central		
Spokane County		
Grays Harbor		

*** Validation Tool used**

Met = high confidence in methodology
Paritally Met = low confidence in methodology
Not Met = methodology unreliable

The 2 PIPs achieving Met status were notable for their well-structured study questions, well-defined indicators, and thorough, appropriate data analysis plans. While neither had progressed beyond the planning stage, the analysis of results post-intervention is predicted to be valid and reliable due to design quality. Those PIHPs achieving a Partial performance assessment also expended considerable effort in the effective design and data analysis plans for their PIPs; however, one or more important elements required re-design or additional detail to support a high confidence level in the results.

Improvements over 2005 evidenced by those PIHPs achieving Met and Partially Met performance included structure of study questions to incorporate impact of an intervention on baseline data; definition of study indicators that allow for the question to be answered or proven and established numerators and denominators; detailed and appropriate data analysis plans; and selection and detailed description of planned interventions based on discussions about possible barriers to achieving desired results.

Improvements over 2005 evidenced by those PIHPs achieving Met and Partially Met performance included the following:

- Structure of study questions to incorporate impact of an intervention on baseline data;

- Definition of study indicators that allow for the question to be answered or proven and established numerators and denominators;
- Detailed and appropriate data analysis plans; and
- Selection and detailed description of planned interventions based on discussions about possible barriers to achieving desired results.

Several PIHPs attempted to create "retrospective" PIPs from work that had been ongoing for a period of years. A few of these were validated if sufficient material was submitted to provide technical assistance based on BBA protocols; others were not, as the material was not sufficiently organized or developed to apply the validation protocol.

2006 PIP Summary and Recommendations

With few notable exceptions, PIPs in 2006 had not progressed appreciably over 2005. Many PIHPs did little more than create a document to submit for APS review, and meeting minutes indicating that the subject was mentioned, irrespective of context. Anticipation of a State-defined PIP and/or the training was most often cited as the reason for lack of activity.

In sharp contrast were those PIHPs (all Met and Partial) that had carefully applied the CMS protocols to new study topics, or had refined existing studies to reflect increased understanding of the PIP process. Their study questions, interventions, and data analysis plans reflected significant improvement over the 2005 PIPs, and most should yield reliable results once implemented.

Because all PIHPs would be well-served by closely following the CMS protocol, which is documented elsewhere, the following recommendations are made related to the structures and procedures that would effectively support a sound PIP process.

1. The WAEQRO recommends that, by formal contract and meetings with PIHPs, MHD confirm State expectations related to number and type of PIPs required.
2. PIP design and implementation would benefit from PIHPs assigning appropriate staff and/or committees to analyze existing data and develop study topics and methodology. A mechanism to ensure dedicated focus on ongoing implementation, including routine reporting responsibility, would improve reliability and usefulness of improvement projects.
3. The entire system would benefit from ongoing technical assistance related to PIP development, including cross-PIHP sharing of resources and knowledge.

PERFORMANCE MEASUREMENT

As part of the performance measure validation process, the WAEQRO examines the PIHPs and the State to gain perspective on the reliability of results published by the State. Accuracy of data submitted by the PIHPs is assessed through the Encounter Validation Review activity. Validation of MHD calculation methodologies and procedures and procedures consists of interviews with key MHD personnel and reviews of their calculation and measurement processes. Specific topics related to data system capabilities and data submission were discussed at the site visit with PIHP Information Technology (IT) staff as a follow-up to the 2005 report.

In the state of Washington, Performance Measures evaluated by the WAEQRO are State-defined. These measures are:

- **Crisis Only Utilization Rates** – for Medicaid Population;
- **Expenditures per Consumer** – for Community Outpatient Services; and
- **Outpatient Employment Change Over Time** – Working Age Adults (18-64 yrs)**.**

Medicaid Crisis Only Utilization Rates and Outpatient Employment Change Over Time are calculated by MHD and derive from data collected from the PIHPs through their normal data submissions. The Expenditures per Consumer is also calculated by MHD, using dollar amounts from the PIHPs' Revenue and Expenditure Reports, and client counts based on data collected from the PIHPs through their normal data submissions.

2006 PM Results

This year's PIHP interviews were based on system issues identified in 2005. Discussion and responses with respect to specific topics were documented in the individual PIHP reports. A compilation of trends and their implications is presented here.

1. **The mapping of non-standard codes**. Eleven of 13 PIHPs had well-established methodologies and/or documented processes and procedures to guide their provider network in this task. This is an improvement over last year's results; two of four PIHPs requiring a standardized method had developed one over the past year.
2. **Unique member ID**. All PIHPs used appropriate methods to manage duplicate member IDs.
3. **Tracking across product lines**. Twelve of the thirteen PIHPs currently have this capability. The one that does not reports that their provider network's systems are able to make the differentiation.
4. **Tracking individuals through enrollment, disenrollment, and re-enrollment**. All thirteen PIHPs can track this level of detail on their clients.
5. **Calculating member months**. Seven PIHPs report that they can calculate member months and four (an increase of two over the last year) are doing so in management reports, thus enhancing their ability to understand a wide variety of performance measurement

relationships. Of the remaining PIHPs, two were evaluating calculation methods, and one had plans for using member months in reports currently being designed. Three PIHPs were not considering their use or calculation.

6. **Member database**. Twelve PIHPs are now using the data made available by MHD for a member database; one PIHP is not. This database is used as a first stop for checking on client Medicaid eligibility.
7. **Provider database**. Eight PIHPs have a provider database and two collect additional information on providers with other data. Of those who lack a provider database, one collects provider information manually, and two do not collect information beyond that required by the State. Overall, eleven of thirteen PIHPs use provider data in decision-making, and ten maintain that information in some type of database.
8. **Data easily under reported**. All PIHPs have a mechanism to report these activities as they relate to fiscal expenditures. There is no method to count these encounters with other encounter activity reported by the PIHPs.

Validation Results

PIHPs are responsible for submitting timely, accurate, and complete data that drives the performance measures. The encounter validation conducted in 2005 and the 2006 EV Process Review play a significant role in the performance measure evaluation results. For 2005, the State's encounter match rate was 83.15%; PIHPs ranged from a 42.78% match to a 99.39% match. During the 2006 review period, PIHPs engaged in their own encounter validations. Results varied, but positive steps in continuous quality improvement are taking place system-wide. This progress and momentum has had a positive effect on improving the timeliness, accuracy, and completeness of data used for performance measure calculation.

Crisis Only Utilization Rates – for Medicaid Population
Finding: Valid
Significant progress has been made in the overall system controls used to ensure data accuracy and completeness. The PIHPs implemented audits similar to those used by WAEQRO in the 2005 Encounter Validation. These efforts have yielded positive results. The more such reviews are conducted, the more accurate the State's data.

Inconsistencies in service reporting are noted for one PIHP, and the measures for that PIHP reflect these inconsistencies over the three years tracked. Another PIHP shows higher average hours than others, calling into question the encounter reporting methodology used by that PIHP. Ideally, the types of services reported and the method used to report such services should be consistent across the state. Not having this consistency makes comparability difficult and the combined results less accurate than desired.

Expenditures per Consumer – for Community Outpatient Services
Finding: Valid
Again, overall system control improvements have had a positive impact on accuracy of the data used to generate the denominator for this measure. The numerator is derived from the fiscal side of MHD's operations. The fiscal controls used in state government follow GAAP

(generally accepted accounting principles), the gold standard for the accounting world. The employment of GAAP controls and methods, combined with yearly audits from State's Auditor, help to ensure validity of the numbers used in the numerator.

A change in the formula used to collect fiscal information in 2005 had an overall effect of lowering expenditures nearly state-wide. It is interesting to note, however, that expenditures appeared to increase for three smaller PIHPs (one of which no longer exists), which raises questions about the discrepancy between them and the others.

Outpatient Employment Change Over Time – Working Age Adults (18-64 yrs)
Finding: Questionable
The employment change measure appears reliable on its face, in that re-measurement tends to produce similar results. Whether it is valid remains an open question; i.e., whether it actually measures employment status changes. This uncertainty relates to the exact "counting rules" used in constructing the measure. For example, for clients with two employment status readings, it is clear that the cohorts to which they are assigned depend entirely on these two readings. However, for clients with 3 or more employment status readings, it is not clear how intervening readings are handled.

A somewhat related concern is the extent to which denominator clients are comprised of those with two employment status readings taken within a very short period of time. Because employment status is a highly persistent characteristic -- (un)employment today is a strong predictor of (un)employment tomorrow -- enough time should elapse between status readings to allow employment status to express itself. While this may reduce the number of clients available for the measure, it is likely to boost the validity of the result.

Performance Indicator Calculation System

During the 2005 review period, the Mental Health Division contracted with an external entity, Looking Glass Analytics, for calculation and web publication of their performance measures. A new system has been implemented during the 2006 review period, which includes many desirable enhancements that increase the reliability and validity of the performance measures.

- Many of the processes used to generate the measures have been automated, which reduces the chance for error.
- The code has been re-written and appropriately documented. This is a significant enhancement over some of the previous 'black box' processes used in summarizing encounter data that was necessary for production of the performance measures.
- During the transition, measures were produced from both systems to ensure that the new system was working properly.
- As each measure was developed, MHD analyzed both systems to ensure that the original performance measure definition and production was sound, and that the new code accurately reproduces reliable results. This process ensured that both new code and algorithms were correctly reproduced.

- MHD's process of extracting relevant data from the various State systems has been a past concern. The process was complex and undocumented. Current efforts by LGAN to automate the entire system include addressing the MHD extraction process. The original code used for extracting data has been redesigned and streamlined, and the code has been enhanced by in-line documentation. Parts of the system still require attention; however, the eventual result of automating will virtually eliminate concerns about undocumented, questionable code.
- As a function of process redesign, data files created from encounter data and summarized into analysis files used in the production of the performance measures are kept until monthly update of the performance data. In addition, the process used to summarize encounter data is documented. While this is technically not freezing the data set, the process does allow for two important benefits: original data is kept secure, and because data used in the performance measure calculation is updated to reflect revisions to the encounter data, accuracy of the information improves over time. However, data re-evaluation at another time is limited, due to its dynamic nature, and third party use of the data for independent calculation and verification is unlikely.
- The contracted entity has a disaster recovery system that protects this data and related code.

These changes have had a positive impact on the system that generates performance measures, and work continues with respect to developing and documenting the performance measure calculation system.

2006 PM Summary and Recommendations

Strengths

- Data accountability has increased dramatically. Encounter validations, error tracking, and employing routine IT processes state-wide are all important improvements noted in this year's review.
- Looking Glass Analytics, the contracted entity calculating performance measures for the MHD, is making significant progress in re-developing legacy code that has driven performance measures prior to this review period. Previously, this code was inefficient and not documented.
- Transformation of the indicator calculation system, a collaborative effort of MHD and Looking Glass Analytics, has many unseen benefits. The system is being validated, documented, and automated, resulting in increased efficiency and process comprehension for all users.

Recommendations

1. WAEQRO continues to stress the need for reproducible performance measure calculations. To enable this functionality, processes and procedures must be sufficiently documented so as to allow another entity to successfully reproduce results without guidance.

2. The methods employed to extract data used in calculating performance measures continue to need further documentation. While the WAEQRO recognizes that these issues are being addressed, it is critical to keep the recommendation current until that process is complete.
3. Those PIHPs not calculating and using member months should begin doing so. The WAEQRO continues to recommend the use of member month calculations, as the level of granularity available by calculating member months facilitates comparison among PIHPs and between the State and other entities. Per member per month (PMPM) measures are commonly used in the managed healthcare industry, and member month data allows for more accurate utilization and penetration rate calculation.

ENCOUNTER VALIDATION

It is critically important that the management information system (MIS) of the Washington State mental health system contains timely, accurate, and complete data in a secure, reliable environment. This data is used by the PIHPs and the Mental Health Division for encounter reporting and performance measurement. For PIHPs using electronic medical records, it serves as the actual clinical record that documents assessments, treatment planning, and mental health services provided to clients. Critical financial management decisions are based on this data. The calculation of Medicaid enrollment, as well as numbers and types of services provided, determines federal, state, and local funding rates.

In addition, complying with federal and state service delivery requirements and evaluating treatment effectiveness are processes that rely on data reported by the MIS. Because data in this context is virtual (an electronic simile of hardcopy records), steps must be taken to instill user confidence in its accuracy. Conducting an encounter validation is an effective method for evaluating data to make this determination.

2005 EV Results Overview

In 2005, the WAEQRO conducted an encounter validation on the State's fiscal year 2005 mental health encounter data, using the CMS protocol as a guide for developing the process and tools. A simple random sample of encounters was drawn from qualified clients (those with at least one Medicaid service during the defined period of the review). Using the 'Sample Size Calculator' on The Survey System website, a sample size of 411 encounters would ensure a confidence level of 95% and a confidence interval of +/- 5 points, enabling the WAEQRO to draw valid conclusions about the accuracy, timeliness, and completeness of the data. A draw of 30 client records from each PIHP was calculated to yield at least 411 encounters from each.

Findings

Phase 1: In evaluating the State dataset, thirty-one of 34 data elements examined for completeness and accuracy were found to be compliant with the standards. While this result appears reasonable, issues such as data structure, data dictionary definitions, and physical record structure called into question close to 1/3 of those compliant scores.

Phase 2: Two comprehensive sets of data were studied independently to capture data validity in two directions: ensuring that data in the State's data set is fully documented in the clinical record and, in turn, reliably submitted to the State. Results in both directions should have been quite similar (within 5 points); however, an 11.36% difference was found between the two sets in the encounter matches. This difference may have been caused by administrative issues related to record collection needed for the review; another independent encounter validation would further clarify reasons for the discrepancy.

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2006 EV Review Results

In 2006, MHD requested that the WAEQRO review encounter validations conducted by the PIHPs during the review period, a request reflecting focus on continuous improvement in the quality of reported data. The evaluation was designed to determine compliance with requirements specified in the contract between the State of Washington and the PIHPs, and to evaluate the full process used to conduct the encounter validations.

The Review Process

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, **Attachment B**, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases, a data/record comparison was reviewed.

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers; review data dictionaries and policies and procedures (as well as any memoranda of understanding); identify PIHP requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data, and requires data screening to determine completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation, as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

EV Review Scoring

The WAEQRO and the Mental Health Division developed a review tool based on CMS protocols (see Attachment B). A key goal of the 2006 review was introduction of a standard framework for PIHP use in further developing their own processes; therefore, the tool provided review structure as well as a framework to aid PIHPs in further developing their EV processes. The review items in the tool (described in detail later in the report) include:

- Data Requirements
- Network Capability
- Analysis of the Data
- Review of Records
- Submission of Findings
- Follow-up Activities

A total of 14 elements were assessed as Met, Partially Met, Not Met, and NA based on criteria in the table below.

Figure 23

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP EV Compliance

The review tool includes a subset of activities required by PIHPs to meet state contract terms (referred to as "compliance"). The specific contract requirements include:

1. Analysis of data for accuracy and completeness.
2. A review of 1% of all encounters or 250 encounters, whichever is less during the first 6 months of the Agreement period, comparing the clinical record against the subcontractor's encounter data to determine agreement in type of service, date of service, and service provider. This review must verify that the service reported actually occurred; and
3. A report based on this information to be used by the Contractor in its data-monitoring activities. The report shall be submitted to the MHD 30 days prior to the end of this Agreement.

To receive an overall Met on the compliance part of the review, PIHP ratings review of records (2) and submission of findings (3) both need to be Met, with a minimum of Partially Met required for the analysis of the data (1).

The results of the compliance review are displayed in Figure 24, below.

Figure 24: EV Compliance Review Results

	3a Data Anaysis	4a Review of Medical Records	5a EV Report to the State	*Statewide* Average	Compliance Items
King County	2	2	2	**2.00**	**Met**
Clark County	1	1	2	**1.33**	Partially Met
Greater Columbia	1	2	1	**1.33**	Partially Met
Pierce County	0	1	2	**1.00**	Partially Met
Spokane County	0	1	2	**1.00**	Partially Met
Peninsula	1	2	1	**1.33**	Partially Met
Thurston-Mason	1	1	1	**1.00**	Partially Met
North Sound	1	2	1	**1.33**	Partially Met
Southwest	0	1	1	**0.67**	Not Met
Chelan-Douglas	0	1	1	**0.67**	Not Met
Timberlands	0	0	1	**0.33**	Not Met
North Central	0	1	1	**0.67**	Not Met
Grays Harbor	0	1	1	**0.67**	Not Met

Items highlighted in green (4a & 5a) must be scored Met and the item highlighted in blue (3a) Partial Met for the overall Compliance score to be Met. See the scoring guide (Figure 23) for more details.

Only one PIHP received an overall Met for their encounter validation efforts in the compliance portion of the review; seven received Partially Met, and five were rated Not Met. While specific contract requirements were minimally met by all but one PIHP, the review process encompassed more detail than the steps outlined in the contract. The tool required the process to be adequately documented and, in many cases, it was not. The tool evaluated the type of analysis conducted on the data, which, if conducted at all, was not the type of review that would meet the CMS definition for an encounter validation. Finally, every PIHP submitted an EV activities report to the MHD; however, the included information and conclusions (when drawn) did not adequately describe processes and results obtained from employing them.

The concepts related to conducting a data analysis and methods for validating encounter data were discussed with PIHPs at the site visit, and an outline of information their State reports should contain was included in their individual reports.

EV Process Review

The EV Review tool was designed to evaluate, in detail, the necessary procedures (based on CMS protocol) related to validating encounters. The following describes related activities and the rationale for including them in a comprehensive encounter validation process.

- Data requirements and completeness standards: both should be adequately documented and communicated to appropriate parties in a timely and effective manner; in addition, the system needs an effective process to communicate changes to the data requirements.
- PIHP provider network capability to collect, secure, and transmit data that is timely, accurate and complete: the PIHPs needed to show efforts they have taken to understand their network capabilities and vulnerabilities.
- Data Analysis: requires development of tools to analyze data under review for accuracy and completeness. Freezing the data would allow validation of the finding and secure primary data from inadvertent changes or loss.
- Documentation of the EV process: necessary for repeatability and to ensure a consistent and valid process yielding accurate results.
- Additional data elements routinely checked: ensures review not only of basic encounter information, but that eventually all collected data receives scrutiny.
- Reporting to MHD and other stakeholders: the PIHPs were required to report their encounter validation activities to the MHD; they should also report results internally for quality improvement activities, and externally to the providers reviewed. Reports should be organized and sufficiently detailed to allow a reader clear understanding of process and results.
- Follow-up activities: to ensure consistent oversight and effective system improvement, PIHPs should have a policy and procedure addressing requests for corrective actions (CAs), as well as documentation of related follow-up activities.

The following tables display results of these review activities. To enable analysis, ratings were given numerical values. Under the matrix of PIHP names and review items, a 2 is a Met, a 1 is a Partially Met, and a 0 is a Not Met. The overall score averages follow a slightly different scheme which is detailed below the tables. Figure 25, below, is sorted by review element and displays state-wide EV results using simple and weighted averages. It speaks more specifically to quality of the data. Figure 26 provides a sorted view of specific PIHP results.

Figure 25: 2006 Enrollment Weighted EV Performance - by Element

Item	Weighting Factor: Enrollment (1,000s)	King County	Greater Columbia	North Sound	Pierce County	Spokane County	Clark County	Peninsula	Thurston-Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Grays Harbor	Statewide Average	
		214	153	146	122	89	64	46	42	58	21	21	21	16		
1a	PIHP documents data requirements	2	1	1	2	1	2	1	2	1	1	0	1	2	**1.4**	Partially Met
1b	PIHP communicates data requirements	2	2	1	2	2	2	2	1	2	2	0	2	2	**1.8**	**Met**
2a	Network Capability	2	0	0	1	2	2	0	0	0	2	1	1	0	**0.9**	Partially Met
3a	**Data analysis**	2	1	1	0	0	1	1	1	0	0	0	0	0	0.9	Partially Met
3b	Data analysis tools	2	1	1	0	0	1	0	1	0	0	0	0	0	**0.8**	Partially Met
3c	Data is frozen	0	0	0	0	0	0	0	0	0	1	0	0	0	**0.0**	Not Met
4a	**Review of medical records (EV process)**	2	2	2	1	1	1	2	1	1	1	0	1	1	1.5	Partially Met
4b	Includes additional data elements	2	1	1	1	0	1	1	1	0	1	0	0	0	**1.0**	Partially Met
4c	Adequate tools for EV process	2	1	2	0	0	2	1	0	1	0	0	1	0	**1.1**	Partially Met
5a	**EV Report to State**	2	1	1	2	2	2	1	1	1	1	1	1	1	1.5	Partially Met
5b	Reports to provider agencies	2	2	0	2	2	2	2	2	0	1	2	0	0	**1.5**	Partially Met
5c	Reports internally for QI activities	2	2	0	2	2	1	2	1	0	0	2	0	0	**1.4**	Partially Met
6a	PIHP documents corrective action process	2	2	0	1	1	2	0	2	0	0	0	0	0	**1.1**	Partially Met
6b	Evidence of follow-up activites	2	2		2							1		0	**1.9**	**Met**

To calculate the Compliance score the items bolded and highlighted in green (4a & 5a) must be Met, and the item in blue (3a) must be at least Partially Met to get an overall score of Met. The weighted scores show the state receiving an overall Compliance score of Partially Met.

Greater than:	1.7	= "Met"
Less than:	0.8	= "Not Met"
Between 0.8 and 1.7		= "Partially Met"

* Data reflects combined NEWRSN and NCRSN

Figure 25, above, provides the Medicaid enrollment-weighted average for all encounter validation activities across the system, and by inference, reflects the level of confidence in the handling of each consumer's data, irrespective of where they live. The enrollment-weighted process scores provide a mechanism for evaluating scrutiny applied to the State data set as a whole and are somewhat higher than the simple averages owing to the influence of King County's size and performance. Because King County serves the highest number of consumers (about 20% of the total) and has the largest data set in the state, the influence of its scores

is greater than that of any other PIHP individually. It therefore follows that 1) more of the data statewide receives better scrutiny than would be implied looking only at the simple averages, and 2) confidence in the typical consumer's data statewide (as a result of this scrutiny) is commensurately increased.

Figure 26: 2006 EV Performance - by PIHP

	Documents Data Requirements 1a	Communicates Data Requirements 1b	Network Capability 2a	**Data Anaysis 3a**	Data Analysis Tools 3b	Data is Frozen 3c	**Review of Medical Records 4a**	Includes Additional Data Elements 4b	Adequate Tools for EV Process 4c	**EV Report to the State 5a**	Reports to Provider Agencies 5b	Reports Internally for QI Activities 5c	Documented CA Process 6a	Evidence of Follow-up Activities 6b	*Full Tool* *Statewide Average*		*Compliance Items (3a, 4a & 5a)* *Statewide Average*	
King County	2	2	2	2	2	0	2	2	2	2	2	2	2	2	**1.86**	**Met**	**2.00**	**Met**
Clark County	2	2	2	1	1	0	1	1	2	2	2	1	2		**1.46**	Partially Met	**1.33**	Partially Met
Greater Columbia	1	2	0	1	1	0	2	1	1	1	2	2	2	2	**1.29**	Partially Met	**1.33**	Partially Met
Pierce County	2	2	1	0	0	0	1	1	0	2	2	2	1	2	**1.14**	Partially Met	**1.00**	Partially Met
Spokane County	1	2	2	0	0	0	1	1	0	2	2	2	1		**1.08**	Partially Met	**1.00**	Partially Met
Peninsula	1	2	0	1	0	0	2	1	1	1	2	2	0		**1.00**	Partially Met	**1.33**	Partially Met
Thurston-Mason	2	1	0	1	1	0	1	1	0	1	2	1	2		**1.00**	Partially Met	**1.00**	Partially Met
North Sound	1	1	0	1	1	0	2	1	2	1	0	0	0		**0.77**	Not Met	**1.33**	Partially Met
Southwest	1	2	2	0	0	1	1	1	0	1	1	0	0		**0.77**	Not Met	**0.67**	Not Met
Chelan-Douglas	1	2	1	0	0	0	1	0	1	1	0	0	0		**0.54**	Not Met	**0.67**	Not Met
Timberlands	0	0	1	0	0	0	0	0	0	1	2	2	0	1	**0.50**	Not Met	**0.33**	Not Met
North Central	1	2	0	0	0	0	1	0	1	1	0	0	0		**0.46**	Not Met	**0.67**	Not Met
Grays Harbor	2	2	0	0	0	0	1	0	0	1	0	0	0	0	**0.43**	Not Met	**0.67**	Not Met

Items bolded and highlighted in green (4a & 5a) must be scored Met and the item highlighted in blue (3a) a Partial Met for the overall Compliance score to be Met. See the scoring guide on the tool (Figure 23) for more details.

Greater than: 1.7 = "Met"
Less than: 0.8 = "Not Met"
Between 0.8 and 1.7 = "Partially Met"

Figure 26, above, reflects the performance of each PIHP on each activity and calculates an overall average for the PIHP. On the full tool, counting all PIHPs at Met and those above the mid range of Partially Met (1.25), it is evident that 3 out of 13 PIHPs are conducting encounter validations in a reasonable manner, albeit with some opportunities for improvement. Ten PIHPs are performing at a level requiring significantly more effort to achieve an adequate encounter validation.

As reflected in Figure 26, averaging all weighted totals for each item yielded a 1.2 overall statewide rating on EV activities[2], demonstrating that, on a weighted basis, the quality of the EV reviews was just above Partially Met. Based on these results, confidence in data quality across the state lies just above "fair" (using the terms "fair" and "good" as general measures, with "poor" being the worst, i.e., low confidence in the data, "fair" reflecting mid-level confidence, and "good" reflecting high confidence).

Based on three years of data quality review results, it is evident that processes undertaken by the PIHPs have become progressively more refined and effective with respect to increasing accountability, error follow-up, and the screening of data prior to submission to MHD. Discussions at site visits revealed that PIHPs continue to identify and address opportunities for improving the quality of their data.

Results by Section:

Data requirements and completeness standards – In most cases PIHP documentation and communication relative to data requirements is better than adequate. They have defined processes to make changes to the data dictionaries repeatable and manageable. Many PIHPs, however, do not have documented data completeness standards.

PIHP provider network's capability to collect, secure, and transmit data that is timely, accurate and complete – Not many PIHPs complied with the requirement to conduct an Information System Capability Assessment (ISCA) to evaluate provider data management capability and vulnerabilities; various methods were employed by PIHPs making that attempt. However, most missed critical elements of the process; for example, documenting processes used at the provider level to enter data into the system. One PIHP was able to submit results from a process that gives all information expected/needed from this step.

Data Analysis – Conducting an analysis of data being reviewed was almost universally incorrectly considered synonymous with pre-submission screening. The CMS protocol expects screening of all data in the system and, while some PIHPs came close, none conducted a full data analysis as described in the CMS Encounter Validation protocol.

Most PIHPs did not have adequate data analysis capabilities; even none, in some cases.

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[2] If King County were removed from the calculations, weighted averages would shift significantly: seven items would score as Not Met, and seven as Partially Met. No score of Met was achieved, and no score across all items exceeded 1.3. The average of all items would be less than .8, a difference of .4 points (close to ½ a point less than the full statewide average of 1.2). The quality of the encounter validation processes for these PIHPs is lower than the midpoint of Partially Met and, therefore, confidence in the quality of data across 4/5 of the state's population is on the "poor" side of "fair". The influence of a large PIHP in this environment cannot be overlooked.

Therefore, analyses for use in EV, QAI, and PIP activities were not conducted. The WAEQRO discussed the importance of this function with the PIHPs at the site visits.

None of the PIHPs freeze their data for analysis. The rationale for this practice was discussed at length during the site visits (i.e., to secure original data and allow steps taken in the analysis to be repeated by a third party).

Documentation of the EV process – A state-wide review of medical records was conducted with results showing some PIHPs doing a more diligent job than others. The level of documentation for the processes, tools, and results ran the gamut from excellent to non-existent. In all but one case, the minimum required in the contract between the MHD and the PIHPs was accomplished. In the exceptional case, the PIHP still conducted an encounter validation and documented the results.

The tools used to collect the EV data ranged from excellent to non-existent. The WAEQRO emphasized the importance of designing and documenting a tool that would support the capture of all necessary data for an EV, as well as be useful for analysis activities.

Some PIHPs checked on additional data elements not required by contract. Site visit discussions addressed the importance of periodically checking all data in the system to ensure ongoing reliability. Suggestions were provided for designing a tool to track such reviews.

Reporting to MHD and other stakeholders – All PIHPs submitted a report to the state documenting their EV efforts. Quality of these reports ranged from detailed, complete, and well-written to the provision of minimal data without explanatory information.

Most of the PIHPs submitted evidence of communicating results of the encounter validation reviews to their network providers. In those cases where results were not communicated, reviews were conducted side-by-side with provider staff so that results were known immediately. The WAEQRO recommended that a written summary be provided in all cases.

Some PIHPs did not communicate their review results internally. The WAEQRO recommended that they do so with the quality assurance committee.

Follow-up activities – Many of the PIHPs did not have policies and procedures governing the management of corrective actions, a critical step in ensuring improvement of data management practices (as well as other areas of operation). In most cases warranting follow-up activity, evidence was submitted documenting appropriate activities.

2006 EV Review Summary and Recommendations

The encounter validation efforts across the system indicate that PIHPs are beginning to understand and employ a comprehensive process. However, considerable work is still needed to communicate and implement the requirements and standards needed to effectively conduct reviews. For example, although PIHPs found problems in their data or charts through their EV

process, few understood the implications of these findings. Corrections were made to the offending data or record, but only in a few cases were processes examined to identify the cause of the error and correct the problem systemically.

Strengths

- The WAEQRO has noted great improvements over three years in accountability of data and the processes employed by PIHPs to ensure that data is timely, accurate, and complete. Continuing in this direction set will continue to show positive results.
- The PIHPs have strong processes for documenting and communicating their data requirements.
- Many of the EV processes developed were defined and implemented prior to being required by the contract PIHPs have with the State. This shows a commitment to increasing system accountability and reliability.

Recommendations

The WAEQRO recommends that the PIHPs use their EV review results as guidance to further develop related processes. The State desires that similar processes be used system-wide in conducting these reviews and the review tool is designed toward that end. Continued efforts to develop these reviews will greatly enhance independent EV results like that conducted in 2005 by the WAEQRO.

APS recommends that PIHPs prioritize the following activities:

1. Develop data completeness standards. It is impossible to accurately measure without some type of ruler.
2. Develop tools and begin assessing provider network capabilities.
3. Freeze and analyze data under review.
4. Continue to refine and document the EV processes and tools being employed, with close attention to valid sampling methodologies.
5. Develop methods for incorporating other data elements in the review process. The ultimate goal is to have some level of scrutiny for all data collected.
6. Ensure that reports to the state, providers, and for internal use have adequate information appropriate to the intended audience. Data presented should be accompanied by descriptive analysis. Use trends when possible. Draw conclusions from the information presented.
7. Document corrective action processes in a policy and procedure.
8. PIHPs would benefit from sharing with each other their processes, tools, and, where needed, data analysis skills.
9. PIHPs would benefit from training related to the entire EV process or, at a minimum, assessing network capability, data analysis, sampling procedures, and effective reporting.

10. The WAEQRO recommends the State continue a phased-in approach to implementing PIHP encounter validation requirements until consistent and comprehensive processes are in place across the state.

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Appendices

Appendix 1C - 2006 Scores with Weighted Averages - Subpart C

Appendix 1D - 2006 Scores with Weighted Averages - Subpart D

Appendix 1F - 2006 Scores with Weighted Averages - Subpart F

Appendix 1H - 2006 Scores with Weighted Averages - Subpart H

Appendix 2C - 2005 Scores with Weighted Average - Subpart C

Appendix 2D - 2005 Scores with Weighted Average - Subpart D

Appendix 2F - 2005 Scores with Weighted Average - Subpart F

Appendix 2H - 2005 Scores with Weighted Average - Subpart H

Appendix 3C - 2006 Score Distribution across PIHP - Subpart C

Appendix 3D - 2006 Score Distribution across PIHP - Subpart D

Appendix 3F - 2006 Score Distribution across PIHP - Subpart F

Appendix 3H - 2006 Score Distribution across PIHP - Subpart H

2006 Score Table with Enrollment-Weighted Statewide Averages - Subpart C

(shaded) << Shading indicates 2004 Corrective Action Item

text << Underlining shows 2005 EQRO improvement recommendation

Strength Stars: Q(s1) Is State Wtd Average at least 3.7? · Q(s2) Did more than 9 PIHPs score at least 3.7? · Stars: Items satis-fying both Q(s1) & Q(s2)

Weakness Flags: Q(w1) Is State Wtd Average less than 3? · Q(w2) Did more than 7 PIHPs score under 3? · Flags: Items satis-fying both Q(w1) & Q(w2)

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Grays Harbor	WA State Simple Average	WA State Weighted Average	Q(s1)	Q(s2)	Stars	Q(w1)	Q(w2)	Flags
	Weighting Factor: Enrollment (1,000s)*	216	151	147	121	88	65	47	42	41	21	21	21	16			3.7	9	0 stars	3.0	7	0 flags
Q01	Accessible written information requirements P&P	4	4	3	4	3	4	3	4	1	4	3	4	4	3.5	3.6						
Q02	Policy guaranteeing enrollee rights	3	2	4	3	4	4	4	3	3	4	4	3	3	3.4	3.2						
Q03	Subcontracts require advising enrollees of rights	3	4	4	4	4	3	3	4	4	4	4	4	3	3.7	3.7						
Q04	Subcontractors publicly post rights in req languages	3	4	3	4	4	3	3	3	4	5	4	4	3	3.6	3.5						
Q05	Subcontractors assure client rights understanding	4	3	4	3	4	4	3	5	4	3	4	3	3	3.6	3.7						
Q06	Subcontractors protect exercising of client rights	5	3	3	3	3	3	4	3	3	3	3	3	4	3.3	3.5						
Q07	Policy re: other Federal/State law compliance	3	2	3	3	4	3	1	3	3	4	4	4	4	3.2	2.9				•		
Q08	Subcontracts include Federal/State law compliance	4	3	3	5	5	3	4	3	4	4	3	4	4	3.8	3.8	•					
Q09	Policies ensure specific rights compliance	4	3	3	4	3	3	4	4	3	3	4	3	3	3.4	3.4						
Q10	Subcontracts reference specific rights compliance	3	4	5	3	3	4	4	3	3	3	4	4	3	3.5	3.6						
Q11	PIHP monitors provider compliance with laws/rights	3	3	4	5	2	3	2	4	2	3	3	2	2	2.9	3.2						
Q12	PIHP P&P against prohibitions re: advising enrollees	4	3	3	5	3	3	4	3	4	3	4	4	3	3.5	3.6						
Q13	Enrollee payment liability protections	4	4	4	3	4	3	3	4	4	3	3	3	3	3.5	3.7						
Q14	PIHP P&P re: Mental Health Advance Directives (MHAD)	4	3	4	4	4	4	2	4	1	4	4	4	4	3.5	3.6		•				
Q15	Prompt law upadates to MHAD P&P	4	3	4	3	4	3	3	4	3	3	4	4	3	3.5	3.5						
Q16	Subcontractors req to have MHAD P&P	3	3	4	4	3	3	4	4	3	3	4	3	4	3.5	3.4						
Q17	Document clients informed of MHAD & choice	2	2	4	3	3	3	2	3	3	4	4	3	4	3.1	2.8				•		

** as of June 2005, calculated April 2006*

** Data reflects combined NEWRSN and NCRSN*

2006 Score Table with Enrollment-Weighted Statewide Averages - Subpart D

<< Shading indicates 2004 Corrective Action Item

text << Underlining shows 2005 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Grays Harbor	WA State Simple Average	WA State Weighted Average	Strength Stars: Q(s1) Is State Wtd Average at least 3.7?	Q(s2) Did more than 9 PIHPs score at least 3.7?	Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags: Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 7 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	216	151	147	121	88	65	47	42	41	21	21	21	16			3.7	9	0 stars	3.0	7	0 flags
Q18	PIHP monitors access and service availability	3	2	4	4	3	3	3	4	3	3	5	4	2	3.3	3.2						
Q19	PIHP monitors & reports network sufficiency changes	3	3	3	3	3	4	3	4	3	3	4	3	3	3.2	3.1						
Q20	PIHP manages network adequacy	3	1	3	4	3	3	3	4	3	3	5	3	2	3.1	2.9				•		
Q21	Second opinion mechanism	3	3	4	3	3	3	4	4	4	3	5	3	3	3.5	3.3						
Q22	PIHP has out-of-network P&P	3	3	4	3	3	3	3	3	3	3	3	4	1	3.0	3.1						
Q23	PIHP P&P re: out-of-network payment coordination	4	4	4	3	3	3	3	3	3	3	4	3	1	3.2	3.5						
Q24	PIHP P&P re: out-of-network cost to enrollee	4	2	4	3	4	4	4	3	2	3	4	3	1	3.2	3.4						
Q25	Ensures compliance with timely access standards	4	3	4	4	3	4	4	5	4	4	3	3	4	3.8	3.8	•					
Q26	Timely access standards in subcontracts	3	3	3	4	4	4	4	5	4	3	3	3	4	3.6	3.5						
Q27	PIHP oversight of provider timely access compliance	3	3	4	4	2	3	3	5	3	3	4	4	2	3.3	3.3						
Q28	Culturally competent services by MH Specialists	5	4	2	5	3	5	4	4	3	4	5	3	4	3.9	4.0	•					
Q29	Written & oral translation of client materials	4	3	3	4	3	3	3	3	3	3	3	3	3	3.2	3.3						
Q30	Ensure Interpreter availability	3	3	4	3	4	4	4	3	3	3	3	4	3	3.4	3.4						
Q31	Culturally competent subcontractor specialists	5	4	3	5	3	5	4	4	3	3	3	3	4	3.8	4.1	•					
Q32	Written and oral translation by subcontractors	4	3	3	3	3	3	3	3	3	2	3	3	3	3.0	3.2						
Q33	Monitoring of culturally competent services	4	3	3	4	1	4	3	3	3	4	4	3	3	3.2	3.3						
Q34	Sufficiency of provider network to meet need	3	2	3	4	3	3	3	4	3	3	5	2	2	3.1	3.0						
Q35	Changes in capacity and services reported to State	3	5	3	4	3	4	3	4	3	3	4	3	3	3.5	3.6						
Q39	Consistent authorization standards	4	4	4	4	3	4	3	3	4	3	3	3	4	3.5	3.8	•					
Q40	Authorization conducted by MHPs	3	2	4	4	4	4	3	3	3	3	3	2	2	3.1	3.2						
Q41	Monitoring of consistent authorization practices	3	3	4	4	3	4	4	3	2	4	3	3	2	3.2	3.3						
Q42	Adverse action notices meet requirements	1	1	5	4	3	4	2	3	4	3	2	3	2	2.8	2.7				•		
Q43	Standard authorization requirements	1	4	5	4	2	4	4	3	4	3	4	1	4	3.3	3.2						
Q44	Expedited authorization requirements	4	3	4	3	2	4	4	3	4	3	4	3	2	3.3	3.4						
Q45	Extension of expedited authorization request	4	3	3	3	2	3	4	3	4	3	4	3	2	3.2	3.2						
Q47	Protection against provider discrimination	5	3	3	5	4	3	2	3	3	3	3	3	4	3.4	3.7	•					
Q48	Policy re: excluded providers	3	3	4	3	5	3	4	4	3	3	5	5	3	3.7	3.5						
Q49	Confidentiality compliance	5	5	4	5	4	5	3	5	5	3	5	3	3	4.2	4.6	•					
Q50	Privacy compliance by subcontractors	5	3	4	3	3	3	3	5	5	3	5	3	3	3.7	3.8	•					
Q51	Privacy compliance subcontractor audits	5	3	4	2	2	3	3	4	1	4	3	3	3	3.1	3.4						
Q52	Pre-subdelegation evaluation	5	1	4	5	3	3	5	2	2	2	2	2	2	2.9	3.5						
Q53	Written subdelegation agreement	5	3	3	4	4	4	4	2	3	2	2	2	2	3.1	3.6						
Q54	Annual subcontractor subdelegation performance review	5	3	3	4	3	4	4	2	2	2	2	2	2	2.9	3.5						
Q55	Corrective actions re: subdelegation deficiencies	5	3	5	4	3	4	4	2	3	2	2	2	2	3.2	3.8	•					
Q56	Adoption of evidenced based practice guidelines	4	4	3	3	3	3	3	3	4	4	5	4	2	3.5	3.5						
Q57	Dissemination of practice guidelines	4	3	3	3	3	4	3	3	4	4	4	4	3	3.5	3.4						
Q58	Application of practice guidelines	4	2	3	3	1	1	2	3	2	2	4	4	2	2.5	2.7				•		
Q61	Detection of over & under utilization	3	4	5	3	3	3	2	4	3	2	3	3	2	3.1	3.4						

** as of June 2005, calculated April 2006*

** Data reflects combined NEWRSN and NCRSN*

2006 Score Table with Enrollment-Weighted Statewide Averages - Subpart F

(shaded) << Shading indicates 2004 Corrective Action Item

text << Underlining shows 2005 EQRO improvement recommendation

Strength Stars: Q(s1), Q(s2), Stars — Weakness Flags: Q(w1), Q(w2), Flags

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Grays Harbor	WA State Simple Average	WA State Weighted Average	Q(s1) Is State Wtd Average at least 3.7?	Q(s2) Did more than 9 PIHPs score at least 3.7?	Stars Items satis-fying both Q(s1) & Q(s2)	Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 7 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	216	151	147	121	88	65	47	42	41	21	21	21	16			3.7	9	0 stars	3.0	7	0 flags
Q71	Authority to file grievance	4	3	4	4	4	2	2	4	2	4	3	5	4	3.5	3.5						
Q72	Timing and Procedures for filing	3	3	3	4	3	3	2	4	4	3	3	3	4	3.2	3.2						
Q73	Timing of notice	1	1	3	4	3	4	2	3	4	3	2	3	2	2.7	2.4				•		
Q74	Administrative assitance for enrollees	4	4	4	3	4	3	4	3	4	3	3	3	4	3.5	3.7	•					
Q75	Grievance acknowledgement	3	3	3	3	3	3	3	3	4	3	3	1	3	2.9	3.0				•		
Q76	Appropriate grievance review personnel	3	3	3	3	3	3	4	3	4	3	3	3	3	3.2	3.1						
Q77	Special requirements for appeals	4	3	5	3	3	3	3	3	4	3	3	4	4	3.5	3.6						
Q78	Enrollee access to case file	4	3	3	3	3	3	4	3	4	3	3	4	4	3.4	3.3						
Q79	Included appeal parties	3	3	3	3	3	3	3	4	2	3	3	4	4	3.2	3.0						
Q80	Resolution and notification of grievances & appeals	3	3	4	3	3	3	2	3	4	3	3	2	4	3.1	3.1						
Q81	Content of Notice of Appeal Resolution	3	3	4	3	3	3	3	3	4	3	3	4	2	3.2	3.2						
Q82	State fair hearings requirements	3	3	4	3	3	3	2	4	4	3	3	4	3	3.2	3.2						
Q83	Expedied appeal resolution/prohibition against punitive action	4	3	3	3	3	3	3	3	4	3	3	3	3	3.2	3.3						
Q84	Denial of expedited resolution	3	3	3	3	3	3	3	3	2	3	3	3	3	2.9	3.0				•		
Q85	Use of State developed description in subcontracts	3	3	4	3	3	3	3	3	2	3	3	1	3	2.8	3.1						
Q86	Record keeping	3	4	4	3	3	3	4	3	3	3	1	3	3	3.1	3.3						
Q87	Review and quality improvement	4	4	4	3	3	3	3	3	2	3	4	2	3	3.2	3.5						
Q88	Rights upheld during pended appeal	4	3	2	3	3	3	3	3	4	3	3	4	4	3.2	3.1						
Q89	Rights upheld regarding disputed services	3	3	4	3	3	3	3	3	4	3	3	3	3	3.2	3.2						

** as of June 2005, calculated April 2006*

** Data reflects combined NEWRSN and NCRSN*

2006 Score Table with Enrollment-Weighted Statewide Averages - Subpart H

(shaded) << Shading indicates 2005 Corrective Action Item

text << Underlining shows 2005 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Grays Harbor	WA State Simple Average	WA State Weighted Average	Strength Stars: Q(s1) Is State Wtd Average at least 3?	Q(s2) Did more than 9 PIHPs score at least 3?	Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags: Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 7 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
																	3.0	9	6 stars	3.0	7	0 flags
Q90.a	Source of certification	3	3	3	3	3	3	3	3	3	3	0	3	3	2.8	2.9		•		•		
Q90.b1	Data content certification	3	3	3	3	3	3	3	3	3	3	0	3	3	2.8	2.9		•		•		
Q90.b2	Certification content requirements	3	3	3	3	3	3	3	3	3	3	0	3	3	2.8	2.9		•		•		
Q90.b3	Certification timing	3	3	3	3	3	3	3	3	0	3	0	3	3	2.5	2.8		•		•		
Q91.b1	Written fraud & abuse p&ps/compliance plan	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	star			
Q91.b2	Accountable compliance officer/committee	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	star			
Q91.b3	Effective Compliance training and education	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	star			
Q91.b4	Effective compliance communication	3	3	3	0	3	3	3	3	3	3	3	3	3	2.8	2.6		•		•		
Q91.b5	Well publicized disciplinary guidelines	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	star			
Q91.b6	Internal audit provisions	3	3	3	3	3	0	0	3	3	0	0	0	0	1.6	2.4				•		
Q91.b7	Prompt response to offenses	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	star			
Q92	Prohibited affiliations with the Federally debarred	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	star			

** as of June 2005, calculated April 2006*

** Data reflects combined NEWRSN and NCRSN*

2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart C

<< Shading indicates 2004 Corrective Action Item

text << Underlining indicates 2004 EQRO improvement recommendation

Strength Stars: Q(s1), Q(s2), Stars — Weakness Flags: Q(w1), Q(w2), Flags

Item	Weighting Factor: Enrollment (1,000s)*	King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Q(s1) Is State Wtd Average at least 3.5?	Q(s2) Did more than 10 PIHPs score at least 3.5?	Stars Items satis-fying both Q(s1) & Q(s2)	Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 10 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
		216	151	147	121	88	65	47	42	41	21	21	21	17	16			3.5	10	0 stars	3.0	10	0 flags
Q01	Accessible written information requirements P&P	4	4	3	4	3	4	1	4	1	4	3	2	3	1	2.9	3.4						
Q02	Policy guaranteeing enrollee rights	3	2	4	3	4	4	2	3	3	4	4	3	3	3	3.2	3.1						
Q03	Subcontracts require advising enrollees of rights	3	4	4	4	4	3	3	4	2	4	4	2	4	3	3.4	3.5	•					
Q04	Subcontractors publicly post rights in req languages	3	2	3	4	2	3	3	3	1	5	4	2	1	3	2.8	2.8				•		
Q05	Subcontractors assure client rights understanding	4	3	4	3	4	4	3	5	4	3	4	1	3	3	3.4	3.6	•					
Q06	Subcontractors protect exercising of client rights	5	3	3	3	3	3	4	3	3	3	3	1	3	4	3.1	3.4						
Q07	Policy re: other Federal/State law compliance	3	1	3	3	4	3	1	3	3	2	4	4	4	4	3.0	2.8				•		
Q08	Subcontracts include Federal/State law compliance	4	3	3	5	5	3	2	3	4	4	3	4	4	4	3.6	3.7	•					
Q09	Policies ensure specific rights compliance	2	1	3	4	3	3	4	2	3	3	2	3	3	3	2.8	2.6				•		
Q10	Subcontracts reference specific rights compliance	3	2	5	3	3	4	4	3	3	3	4	2	3	2	3.1	3.2						
Q11	PIHP monitors provider compliance with laws/rights	3	3	4	5	1	3	2	4	2	3	3	1	1	2	2.6	3.1						
Q12	PIHP P&P against prohibitions re: advising enrollees	4	3	3	5	3	3	4	3	4	3	4	4	5	3	3.6	3.6	•					
Q13	Enrollee payment liability protections	1	2	4	3	0	3	3	2	4	3	3	3	3	3	2.6	2.3				•		
Q14	PIHP P&P re: Mental Health Advance Directives (MHAD)	4	3	4	4	1	4	2	4	1	2	4	4	2	4	3.1	3.3						
Q15	Prompt law upadates to MHAD P&P	4	3	4	3	4	3	3	4	3	3	4	4	2	3	3.4	3.5	•					
Q16	Subcontractors req to have MHAD P&P	3	3	4	4	3	3	4	4	3	3	4	3	4	4	3.5	3.4						
Q17	Document clients informed of MHAD & choice	2	2	4	3	1	3	1	3	3	2	4	3	4	4	2.8	2.6				•		

** as of June 2005, calculated April 2006*

2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart D

<< Shading indicates 2004 Corrective Action Item

text << Underlining indicates 2004 EQRO improvement recommendation

Item	Weighting Factor: Enrollment (1,000s)*	King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Strength Stars: Q(s1) Is State Wtd Average at least 3.5?	Q(s2) Did more than 10 PIHPs score at least 3.5?	Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags: Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 10 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
		216	151	147	121	88	65	47	42	41	21	21	21	17	16			3.5	10	0 stars	3.0	10	2 flags
Q18	PIHP monitors access and service availability	3	2	4	4	3	3	3	4	3	3	5	4	3	2	3.3	3.2						
Q19	PIHP monitors & reports network sufficiency changes	3	3	3	3	3	4	3	4	3	3	4	3	3	3	3.2	3.1						
Q20	PIHP manages network adequacy	3	1	3	4	3	3	3	4	3	3	5	3	3	2	3.1	2.9				•		
Q21	Second opinion mechanism	3	3	4	3	3	3	2	2	4	3	5	3	2	2	3.0	3.1						
Q22	PIHP has out-of-network P&P	3	3	4	3	3	3	3	3	3	2	3	2	2	1	2.7	3.1						
Q23	PIHP P&P re: out-of-network payment coordination	2	4	4	3	3	3	3	3	3	2	2	3	2	1	2.7	3.0				•		
Q24	PIHP P&P re: out-of-network cost to enrollee	2	2	4	3	0	2	4	3	2	2	4	3	3	1	2.5	2.4				•		
Q25	Ensures compliance with timely access standards	4	3	4	4	3	4	4	5	4	4	3	3	4	4	3.8	3.8	•					
Q26	Timely access standards in subcontracts	3	3	3	4	2	4	4	5	4	3	3	3	3	4	3.4	3.3						
Q27	PIHP oversight of provider timely access compliance	3	3	4	4	1	3	3	5	3	3	4	4	4	2	3.3	3.2						
Q28	Culturally competent services by MH Specialists	5	4	2	5	3	5	4	4	3	4	5	3	4	4	3.9	4.0	•					
Q29	Written & oral translation of client materials	2	3	2	4	2	3	2	3	1	3	2	1	4	1	2.4	2.5				•		
Q30	Ensure Interpreter availability	3	3	4	3	2	4	2	3	3	3	3	4	4	3	3.1	3.1						
Q31	Culturally competent subcontractor specialists	5	4	3	5	3	5	4	4	3	3	3	3	4	4	3.8	4.1	•					
Q32	Written and oral translation by subcontractors	2	3	3	3	2	3	3	3	1	2	3	2	2	2	2.4	2.5				•		
Q33	Monitoring of culturally competent services	4	3	3	4	1	4	3	3	3	2	4	2	4	3	3.1	3.2						
Q34	Sufficiency of provider network to meet need	3	2	3	4	3	2	3	4	3	3	5	2	3	2	3.0	3.0				•		
Q35	Changes in capacity and services reported to State	3	5	3	4	3	4	3	4	3	3	4	1	3	3	3.3	3.5	•					
Q39	Consistent authorization standards	4	2	4	4	3	4	3	3	4	3	3	3	2	2	3.1	3.4						
Q40	Authorization conducted by MHPs	1	1	4	2	4	4	3	3	3	3	3	1	3	2	2.6	2.4				•		
Q41	Monitoring of consistent authorization practices	3	0	4	4	3	4	2	3	2	1	3	3	2	2	2.6	2.7				•		
Q42	Adverse action notices meet requirements	1	1	5	4	2	1	2	3	2	1	2	1	1	1	1.9	2.2				•	•	*flag*
Q43	Standard authorization requirements	1	1	5	4	2	4	2	3	2	3	2	1	2	2	2.4	2.5				•		
Q44	Expedited authorization requirements	2	1	2	3	2	4	1	3	2	2	2	3	3	2	2.3	2.1				•		
Q45	Extension of expedited authorization request	0	1	2	3	2	3	1	3	1	2	2	3	2	2	1.9	1.6				•		
Q47	Protection against provider discrimination	2	0	3	5	2	3	2	3	3	3	3	3	3	4	2.8	2.5				•		
Q48	Policy re: excluded providers	3	3	4	3	2	3	4	4	3	3	5	5	3	3	3.4	3.2						
Q49	Confidentiality compliance	5	5	4	5	4	5	3	5	5	2	5	3	3	3	4.1	4.5	•					
Q50	Privacy compliance by subcontractors	5	3	4	3	3	2	3	5	5	3	5	3	3	3	3.6	3.7	•					
Q51	Privacy compliance subcontractor audits	5	3	4	0	2	3	0	4	1	1	3	3	2	3	2.4	2.9				•		
Q52	Pre-subdelegation evaluation	5	1	2	1	3	3	1	2	2	2	2	2	1	2	2.1	2.5				•	•	*flag*
Q53	Written subdelegation agreement	5	1	3	2	4	4	1	1	1	1	1	2	1	1	2.0	2.7				•		
Q54	Annual subcontractor subdelegation performance review	5	1	3	2	3	4	1	1	1	2	2	2	1	2	2.1	2.7				•		
Q55	Corrective actions re: subdelegation deficiencies	5	1	5	2	3	4	2	2	2	2	2	2	1	2	2.5	3.1						
Q56	Adoption of evidenced based practice guidelines	4	1	3	3	1	1	2	3	1	1	5	2	2	2	2.2	2.4				•		
Q57	Dissemination of practice guidelines	4	1	3	3	1	2	3	3	1	0	4	2	3	3	2.4	2.5				•		
Q58	Application of practice guidelines	1	0	3	3	1	0	2	3	1	1	4	1	1	2	1.6	1.5				•		
Q60	Performance measurement data submission	2	3	2	2	2	3	2	2	3	3	4	4	2	2	2.6	2.4				•		
Q61	Detection of over & under utilization	3	4	5	2	3	3	2	4	1	2	3	3	1	2	2.7	3.2						
Q62	Quality care to enrollees with special health needs	4	4	4	2	3	5	4	3	3	1	2	2	3	2	3.0	3.5						
Q64	Annual data submission to State	2	4	3	2	2	2	2	2	2	1	5	3	3	2	2.5	2.5				•		

** as of June 2005, calculated April 2006*

2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart F

<< Shading indicates 2004 Corrective Action Item

text << Underlining indicates 2004 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Strength Stars: Q(s1) Is State Wtd Average at least 3.5?	Q(s2) Did more than 10 PIHPs score at least 3.5?	Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags: Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 10 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	216	151	147	121	88	65	47	42	41	21	21	21	17	16			3.5	10	0 stars	3.0	10	0 flags
Q71	Authority to file grievance	4	3	4	4	4	2	2	2	2	4	3	5	3	2	3.1	3.4						
Q72	Timing and Procedures for filing	3	3	3	4	3	3	2	2	2	3	3	3	3	1	2.7	3.0				•		
Q73	Timing of notice	1	1	3	4	3	1	2	3	1	1	2	2	1	2	1.9	2.0				•		
Q74	Administrative assitance for enrollees	2	4	4	3	1	3	2	3	2	3	3	3	3	2	2.7	2.8				•		
Q75	Grievance acknowledgement	3	3	3	3	3	3	3	3	2	3	3	1	3	3	2.8	2.9				•		
Q76	Appropriate grievance review personnel	3	3	3	3	3	3	2	3	2	3	3	3	3	3	2.9	2.9				•		
Q77	Special requirements for appeals	1	3	5	3	3	3	3	3	2	3	3	2	3	2	2.8	2.8				•		
Q78	Enrollee access to case file	4	3	3	3	3	3	2	3	4	3	3	2	3	2	2.9	3.2						
Q79	Included appeal parties	3	3	3	3	3	3	3	2	2	3	3	2	3	2	2.7	2.9				•		
Q80	Resolution and notification of grievances & appeals	3	3	4	3	3	3	2	3	2	3	3	2	3	2	2.8	3.0						
Q81	Content of Notice of Appeal Resolution	3	3	4	3	3	3	3	3	4	3	3	4	3	2	3.1	3.2						
Q82	State fair hearings requirements	3	3	4	3	3	3	2	2	2	3	3	2	2	2	2.6	3.0				•		
Q83	Expedied appeal resolution/prohibition against punitive actioi	2	3	3	3	3	3	3	3	2	3	3	3	3	2	2.8	2.7				•		
Q84	Denial of expedited resolution	3	3	3	3	3	3	3	3	2	3	3	3	3	2	2.9	2.9				•		
Q85	Use of State developed description in subcontracts	3	3	4	3	3	3	3	3	2	3	3	1	3	3	2.9	3.1						
Q86	Record keeping	3	4	4	3	3	3	2	3	2	3	1	3	2	2	2.7	3.1						
Q87	Review and quality improvement	4	4	4	3	3	3	3	3	2	3	2	2	4	3	3.1	3.4						
Q88	Rights upheld during pended appeal	4	3	2	3	3	3	3	3	1	3	3	4	3	1	2.8	3.0				•		
Q89	Rights upheld regarding disputed services	3	3	4	3	3	3	3	3	4	3	3	3	3	3	3.1	3.2						

** as of June 2005, calculated April 2006*

2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart H

(shaded)	<< Shading indicates 2004 Corrective Action Item
<u>text</u>	<< Underlining indicates 2004 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	*Strength Stars* Q(s1) Is State Wtd Average at least 3?	Q(s2) Did more than 10 PIHPs score at least 3?	Stars Items satis-fying both Q(s1) & Q(s2)	*Weakness Flags* Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 10 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	216	151	147	121	88	65	47	42	41	21	21	21	17	16			3.0	10	3 stars	3.0	10	0 flags
Q90.a	Source of certification	3	3	3	3	3	3	3	3	0	3	0	3	3	3	2.6	2.8		•		•		
Q90.b1	Data content certification	3	3	3	3	3	3	3	3	3	3	0	3	3	3	2.8	2.9		•		•		
Q90.b2	Certification content requirements	3	3	3	3	3	3	3	3	3	3	0	3	3	3	2.8	2.9		•		•		
Q90.b3	Certification timing	3	3	0	3	3	3	0	3	0	3	0	3	3	3	2.1	2.2				•		
Q91.b1	Written fraud & abuse p&ps/compliance plan	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	*star*			
Q91.b2	Accountable compliance officer/committee	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	*star*			
Q91.b3	Effective Compliance training and education	3	3	3	3	3	3	3	3	3	3	3	3	3	0	2.8	3.0		•		•		
Q91.b4	Effective compliance communication	3	3	0	0	3	3	3	3	3	3	3	0	3	3	2.4	2.1		•		•		
Q91.b5	Well publicized disciplinary guidelines	3	3	3	3	3	0	3	3	3	3	3	3	3	3	2.8	2.8		•		•		
Q91.b6	Internal audit provisions	3	3	3	3	3	0	0	0	3	0	0	0	0	0	1.3	2.3				•		
Q91.b7	Prompt response to offenses	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0	3.0	•	•	*star*			
Q92	Prohibited affiliations with the Federally debarred	3	3	3	3	3	3	3	3	0	3	3	3	3	3	2.8	2.9		•		•		

** as of June 2005, calculated April 2006*

2006 Score Distribution acoss PIHPs - Subpart C

Item	Short Description	Score: 0	1	2	3	4	5	Distribution: 0s	1s	2s	3s	4s	5s	3, 4 or 5
Q01	Accessible written information requirements P&P	0	1	0	4	8	0	0%	8%	0%	31%	62%	0%	**92%**
Q02	Policy guaranteeing enrollee rights	0	0	1	6	6	0	0%	0%	8%	46%	46%	0%	**92%**
Q03	Subcontracts require advising enrollees of rights	0	0	0	4	9	0	0%	0%	0%	31%	69%	0%	**100%**
Q04	Subcontractors publicly post rights in req languages	0	0	0	6	6	1	0%	0%	0%	46%	46%	8%	**100%**
Q05	Subcontractors assure client rights understanding	0	0	0	6	6	1	0%	0%	0%	46%	46%	8%	**100%**
Q06	Subcontractors protect exercising of client rights	0	0	0	10	2	1	0%	0%	0%	77%	15%	8%	**100%**
Q07	Policy re: other Federal/State law compliance	0	1	1	6	5	0	0%	8%	8%	46%	38%	0%	**85%**
Q08	Subcontracts include Federal/State law compliance	0	0	0	5	6	2	0%	0%	0%	38%	46%	15%	**100%**
Q09	Policies ensure specific rights compliance	0	0	0	8	5	0	0%	0%	0%	62%	38%	0%	**100%**
Q10	Subcontracts reference specific rights compliance	0	0	0	7	5	1	0%	0%	0%	54%	38%	8%	**100%**
Q11	PIHP monitors provider compliance with laws/rights	0	0	5	5	2	1	0%	0%	38%	38%	15%	8%	**62%**
Q12	PIHP P&P against prohibitions re: advising enrollees	0	0	0	7	5	1	0%	0%	0%	54%	38%	8%	**100%**
Q13	Enrollee payment liability protections	0	0	0	7	6	0	0%	0%	0%	54%	46%	0%	**100%**
Q14	PIHP P&P re: Mental Health Advance Directives (MHAD)	0	1	1	1	10	0	0%	8%	8%	8%	77%	0%	**85%**
Q15	Prompt law upadates to MHAD P&P	0	0	0	7	6	0	0%	0%	0%	54%	46%	0%	**100%**
Q16	Subcontractors req to have MHAD P&P	0	0	0	7	6	0	0%	0%	0%	54%	46%	0%	**100%**
Q17	Document clients informed of MHAD & choice	0	0	3	6	4	0	0%	0%	23%	46%	31%	0%	**77%**
	All Scores of 0 through 5:	**0**	**3**	**11**	**102**	**97**	**8**	**0%**	**1%**	**5%**	**46%**	**44%**	**4%**	**94%**

<< Shading indicates 2004 Corrective Action Item

text << Underlining indicates 2005 EQRO improvement recommendation

2006 Score Distribution acoss PIHPs - Subpart D

Item	Short Description	Score: 0	1	2	3	4	5	Distribution: 0	1	2	3	4	5	3, 4 or 5
Q18	PIHP monitors access and service availability	0	0	2	6	4	1	0%	0%	15%	46%	31%	8%	**85%**
Q19	PIHP monitors & reports network sufficiency changes	0	0	0	10	3	0	0%	0%	0%	77%	23%	0%	**100%**
Q20	PIHP manages network adequacy	0	1	1	8	2	1	0%	8%	8%	62%	15%	8%	**85%**
Q21	Second opinion mechanism	0	0	0	8	4	1	0%	0%	0%	62%	31%	8%	**100%**
Q22	PIHP has out-of-network P&P	0	1	0	10	2	0	0%	8%	0%	77%	15%	0%	**92%**
Q23	PIHP P&P re: out-of-network payment coordination	0	1	0	8	4	0	0%	8%	0%	62%	31%	0%	**92%**
Q24	PIHP P&P re: out-of-network cost to enrollee	0	1	2	4	6	0	0%	8%	15%	31%	46%	0%	**77%**
Q25	Ensures compliance with timely access standards	0	0	0	4	8	1	0%	0%	0%	31%	62%	8%	**100%**
Q26	Timely access standards in subcontracts	0	0	0	6	6	1	0%	0%	0%	46%	46%	8%	**100%**
Q27	PIHP oversight of provider timely access compliance	0	0	2	6	4	1	0%	0%	15%	46%	31%	8%	**85%**
Q28	Culturally competent services by MH Specialists	0	0	1	3	5	4	0%	0%	8%	23%	38%	31%	**92%**
Q29	Written & oral translation of client materials	0	0	0	11	2	0	0%	0%	0%	85%	15%	0%	**100%**
Q30	Ensure Interpreter availability	0	0	0	8	5	0	0%	0%	0%	62%	38%	0%	**100%**
Q31	Culturally competent subcontractor specialists	0	0	0	6	4	3	0%	0%	0%	46%	31%	23%	**100%**
Q32	Written and oral translation by subcontractors	0	0	1	11	1	0	0%	0%	8%	85%	8%	0%	**92%**
Q33	Monitoring of culturally competent services	0	1	0	7	5	0	0%	8%	0%	54%	38%	0%	**92%**
Q34	Sufficiency of provider network to meet need	0	0	3	7	2	1	0%	0%	23%	54%	15%	8%	**77%**
Q35	Changes in capacity and services reported to State	0	0	0	8	4	1	0%	0%	0%	62%	31%	8%	**100%**
Q39	Consistent authorization standards	0	0	0	6	7	0	0%	0%	0%	46%	54%	0%	**100%**
Q40	Authorization conducted by MHPs	0	0	3	6	4	0	0%	0%	23%	46%	31%	0%	**77%**
Q41	Monitoring of consistent authorization practices	0	0	2	6	5	0	0%	0%	15%	46%	38%	0%	**85%**
Q42	Adverse action notices meet requirements	0	2	3	4	3	1	0%	15%	23%	31%	23%	8%	**62%**
Q43	Standard authorization requirements	0	2	1	2	7	1	0%	15%	8%	15%	54%	8%	**77%**
Q44	Expedited authorization requirements	0	0	2	5	6	0	0%	0%	15%	38%	46%	0%	**85%**
Q45	Extension of expedited authorization request	0	0	2	7	4	0	0%	0%	15%	54%	31%	0%	**85%**
Q47	Protection against provider discrimination	0	0	1	8	2	2	0%	0%	8%	62%	15%	15%	**92%**
Q48	Policy re: excluded providers	0	0	0	7	3	3	0%	0%	0%	54%	23%	23%	**100%**
Q49	Confidentiality compliance	0	0	0	4	2	7	0%	0%	0%	31%	15%	54%	**100%**
Q50	Privacy compliance by subcontractors	0	0	0	8	1	4	0%	0%	0%	62%	8%	31%	**100%**
Q51	Privacy compliance subcontractor audits	0	1	2	6	3	1	0%	8%	15%	46%	23%	8%	**77%**
Q52	Pre-subdelegation evaluation	0	1	6	2	1	3	0%	8%	46%	15%	8%	23%	**46%**
Q53	Written subdelegation agreement	0	0	5	3	4	1	0%	0%	38%	23%	31%	8%	**62%**
Q54	Annual subcontractor subdelegation performance review	0	0	6	3	3	1	0%	0%	46%	23%	23%	8%	**54%**
Q55	Corrective actions re: subdelegation deficiencies	0	0	5	3	3	2	0%	0%	38%	23%	23%	15%	**62%**
Q56	Adoption of evidenced based practice guidelines	0	0	1	6	5	1	0%	0%	8%	46%	38%	8%	**92%**
Q57	Dissemination of practice guidelines	0	0	0	7	6	0	0%	0%	0%	54%	46%	0%	**100%**
Q58	Application of practice guidelines	0	2	5	3	3	0	0%	15%	38%	23%	23%	0%	**46%**
Q61	Detection of over & under utilization	0	0	3	7	2	1	0%	0%	23%	54%	15%	8%	**77%**
	All Scores of 0 through 5:	**0**	**13**	**59**	**234**	**145**	**43**	**0%**	**3%**	**12%**	**47%**	**29%**	**9%**	**85%**

	<< Shading indicates 2004 Corrective Action Item
text	<< Underlining indicates 2005 EQRO improvement recommendation

2006 Score Distribution acoss PIHPs - Subpart F

Item	Short Description	Score: 0	1	2	3	4	5	Distribution: 0	1	2	3	4	5	3, 4 or 5
Q71	Authority to file grievance	0	0	3	2	7	1	0%	0%	23%	15%	54%	8%	**77%**
Q72	Timing and Procedures for filing	0	0	1	8	4	0	0%	0%	8%	62%	31%	0%	**92%**
Q73	Timing of notice	0	2	3	5	3	0	0%	15%	23%	38%	23%	0%	**62%**
Q74	Administrative assitance for enrollees	0	0	0	6	7	0	0%	0%	0%	46%	54%	0%	**100%**
Q75	Grievance acknowledgement	0	1	0	11	1	0	0%	8%	0%	85%	8%	0%	**92%**
Q76	Appropriate grievance review personnel	0	0	0	11	2	0	0%	0%	0%	85%	15%	0%	**100%**
Q77	Special requirements for appeals	0	0	0	8	4	1	0%	0%	0%	62%	31%	8%	**100%**
Q78	Enrollee access to case file	0	0	0	8	5	0	0%	0%	0%	62%	38%	0%	**100%**
Q79	Included appeal parties	0	0	1	9	3	0	0%	0%	8%	69%	23%	0%	**92%**
Q80	Resolution and notification of grievances & appeals	0	0	2	8	3	0	0%	0%	15%	62%	23%	0%	**85%**
Q81	Content of Notice of Appeal Resolution	0	0	1	9	3	0	0%	0%	8%	69%	23%	0%	**92%**
Q82	State fair hearings requirements	0	0	1	8	4	0	0%	0%	8%	62%	31%	0%	**92%**
Q83	Expedied appeal resolution/prohibition against punitive actio	0	0	0	11	2	0	0%	0%	0%	85%	15%	0%	**100%**
Q84	Denial of expedited resolution	0	0	1	12	0	0	0%	0%	8%	92%	0%	0%	**92%**
Q85	Use of State developed description in subcontracts	0	1	1	10	1	0	0%	8%	8%	77%	8%	0%	**85%**
Q86	Record keeping	0	1	0	9	3	0	0%	8%	0%	69%	23%	0%	**92%**
Q87	Review and quality improvement	0	0	2	7	4	0	0%	0%	15%	54%	31%	0%	**85%**
Q88	Rights upheld during pended appeal	0	0	1	8	4	0	0%	0%	8%	62%	31%	0%	**92%**
Q89	Rights upheld regarding disputed services	0	0	0	11	2	0	0%	0%	0%	85%	15%	0%	**100%**
	All Scores of 0 through 5:	**0**	**5**	**17**	**161**	**62**	**2**	**0%**	**2%**	**7%**	**65%**	**25%**	**1%**	**91%**

	<< Shading indicates 2004 Corrective Action Item
text	<< Underlining indicates 2005 EQRO improvement recommendation

2006 Score Distribution acoss PIHPs - Subpart H

Item	Short Description	Score: 0	1	2	3	4	5	Distribution: 0	1	2	3	4	5	3, 4 or 5
Q90.a	Source of certification	1	0	0	12	0	0	8%	0%	0%	92%	0%	0%	**92%**
Q90.b1	Data content certification	1	0	0	12	0	0	8%	0%	0%	92%	0%	0%	**92%**
Q90.b2	Certification content requirements	1	0	0	12	0	0	8%	0%	0%	92%	0%	0%	**92%**
Q90.b3	Certification timing	2	0	0	11	0	0	15%	0%	0%	85%	0%	0%	**85%**
Q91.b1	Written fraud & abuse p&ps/compliance plan	0	0	0	13	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q91.b2	Accountable compliance officer/committee	0	0	0	13	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q91.b3	Effective Compliance training and education	0	0	0	13	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q91.b4	Effective compliance communication	1	0	0	12	0	0	8%	0%	0%	92%	0%	0%	**92%**
Q91.b5	Well publicized disciplinary guidelines	0	0	0	13	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q91.b6	Internal audit provisions	6	0	0	7	0	0	46%	0%	0%	54%	0%	0%	**54%**
Q91.b7	Prompt response to offenses	0	0	0	13	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q92	Prohibited affiliations with the Federally debarred	0	0	0	13	0	0	0%	0%	0%	100%	0%	0%	**100%**
	All Scores of 0 through 5:	**12**	**0**	**0**	**144**	**0**	**0**	**8%**	**0%**	**0%**	**92%**	**0%**	**0%**	**92%**

	<< Shading indicates 2004 Corrective Action Item
text	<< Underlining indicates 2005 EQRO improvement recommendation

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Attachments

Attachment A – Individual PIHP Reports

Attachment B – PIHP Communications

Attachment C – Site Visit Documentation

Attachment D – Subpart Scoring Guidelines

Attachment E – Subpart Scoring Tool

Attachments

Attachment A – Individual PIHP Reports

- Thurston-Mason
- Grays Harbor
- Southwest
- Timberlands
- Peninsula
- Pierce County
- Clark County
- North Sound
- Greater Columbia
- Spokane County
- Chelan-Douglas
- North Central
- King County

Washington External Quality Review Organization

Thurston-Mason
Prepaid Inpatient Health Plan

External Quality Review
2006

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I. Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

The Thurston Mason PIHP2006 review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period <Date> through <Date>, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider networks and regional systems of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

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The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	August 9, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	August 25, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	September 5, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials	September 15-19, 2006	
Onsite Activities	September 25, 2006	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		

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Activity	Timeline	Documents/Content
Post Onsite Activities		
1. Phone interview with Ombuds	October 17, 2006	
2. Complete initial scoring and results documentation; construct report	October 23, 2006	
3. Draft report to PIHP	October 24, 2006	
4. Debrief conference call	November 6, 2006	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	November 10, 2006	

Thurston Mason PIHP is responsible for managing mental health care and services for Medicaid consumers in Thurston and Mason counties in the state of Washington. The PIHP is located in Olympia, Washington and is governed by a board comprised of three Thurston County Commissioners. The PIHP Administrator reports to this board. Thurston Mason PIHP contracts with three community mental health centers and specialty providers to serve approximately 4,000 adult and child consumers annually. Total annual Medicaid enrollment in the PIHP is approximately 34,000. In addition, the PIHP <contracts with an outside vendor for MIS support>.

This report covers the period between September 9, 2005 and September 8, 2006 and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Thurston Mason PIHP did not submit a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;

5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

WAEQRO seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1,2,3, and 4, and site visit information is found in Attachments12, 13, and 16

II. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Thurston Mason PIHP, no significant changes occurred during the past year..

III. 2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

IV. 2006 Review Results

This report provides results and a summary of Thurston Mason PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Thurston Mason PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.106 [Q13]	**Subcontracts ensure enrollee payment liability protections**			
	Liability for Payment-Current policy does not address ensuring that enrollees are not charged in the event of insolvency of a community psychiatric hospital. Current policy does not identify mechanisms to monitor these provisions.	Submit a corrective action plan to the MHD by 4/4/05	CAP submitted 3/14/05 Additional Info requested by MHD submitted 4/20/05	Relevant policies and procedures include all requirements of this provision. PIHP has attained a score of **4- Substantial Compliance**.
438.206 (b)(3) [Q21]	**Systematic method of accessing a second opinion throughout service delivery system**			
	Delivery Network-Second Opinion. Procedures have	Submit a corrective action plan to	CAP submitted 3/14/05	Revised CI-407 Second Opinions policy and

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CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	not been developed and incorporated into the policy. Policy does not identify mechanisms to ensure this is accomplished in a systematic way.	the MHD by 4/405	Additional Info requested by MHD submitted 4/20/05	procedures includes required timeframes, access within and outside of provider network, description of second opinion assessment, review with consumer, include in consumer's decision about treatment options-when applicable, and mechanisms to monitor second opinion. PIHP has attained a score of **4-Substantial Compliance**.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks. (See, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards

  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of Expected performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F
- A score of 1 for Subpart H

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);
- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Thurston Mason PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

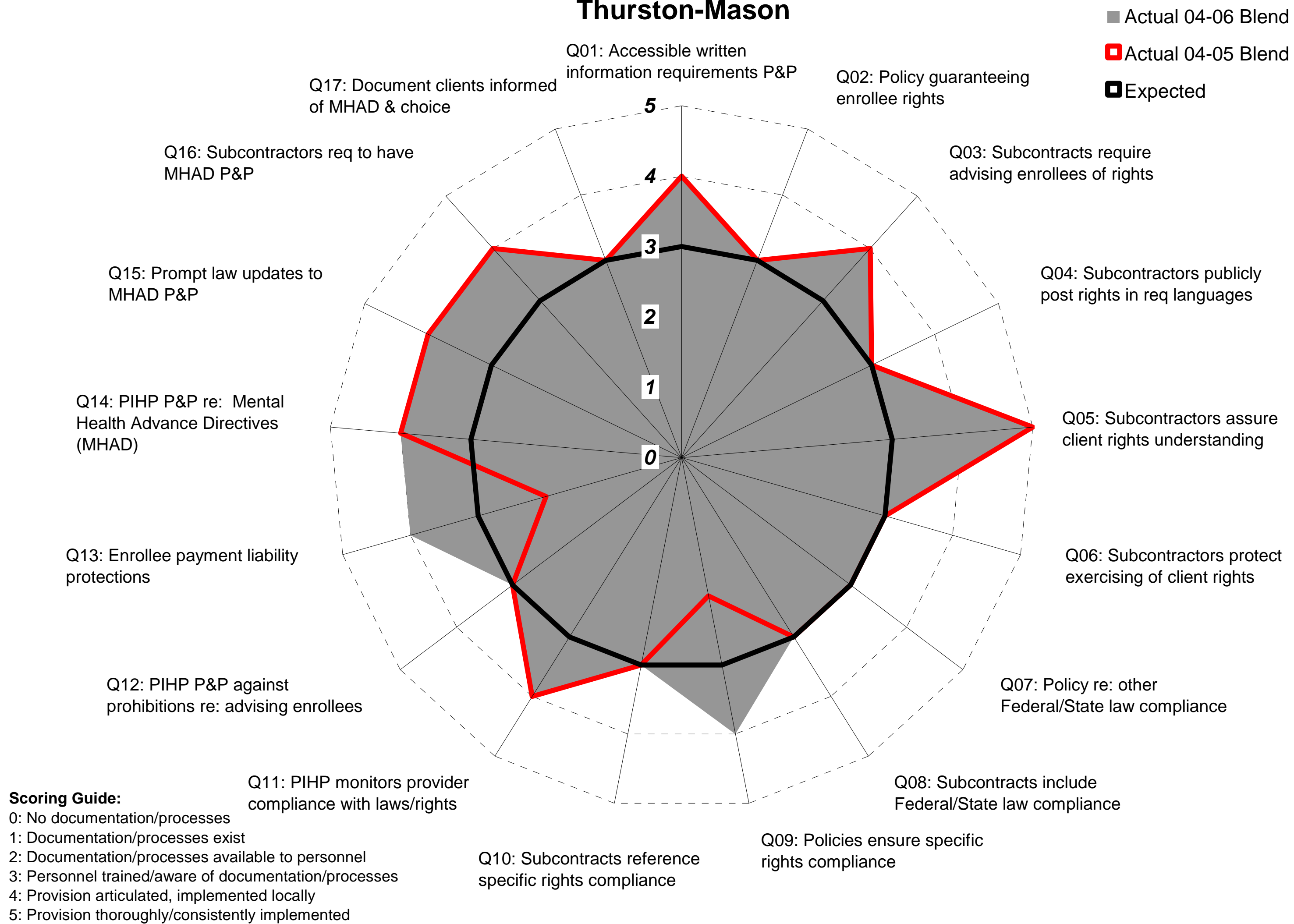
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all

elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. “Expected” performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.


Subpart C: Enrollee Rights & Protections
Thurston-Mason
Actual 04-06 Blend
Actual 04-05 Blend
Expected
Q01: Accessible written information requirements P&P
Q02: Policy guaranteeing enrollee rights
Q03: Subcontracts require advising enrollees of rights
Q04: Subcontractors publicly post rights in req languages
Q05: Subcontractors assure client rights understanding
Q06: Subcontractors protect exercising of client rights
Q07: Policy re: other Federal/State law compliance
Q08: Subcontracts include Federal/State law compliance
Q09: Policies ensure specific rights compliance
Q10: Subcontracts reference specific rights compliance
Q11: PIHP monitors provider compliance with laws/rights
Q12: PIHP P&P against prohibitions re: advising enrollees
Q13: Enrollee payment liability protections
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)
Q15: Prompt law updates to MHAD P&P
Q16: Subcontractors req to have MHAD P&P
Q17: Document clients informed of MHAD & choice
5
4
3
2
1
0
Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Thurston Mason

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart C:	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	4		4
Q02: Policy guaranteeing enrollee rights	3		3
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	3		3
Q05: Subcontractors assure client rights understanding	5		5
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	3		3
Q08: Subcontracts include Federal/State law compliance	3		3
Q09: Policies ensure specific rights compliance	2	4	4
Q10: Subcontracts reference specific rights compliance	3		3
Q11: PIHP monitors provider compliance with laws/rights	4		4
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	2	4	4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	4		4
Q16: Subcontractors req to have MHAD P&P	4		4
Q17: Document clients informed of MHAD & choice	3		3

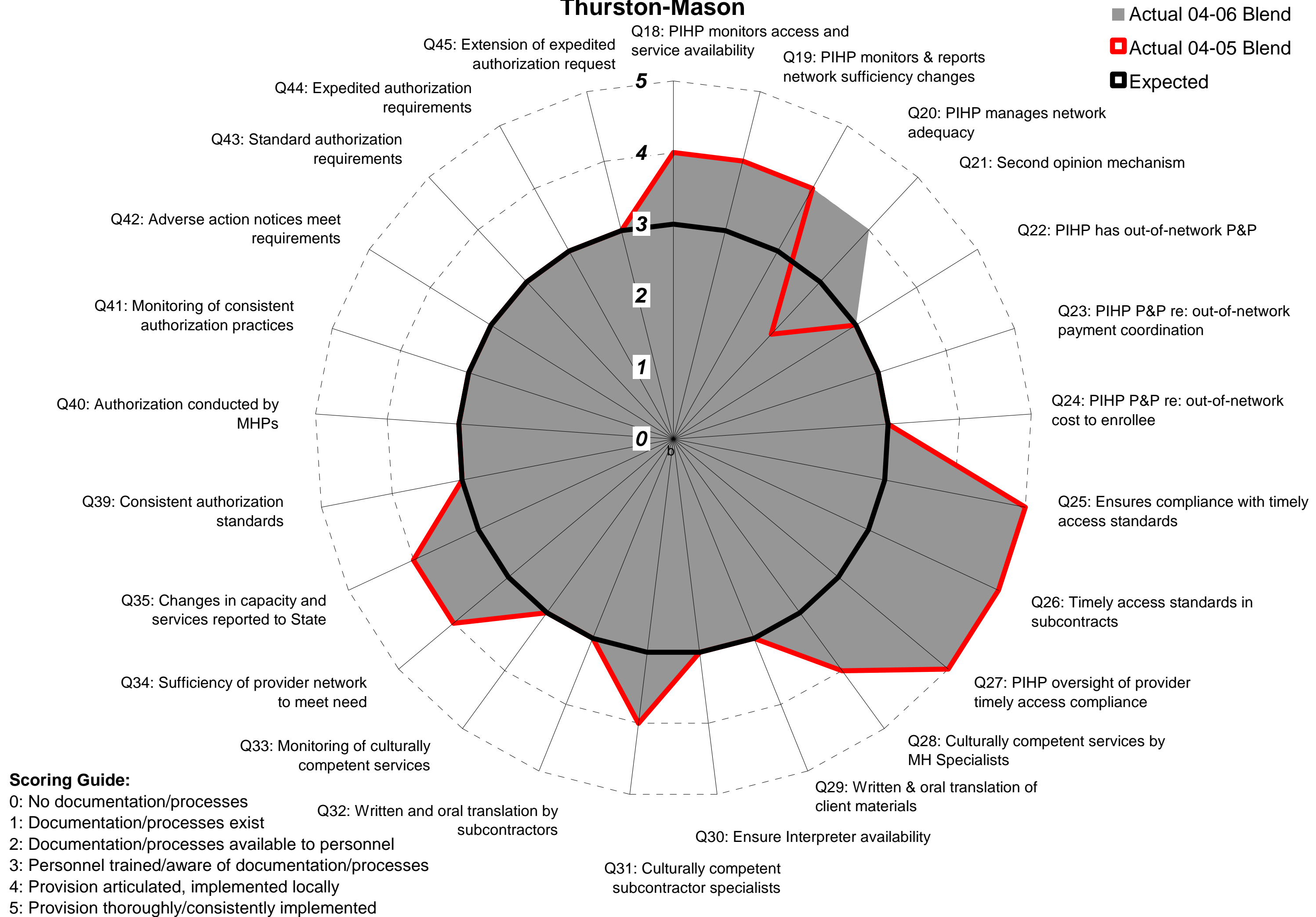
Thurston Mason PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
438.100(d)	**Compliance with Other Federal and State laws**	
[Q9]	**PIHP policies assure compliance with right to a 2nd opinion, client participation in treatment, and access to clinical records** Evidence: • Revised CI-402 Client Rights & Responsibilities policy and procedures contains specific procedures related to client access to clinical record and second opinion. Policy references client's right to participate in treatment decisions—does not include specific procedures related to this right. • Revised CI-407 Second Opinions policy and procedures includes required timeframes, access within and outside of provider network, description of second opinion assessment, review with consumer, include in consumer's decision about treatment options-when applicable, and mechanisms to monitor second opinion. • Participation in July 2006 WRAP training • Network provider management has awareness of policies listed above. Management reports PIHP monitors second opinions through MIS (new activity code). No knowledge of PIHP reviewing for client access to clinical records. • Direct service staff able to articulate basic understanding of procedures related to access to a second opinion, and client voice and involvement in treatment decisions. Reported they would contact staff responsible for medical records if client requested access to the clinical record. • Monitoring of client participation in treatment decisions occurs via Quality of Care Chart Review and QRT Forum Group Interviews. (Substantial Compliance)	4
438.106	**Liability for Payment**	
[Q13]	**Subcontracts ensure enrollee payment liability protections** Evidence: • '05-'06 Provider Outpatient Services Contract includes relevant language meeting the requirements of this provision. • Revised FM-110 Payments from Medicaid Enrollees policy and procedures protects Medicaid enrollees from liability for payment in all required circumstances outlined in this provision.	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	• P&P outlines how the PIHP will ensure no Medicaid enrollee will be charged for covered services including: informing and educating consumers with regard to their financial rights in the Benefits Booklet, consumer notification of insolvency, assisting consumers with erroneous charges, auditing and monitoring providers' solvency and billing practices. • P&P also includes provider billing and encounter data procedures to ensure Medicaid enrollees are not charged for services. • PIHP Management reported that all provider network charges and billings come through their financial system in the MIS for monitoring purposes. No documentation was submitted showing evidence of this monitoring mechanism or any other related monitoring activities. • Provider management staff reported the PIHP monitors to ensure Medicaid enrollees are not held liable for payment by reviewing encounter data through their MIS. (Substantial Compliance)	4

Subpart D (Part 1): Access Standards



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2004-2006 Subpart Scoring Trend and Detail for Thurston Mason

Scoring Guide for Subparts C, D and F:
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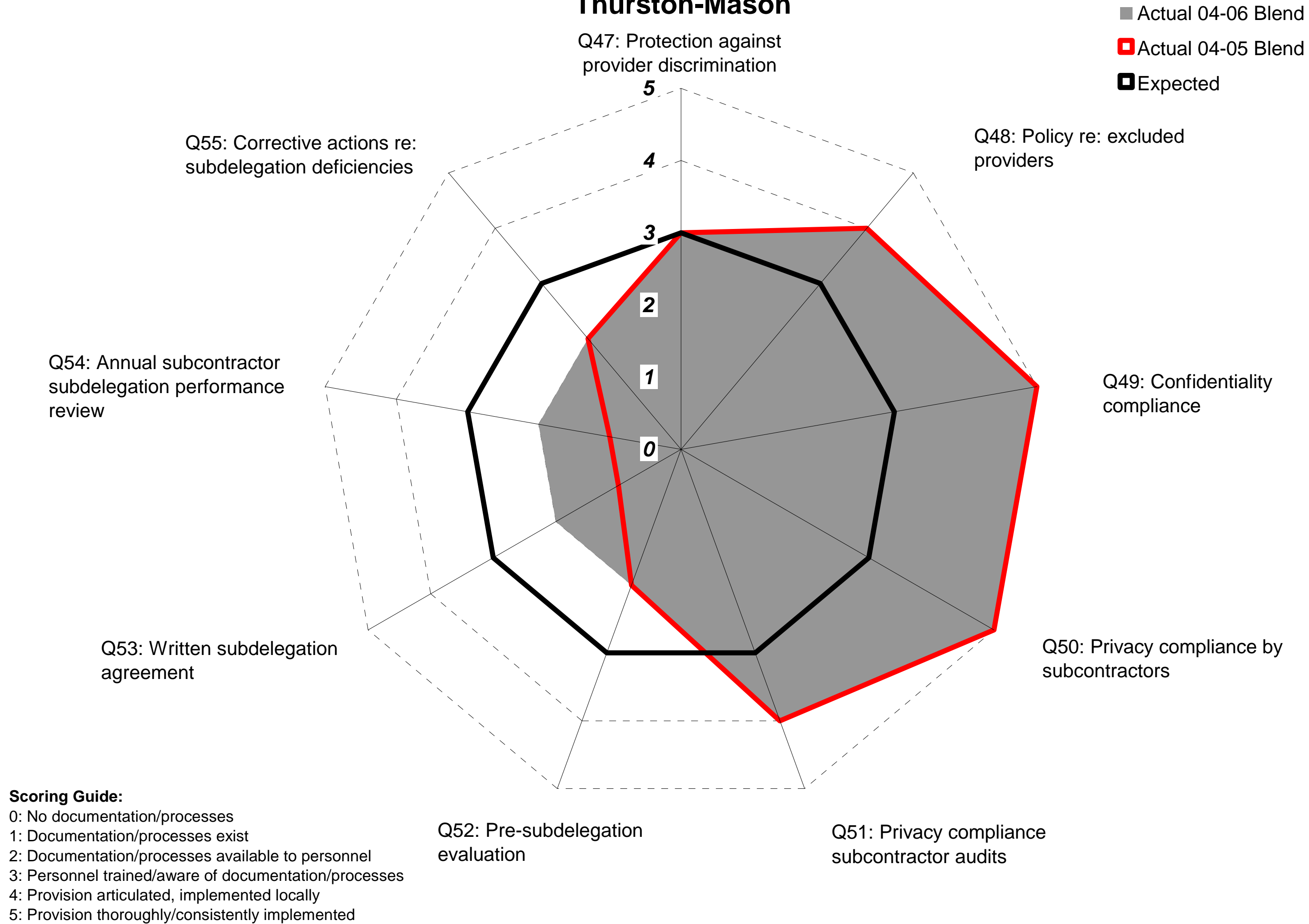
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	4		4
Q19: PIHP monitors & reports network sufficiency changes	4		4
Q20: PIHP manages network adequacy	4		4
Q21: Second opinion mechanism	2	4	4
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	3		3
Q24: PIHP P&P re: out-of-network cost to enrollee	3		3
Q25: Ensures compliance with timely access standards	5		5
Q26: Timely access standards in subcontracts	5		5
Q27: PIHP oversight of provider timely access compliance	5		5
Q28: Culturally competent services by MH Specialists	4		4
Q29: Written & oral translation of client materials	3		3
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	4		4
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	4		4
Q35: Changes in capacity and services reported to State	4		4
Q39: Consistent authorization standards	3		3
Q40: Authorization conducted by MHPs	3		3
Q41: Monitoring of consistent authorization practices	3		3
Q42: Adverse action notices meet requirements	3		3
Q43: Standard authorization requirements	3		3
Q44: Expedited authorization requirements	3		3
Q45: Extension of expedited authorization request	3		3



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2004-2006 Subpart Scoring Trend and Detail for Thurston Mason

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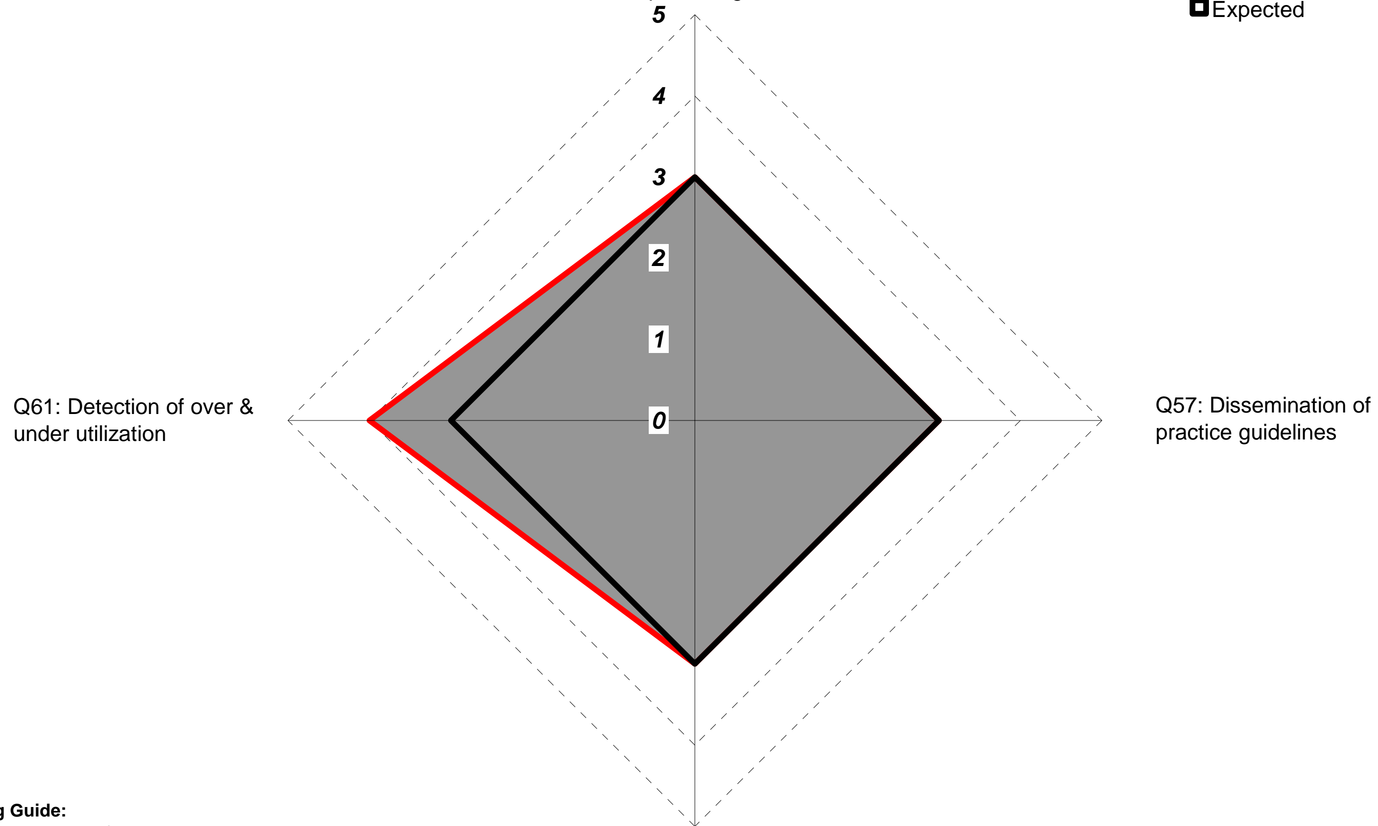
5: Provision thoroughly/consistently implemented

Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	4		4
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	5		5
Q51: Privacy compliance subcontractor audits	4		4
Q52: Pre-subdelegation evaluation	2	2	2
Q53: Written subdelegation agreement	1	2	2
Q54: Annual subcontractor subdelegation performance review	1	2	2
Q55: Corrective actions re: subdelegation deficiencies	2	2	2

Subpart D (Part 3): Measurement and Improvement Standards

Thurston-Mason



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2004-2006 Subpart Scoring Trend and Detail for
Thurston-Mason

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

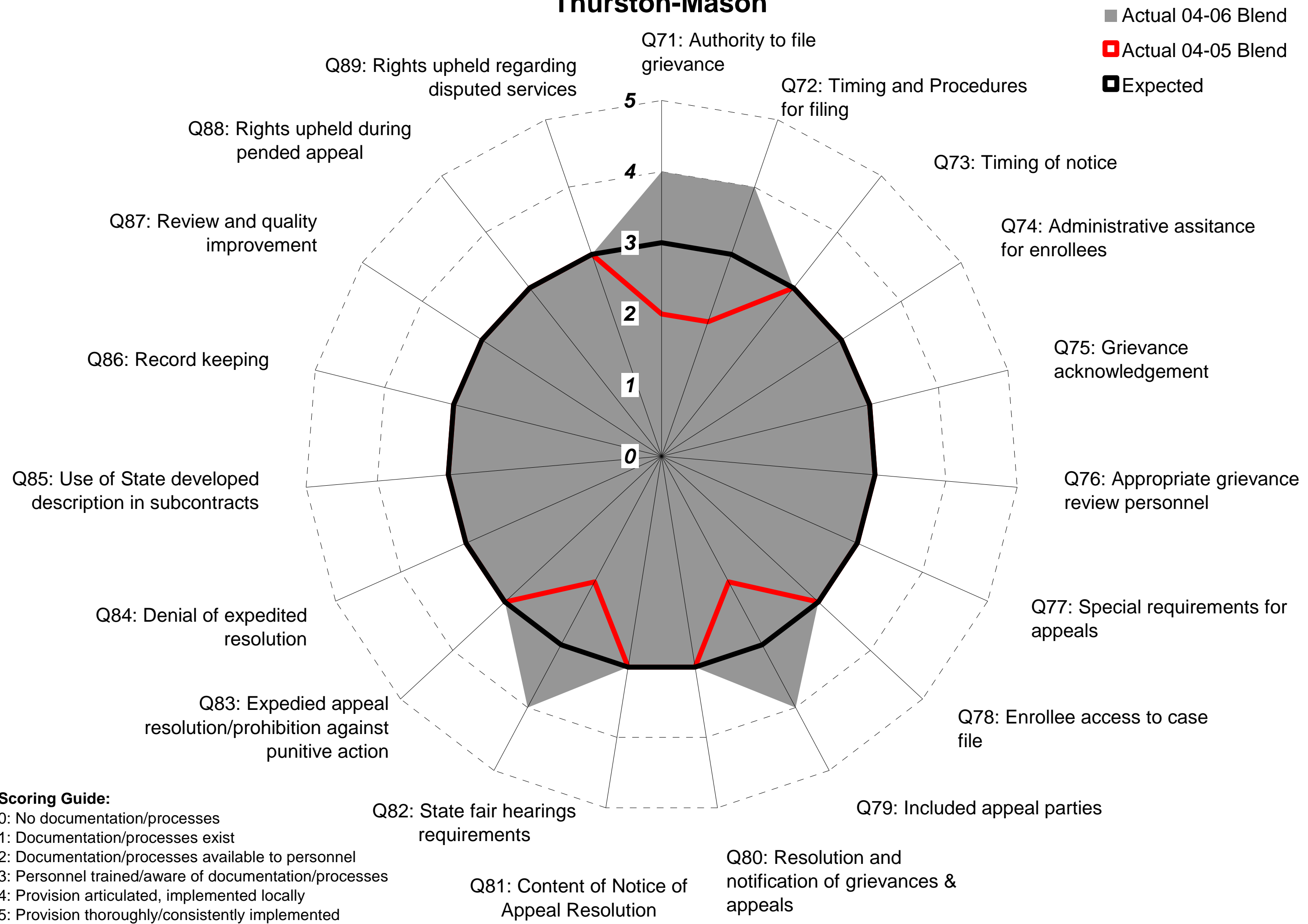
Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	3		3
Q57: Dissemination of practice guidelines	3		3
Q58: Application of practice guidelines	3		3
Q61: Detection of over & under utilization	4		4

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (b)(3)	**Delivery Network-Second Opinion**	
[Q21]	**Systematic method of accessing a second opinion throughout service delivery system** Evidence: • Revised CI-407 Second Opinions policy and procedures includes required timeframes, access within and outside of provider network, description of second opinion assessment, review with consumer, include in consumer's decision about treatment options-when applicable, and mechanisms to monitor second opinion. • '05-'06 Provider Outpatient Services Contract incorporates all the PIHP's P&Ps, requires providers to incorporate specific language pertaining to second opinions in the client rights provided to consumers and posted in their agencies. • Revised CI-406 Availability of Services also incorporates the basic right and procedures for a second opinion. • Medicaid Denial Review Form and blank sample of Authorization Denial Second Opinion Form show second opinion option available to enrollees. • Network provider management has awareness of policies listed above. Management reports that initial care second opinions happen fairly automatically. State they are still working through the process of tracking, accessing and documenting requests for second opinions later in care. Report the PIHP monitors second opinions through MIS (new activity code) and by tracking and reviewing grievances and appeals. • Direct service staff able to articulate procedures for accessing a second opinion. • No evidence showing implementation of monitoring activities outlined in second opinion policy submitted for review. (Substantial Compliance)	4
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • New SD-216 Provider Credentialing, new SD-216.1 Provider	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	Credentialing Application 2006 Application Form, new SD-216.1B Staffing Report, revised Provider Network Management Plan, and revised Resource Management Plan policies and procedures indicate PIHP has recently developed a comprehensive process for evaluating, selecting and credentialing network providers. • '05-'06 Provider Outpatient Services Contract incorporates the PIHP's P&Ps, as well as specific contract language and requirements related to providers as subcontractors, and to any subcontracts providers may have related to the provision of Medicaid mental health services. • Minutes from the September 1, 2006 PIHP and provider Credentialing Application Form review meeting indicate revisions will be made to the form to make it more user friendly for providers. Form to be revised and sent to providers by Sept 7, 2006. Providers required to submit completed application within 30 days. No completed applications submitted for review, still in process of initial implementation at time of onsite interviews. • Revised SD-204 Sub-Contractual Relationships and Delegation, reviewer is unable to determine if policy and procedures are being implemented with Jet Computers, a subcontractor to whom the PIHP partially delegates MIS (i.e. submits data to MHD). • PIHP reported they did not think they were required to implement their Sub-Contractual Relationships and Delegation policy and procedures with Jet Computers as they do not see them as a sub-delegation entity. (Partial Compliance)	2
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • Documents listed in [Q52]. • '05-'06 Provider Outpatient Services Contract specifies the activities and services to be performed, as well as administrative responsibilities delegated to the subcontractor; provides for revoking delegation or imposing remedial actions and other sanctions if the subcontractor's performance is inadequate. • No written agreement between the PIHP and Jet Computers was submitted for review, therefore reviewer unable to determine if agreement meets requirements of this provision. (Partial Compliance)	2

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • Documents listed in [Q52]. • Data monitoring reports related to access, parity, safety, over and underutilization. • PIHP network provider audit finding letters and reports, provider written responses to audit findings and corrective action plans demonstrate the PIHP is monitoring providers' performance regularly. • No annual performance review or other monitoring activities of Jet Computers was submitted for review, therefore reviewer unable to determine if PIHP is monitoring the performance of Jet Computers on a regular basis. (Partial Compliance)	2
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • Documents listed in [Q52]. • Data monitoring reports related to access, parity, safety, over and underutilization. • PIHP network provider audit finding letters and reports, provider written responses to audit findings and corrective action plans demonstrate the PIHP is monitoring providers' performance regularly. • No annual performance review or other monitoring activities of Jet Computers was submitted for review, therefore reviewer unable to determine if PIHP is monitoring the performance of Jet Computers on a regular basis. Also unable to determine if the PIHP has imposed any quality improvements or corrective actions. (Partial Compliance)	2



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Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	2	4	4
Q72: Timing and Procedures for filing	2	4	4
Q73: Timing of notice	3		3
Q74: Administrative assitance for enrollees	3		3
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	2	4	4
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	2	4	4
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	3		3
Q87: Review and quality improvement	3		3
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

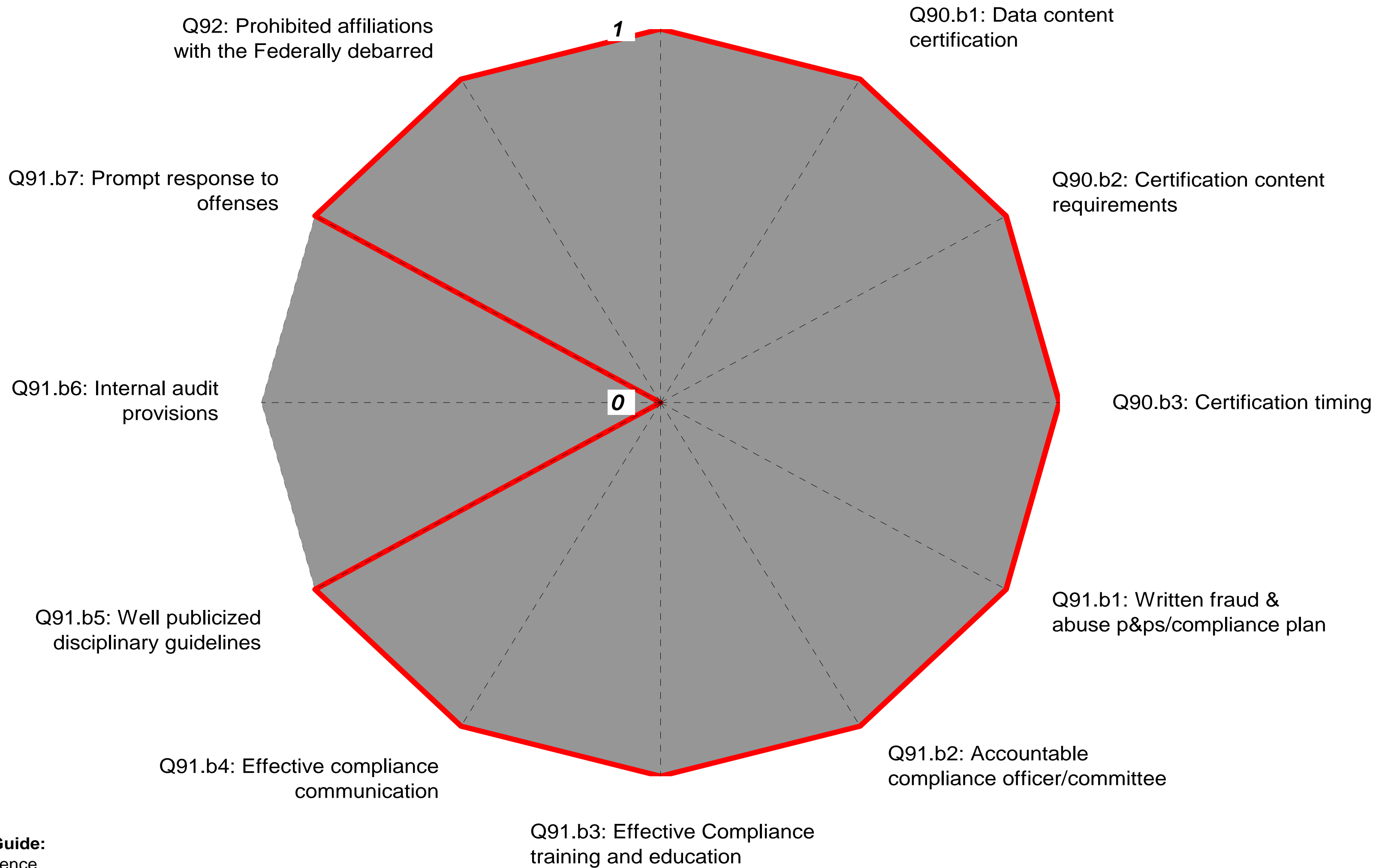
Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.402	**Grievance System and Filing Requirements**	
[Q71]	**Authority to file a grievance, appeal, or State fair hearing** Evidence: • Revised CI-409 Grievance Plan, CI-415 Notification Requirements policies and procedures indicate the PIHP has an enrollee grievance and appeal process, and access to the State's fair hearing system, with accurate filing, timing, authority, and procedural requirements. • Grievance Training Plan, Grievance Training Attendance Record, Grievance Plan Power Point Training curriculum for September 2005 training. (Since policy and procedure have been revised, Power Point may need to be updated). • Provider direct service staff able to articulate basic understanding of who can file a grievance and appeal. • Recent Ombuds reports and PIHP Exhibit N Reports show evidence of tracking and monitoring complaints, grievances, appeals and fair hearings. No evidence of QA&I activities demonstrating continuous quality improvement (CQI) interventions and follow-up. (Substantial Compliance)	4
[Q72]	**Timing and Procedures for filing a grievance, appeal, or State fair hearing** Evidence: • Revised CI-409 Grievance Plan, CI-415 Notification Requirements policies and procedures indicate the PIHP has an enrollee grievance and appeal process, and access to the State's fair hearing system, with accurate filing, timing, authority, and procedural requirements. • Grievance Training Plan, Grievance Training Attendance Record, Grievance Plan Power Point Training curriculum for September 2005 training. (Since policy and procedure have been revised, Power Point may need to be updated). • Provider direct service staff able to articulate basic understanding of how to file a grievance and appeal and associated timeframes. • Recent Ombuds reports and PIHP Exhibit N Reports show evidence of tracking and monitoring complaints, grievances, appeals and fair hearings. No evidence of QA&I activities demonstrating continuous quality improvement (CQI) interventions and follow-up.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	(Substantial Compliance)	4
438.406	**Handling of Grievances and Appeals**	
[Q79]	**Included parties to the appeal** Evidence: • Revised CI-409 Grievance Plan, CI-415 Notification Requirements policies and procedures include all potential parties to the appeal as required by this provision. • '05-'06 PIHP Provider Outpatient Contract relevant sections. • Grievance Training Plan, Grievance Training Attendance Record, Grievance Plan Power Point Training curriculum for September 2005 training. (Since policy and procedure have been revised, Power Point may need to be updated). • Provider direct service staff able to articulate basic understanding of the potential parties to an appeal. • Recent Ombuds reports and PIHP Exhibit N Reports show evidence of tracking and monitoring complaints, grievances, appeals and fair hearings. No evidence of QA&I activities demonstrating continuous quality improvement (CQI) interventions and follow-up. (Substantial Compliance)	4
438.408	**Resolution and Notification of Grievances and Appeals**	
[Q82]	**State fair hearings requirements** Evidence: • Revised CI-409 Grievance Plan, policy and procedures accurately stipulates availability of State Fair Hearings to enrollees, timeframes, reasons a State Fair Hearing can be requested without first filing a grievance or appeal locally, and potential parties to be included in the Fair Hearing. • '05-'06 PIHP Provider Outpatient Contract relevant sections. • Grievance Training Plan, Grievance Training Attendance Record, Grievance Plan Power Point Training curriculum for September 2005 training. (Since policy and procedure have been revised, Power Point may need to be updated). • Provider direct service staff able to articulate basic understanding of fair hearings and potential parties that may be included. • Recent Ombuds reports and PIHP Exhibit N Reports show evidence of tracking and monitoring complaints, grievances, appeals and fair hearings. No evidence of QA&I activities demonstrating continuous quality improvement (CQI) interventions and follow-up. (Substantial Compliance)	4

Subpart H: Certifications & Program Integrity

Thurston-Mason



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for Thurston Mason

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H:	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse P&Ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	0	1	1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90]	(a) Evidence of certifications. (Compliance)	1
	(b) Content Certification	
	(1) To the accuracy, completeness and truthfulness of the data (Compliance)	1
	(2) To the accuracy, completeness and truthfulness of the documents specified by the State (Compliance)	1
	(3) Timing of the certification (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b6]	**Provisions for internal monitoring** Evidence for the provision of internal monitoring and auditing exists in the PIHP's revised CM-302 Compliance Program and new FM-123 Internal Controls policies and procedures, and 2006 Annual Compliance Audit Plan. In addition, the MHD PIHP Fiscal Review Report demonstrated evidence of external review of the PIHP's fiscal management and procedures by the managed care contractor. (Compliance)	1

Scoring Frequency Overview

APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Thurston-Mason

These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

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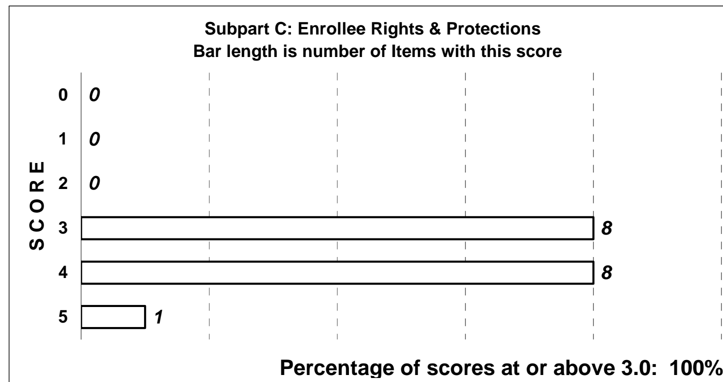
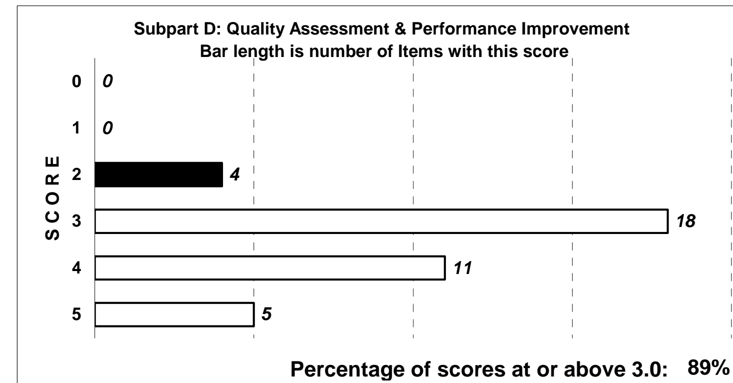
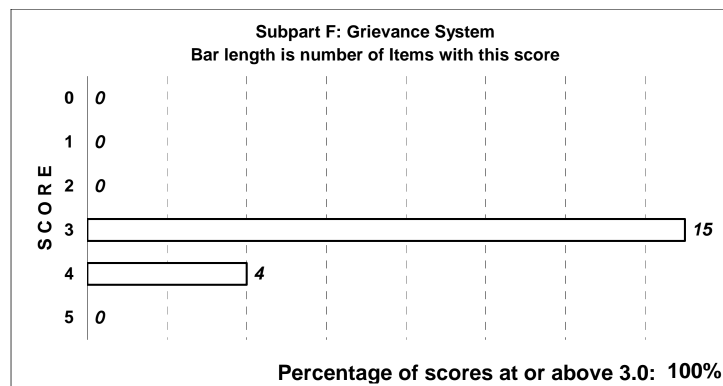
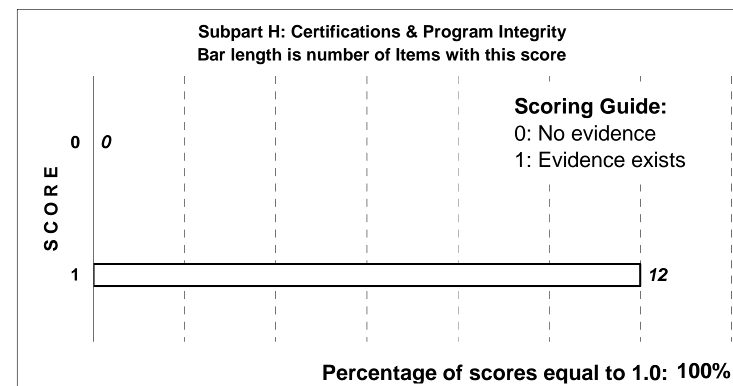








Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 100%
Subpart D: 89%
Subpart F: 100%
Subpart H: 100%

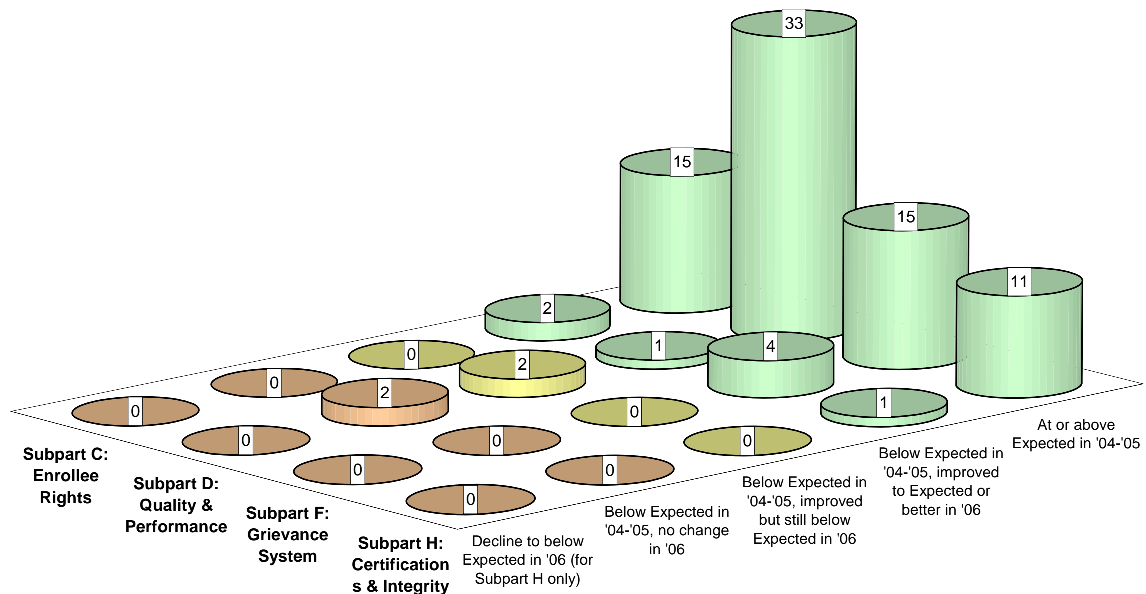
Thurston Mason PIHP meets the minimum standard for all the specific requirements in Subparts C, F, and H. The PIHP has prioritized Subpart C by ensuring that direct service staff are knowledgeable about rights and protections and provide this information to consumers. With respect to Subpart F, PIHP staff have prioritized ensuring that their network providers have access to grievance system policies and procedures, and have provided some basic training in this area. For Subpart H, the PIHP has made efforts to ensure that all data certifications meet source, content, and timing requirements, and that the required elements for program integrity are in place.

The PIHP continues to make progress with respect to Subpart D. Specific areas that remain a challenge include elements related to delegation of PIHP functions.

Score Trend Summary for:
Thurston-Mason

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



	Subpart C: Enrollee Rights		Subpart D: Quality & Performance		Subpart F: Grievance System		Subpart H: Certifications & Integrity	
Score Trend Category	Item Count	Percent	Item Count	Percent	Item Count	Percent	Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	2	5.3%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	2	5.3%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	2	11.8%	1	2.6%	4	21.1%	1	8.3%
At or above Expected in '04-'05	15	88.2%	33	86.8%	15	78.9%	11	91.7%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Subpart C (*Enrollee Rights*) entered the 2006 review with 15 out of 17 items (88.2%) already at or above the Expected level of performance. After the 2006 review, 17 items (100%) are at the Expected level, reflecting improvement in all elements that scored below Expected in 2005.

Subpart F (*Grievance System*) entered the 2006 review with 15 out of 19 items (78.9%) already at or above Expected. After the 2006 review, 19 items (100%) meet the Expected level of performance, again indicating improvement in all elements that scored below Expected in 2005.

The improvement Thurston-Mason PIHP has made in all four (4) of the Subparts reflects focused efforts on continuous quality improvement during 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- Evidence of new and revised policies and procedures pertaining to the Subpart requirements demonstrates the PIHP's efforts to document, standardize, and operationally define processes to effectively manage care throughout the region.
- In collaboration with provider management, PIHP staff developed a new work group to create effective protocols related to training and the implementation of new policies and procedures throughout the provider network.
- The PIHP has an increased commitment to integrating consumer voice and participation in decision making throughout all levels of managed care operations and service delivery. This is evidenced by a new PIHP Consumer Affairs/Family Specialist position, a Consumer Council, Certified Peer Counselors, Consumer Advocate participation in clinical reviews, and expanded/accessible Clubhouse services.

Subpart Challenges

- Revised policies and procedures were not re-approved once revisions were finalized.
- PIHP is unclear as to which PIHP functions require the application of subcontractor delegation conditions.
- PIHP has difficulty acknowledging and ensuring the voice and diverse, unique needs of all providers in the PIHP provider network are given consideration

Subpart Recommendations

1. Create a process to officially approve **revised** policies and procedures. Include dated signatures of PIHP officials or designees, date of revisions, and effective date of policy.

2. Clarify delegated PIHP functions and develop processes related to **all** subcontractor delegation:
    a. Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    b. Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    c. Review their related performance on an annual basis.

3. Establish well-defined procedures for analyzing aggregate complaint, grievance and appeal data to identify trends and related quality improvements to enhance care and services.

4. Include monitoring of client access to second opinions and clinical records as part of annual clinical reviews.

5. Develop methods of communication that give equitable consideration to the voice, needs, and contributions of each provider in the PIHP provider network.

6. Continue focused attention to providing organized trainings for PIHP and Provider Network staff to ensure awareness, understanding, skill development, and consistent implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   This item remains unchanged from the 2005 review status. The PIHP has plans to formalize this activity in a policy and procedure prior to next year's contract with their providers; thus, it will be considered a requirement for them thereafter.

   The PIHP stated that its Information Technology (IT) support contractor, Jet Computer, follows a written procedure not formalized as an organizational policy or procedure. The PIHP uses a coding specialist at Jet Computer to maintain their crosswalk between the State's defined coding and codes used in the field, including any non-standard service codes. Although a mapping process appears to be employed by the network providers, the WAEQRO recommends this process be formalized as a policy and procedure to ensure consistent compliance. Not following a formally codified process could result in underreporting of encounters, since ad hoc codes would not be accepted and counted as services by the State.

2. Unique member ID
   This item remains unchanged from 2005. The PIHP is in the process of documenting the procedure used to check for duplicate IDs.

   The PIHP stated that the member ID is unique to their PIHP and that they use a procedure to check for duplicates.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The PIHP can track members, regardless of changes in status, periods of enrollment and disenrollment, or changes across product lines.

4. Calculating member months

   The Utilization Management Committee plans to incorporate Per Member/Per Month (PM/PM) data into outcome/monitoring reports to track penetration rate changes, ensure managed care industry standards compliance, and to ensure that yearly MHD Performance Indicator reports accurately reflect Thurston Mason RSN penetration rate and are consistent with RSNs across the state.

5. Member database

   The PIHP expressed concern about the accuracy, timeliness, and usefulness of the member data provided by the state. The MHD is aware of these concerns. The problems will not be resolved until the new system, Provider One, is online.

6. Provider Database

   Thurston Mason PIHP maintains provider data on a server; data is specific down to the individual practitioners. This data will be used in a credentialing tracking database to be developed by the PIHP. The PIHP is also considering other ways this data may be helpful; as, for example, in tracking network adequacy.

7. Data easily under-reported

   This item remains unchanged from 2005. PIHP staff expect to develop a policy and procedure to cover out-of-network data in the coming year.

PM Summary

Thurston Mason has strong pre-submission screening processes on its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. Unfortunately, the PIHP's efforts fell short in this year's analysis and encounter validation review (described below). The overall score of Partially Met in the 2006 encounter validation review undermines confidence in the general state of the PIHP's performance measure accuracy. The general state of the PIHP's data is evaluated as "fair", therefore, despite being aided by the 2005 performance. Unfortunately, no steps are being taken to help bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent bconfidence).

PM Strengths

- This PIHP has very strong pre-submission processes to identify errors before data is entered into their system. These processes are largely responsible for the fairly positive results in last year's encounter validation.

PM Challenges

- All areas discussed in the encounter validation review later in this report are relevant here.
- The PIHP has done little to reconcile data already in their system, data which could provide much useful information in a variety of QA/QI arenas.
- Of the topical items listed above, the PIHP has made little, if any, progress since the

last review cycle.

PM Recommendations

1. Develop a policy and procedure to ensure that handling of non-standard codes is handled properly and consistently.

2. Develop a policy and procedure to ensure that staff who work the duplicate member process do so correctly and consistently.

3. Develop a policy and procedure outlining the requirement for data submission when out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two submitted PIPs for Thurston Mason PIHP: “Seven-day Face-to-Face OP Visit Post-hospital Discharge Compliance”, which was identified by the PIHP as clinical. Included in the document request were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and evaluate their performance. Site visit interviews focused on increasing the WAEQRO’s understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006. (See, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

Thurston Mason submitted two PIPs for review, both reflecting study topics selected by MHD in 2004. Selected for review was the clinical PIP, titled by the PIHP as “Seven-day Face-to-Face OP Visit Post-hospital Discharge Compliance”. The PIPH undertook to track discharges from the State Hospital and the local community hospital to ensure that initial follow-up appointments occurred within the required 7 days post-discharge. They tracked discharge activity for 4 months in 2006, and reported on number of days to first appointment as well as some associated measures, and compared their results against the MHD threshold of 85%. They identified multiple points along the discharge process that could have posed barriers to achieving the target; however, they identified those activities as indicators. The PIHP expressed appreciation for the training provided by MHD in mid-September and were able to articulate significantly increased understanding of the protocol and expectations. Below is the validation of their submission.

PERFORMANCE IMPROVEMENT PROJECT
Validation Worksheet
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				High risk: all consumers being discharged from inpatient care
1.2. Is selected following collection and analysis of data (or was selected by the State).	X				Selected by the State
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	This is first PIP for this PIHP
1.4 Includes all eligible populations that meet the study criteria.	X				Studying all Medicaid enrolled discharges
1.5. Does not exclude members with special health care needs.	X				
1.6 Has the potential to affect member health, functional status, or satisfaction.	X				While no research cited in description, common wisdom accepts that consumers are more likely to spend less time in hospitals if their follow-up services are provided in a timely and effective manner.
Totals for Step 1:	5			1	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Number of shaded critical evaluation elements met for Step 1:: 1/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.		X			The PIP was designed as a tracking process to assess compliance with the State requirement for number of days between discharge and 1st follow-up appointment.
2.2 Is answerable/provable.				X	While there is no question being asked, there is data to ascertain compliance
Totals for Step 2:		1		1	
Number of shaded critical evaluation elements met for Step 2:					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.		X			Items identified in description are not indicators; however, implicit in the project is the indicator of number of days to 1st appointment. This is objective and measurable
3.2. Are based on practice guidelines, with sources identified.			X		
3.3 Allow for the study question/hypothesis to be answered or proven.				X	There is no study question
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.			X		Does not measure change, as there has been no intervention identified

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
3.5 Have available data that can be collected on each indicator.	X				Discharge data are available, either manually or through a MIS
3.6 Include the basis on which each indicator was adopted, if internally developed.	X				Indicator was identified by the state; it is one of the standard performance measures tracked state-wide.
Totals for Step 3:	**2**	**1**	**2**	**1**	
Number of shaded critical evaluation elements met for Step 3: N/A					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					
4.1. Is accurately and completely defined.	X				
4.2. Includes requirements for the length of a member's enrollment in the MCP.			X		
4.3 Captures all members to whom the study question applies.	X				
Totals for Step 4:	**2**		**1**		
Number of shaded critical evaluation elements met for Step 4: 2/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).	X				Using the entire population; sampling questions not relevant
5.2. Identify the sample size (or use the entire population).				X	
5.3. Specify the confidence interval to be used (or use the entire population).				X	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
5.4 Specify the acceptable margin of error (or use the entire population).				X	
5.5 Ensure a representative sample of the eligible population.				X	
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.				X	
Totals for Step 5:				**N/A**	
Number of shaded critical evaluation elements met for Step 5:					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.	X				Three data points specified
6.2. Identification of specified sources of data.	X				MIS and actual discharge record from hospital
6.3. A defined and systematic process for collecting baseline and remeasurement data.			X		No detail provided other than source of the data
6.4. A timeline for collection of baseline and remeasurement data.			X		
6.5. Qualified staff and personnel to abstract manual data.			X		
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.			X		
6.7 A manual data collection tool that supports inter-rater reliability.			X		

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
6.8 Clear and concise written instructions for completing the manual data collection tool.			X		
6.9 An overview of the study in written instructions.			X		
6.10 Automated data collection algorithms that show steps in the production of indicators.			X		
6.11 An estimated degree of automated data completeness.			X		
Totals for Step 6:	**2**		**9**		
Number of shaded critical evaluation elements met for Step 6: 0/1					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.			X		Improvement strategies had not been defined
7.2 System changes that are likely to induce permanent change.			X		
7.3 Revised if original interventions are not successful.			X		
7.4 Standardized and monitored if interventions are successful.			X		
Totals for Step 7:					
Number of shaded critical evaluation elements met for Step 7:					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
8.1. Is conducted according to the data analysis plan in the study design.			X		PIHP did not define a data analysis plan other than to document results each time indicator measured
8.2. Allows for generalization of the results to the study population if a sample was selected.				X	
8.3. Identified factors that threaten internal or external validity of findings.		X			Discussed data integrity issues and plans to correct
8.4. Includes and interpretation of findings.			X		
8.5 Is presented in a way that provides accurate, clear, and easily understood information.		X			Tables clearly laid out and understandable. Analysis of findings would have added complexity to text and data, thus posing challenge of clarity
8.6 Identifies initial measurement and remeasurement of study indicators.	X				Data presented over multiple points in time
8.7 Identifies statistical differences between initial measurement and remeasurement.			X		
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.			X		
8.9 Includes the interpretation of the extent to which the study was successful.			X		
Totals for Step 8:	**1**	**2**	**5**	**1**	
Number of shaded critical evaluation elements met for Step 8: 0/2					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
9.1. Remeasurement methodology is the same as baseline methodology.	X				
9.2. There is documented improvement in processes or outcomes of care.		X			There was some improvement, although variable, over the periods reported; however, there was no intervention defined to which to attribute the improvement
9.3. The improvement appears to be the result of planned intervention(s).				X	
9.4. There is statistical evidence that observed improvement is true improvement.				X	
Totals for Step 9:	**1**	**1**		**2**	
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.				X	
Totals for Step 10:				**1**	
Number of shaded critical evaluation elements met for Step 10: N/A					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS

***Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported**

**** Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported**

***** Not Met = Reported PIHP PIP results or plan/activities not credible**

Summary of Aggregate Validation Findings

* ☐ **Met** * * ☐ **Partially Met** *** ☒ **Not Met**

Summary of PIP validation findings:

This project, tracking number of days from inpatient discharge to 1st follow-up appointment, was selected by the State Mental Health Division for all PIHPs for the 2004 review year. As did most other PIHPs in Washington, Thurston Mason RSN set up a tracking system to measure compliance with State requirements (85% of discharged patients to have 1st appointment within 7 days). Performance Improvement Project design and implementation was little understood in Washington, particularly the necessity of designing an intervention to impact a problematic area of consumer outcomes or processes of care. Hence, most of the projects did not conform to CMS protocols. Thurston Mason and all other PIHPs have recently been provided training in this area; this PIHP was able, at their EQR site visit, to articulate a better understanding and an intention to develop a PIP according to the protocols.

PIP Strengths

- The PIHP has a lot of data available and understands the need to automate as much as possible to achieve reliable results
- The PIHP demonstrates an understanding of the need to look at a full process in order to understand what might be affecting an outcome they're seeing

PIP Challenges

- The PIHP currently lacks the expertise to engage in meaningful data analysis
- The Quality Management Committee has met only sporadically this past year; engaging in the selection of a study topic requires a close look and analysis of at least several months worth of data, and the PIHP has not attended to this consistently

PIP Recommendations

1. Select a study topic based on an analysis of available data from indicators currently being tracked

2. Develop a plan for accomplishing valid sampling methodology (if indicated) and data analysis

3. Devise an intervention that relates to possible barriers to achieving a desired outcome

4. Ensure that all steps in the process are completely developed, defined, and communicated clearly to those involved in data collection and implementation of the proposed intervention

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation too developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and

- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.

N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation
Process Review

Scoring:
Ratings are given for each area with comments explaining the results. The ratings used are Met, Not Met, Partially Met and N/A. Please see the above table titled, "EV Element Scoring Methodology" for additional scoring details.

Item	*Rating*	*Comments*
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Met	TMRSN documents the data requirements in an RSN-specific data dictionary. This document and the policies submitted were in evidence at the provider agency. Completeness standards are addressed directly in the documents submitted for sections 3, 4, and 5. The completion standards are problematic in that they specify different thresholds in different documents. Interviews with PIHP IT staff indicate that the PIHP is in the process of defining a complete standard and that any present inconsistency may be a result of that effort. In time, they will ensure that the standard is clear and consistent among their various policies and procedures. The PIHP's policy on fiscal and data management lists two procedures for chart audits and spot checks, but lacks necessary detail with respect to how such audits are conducted (see, FM111, Section III. Procedures A(8)a and c). The document titled TMRSN Protocol 2 - Jail Coordination Services 0806.doc.pdf needed clarification. The document calls for specific action by the provider agency and asks that it provide an implementation plan to

Item	Rating	Comments
		address these requirements. The response by the provider agency indicates that they already track this information in another way and asks if they can continue doing so. The interview with PIHP staff revealed that the PIHP is not working in a coordinated fashion with its providers, resulting in duplicate efforts and confusion. The MIS Data Entry Rules provided for review lists a permissible default for birthdates if the actual date is unknown (11/11/1911). This document does not give further details concerning use of this default. Understanding that this default is not widely used, it nevertheless has limitations. Since the default is possibly valid, there is no way to ascertain any unintended inaccuracy. The situation would be better addressed by leaving the field blank and including a comment section where an appropriate age or age group can be entered
PIHP communicates data requirements to all entities responsible for data entry and submission.	Partially Met	The policies and procedures entered into evidence by the RSN were also in evidence at the providers visited. Many of these were either modified or new, but the next step in their implementation was not clear. The RSN has made great effort to cover required items with policies and procedures but needs a more clearly defined implementation process, including timeline.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	There was no direct evidence presented to support that the RSN has made efforts to document its provider network IT capabilities and vulnerabilities. Such evidence would include documentation of processes used by provider staff to enter data, as well as maintain and transmit it accurately and in a timely manner. The documents submitted define access and security procedures to be used and the RFQ for an IT security assessment being conducted on the PIHP's IT systems that was not completed by the time of

Item	Rating	Comments
		this review.

3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Partially Met	The PIHP employs an array of processes to ensure that data is accurate and complete prior to submission. The various processes used are documented and are scheduled in a yearly master calendar. The PIHP does not conduct a specific data analysis for the purpose of validating its completeness and accuracy. Efforts to verify such data prior to transmission are excellent, but it does not provide the views needed to calculate actual completeness values needed in this analysis.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Partially Met	The PIHP uses standardized reports to check data in predefined processes. The PIHP requires documentation of errors identified in data analysis by either themselves or their providers.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data analysis specific to an encounter validation is not done.

4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for	Partially Met	There was insufficient information in the documentation provided to determine whether the encounter validation/matching exercise efforts meet the requirement outlined in the contract between the MHD and TMRSN. It was clear that encounter information was matched against the clinical record. But steps ensuring that encounter dates, codes used, chart service

Item	Rating	Comments
agreement in type of service, date of service, and service provider.		descriptions, and provider's names match are not evident. There was also no evidence that further steps were taken to ensure that the encounter actually took place. The PIHP's sample size misses the standard due to a technicality. The contract between the MHD and the PIHP requires a sample size of 1% of the first six months of encounters, or 250, whichever is less. The pay point summary included as an attachment incorrectly states: "1% of the 6th month". This was the method used by this PIHP. As a result, the PIHP checked fewer encounters. The documentation made available to the providers on the results of the audit indicates percentage scores and averages but does not include encounter numbers and sampling specifics (although it does reflect chart counts).
PIHP includes additional data elements in matching exercise.	Partially Met	Because the EV process was conducted in conjunction with a full clinical chart review, other data elements were present. If the PIHP had a method to identify data that is seldom (if ever) verified, such data could be added to reviews on a rotating basis to ensure its eventual scrutiny.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Not Met	The tool used in the EV process is the primary tool used for clinical chart reviews by this PIHP. The tool is not modified to make it specifically applicable to this exercise. While employment of the tool in concert with the clinical chart review is reasonable, it should be modified to ensure that it captures the required elements of the encounter validation and additional data elements chosen for that particular review.

Item	Rating	Comments
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report to the state lists numbers of encounters per chart audited, numbers of encounters matching, numbers of encounters missing, number of charts missing, and percentage of compliance. An audit summary is also provided. Ideally, the report should contain the information requested by this tool. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	PIHP staff provided evidence showing the practice of sharing results of these review exercises with their providers.
PIHP regularly reports internally for quality improvement activities.	Partially Met	Reports are used extensively with respect to checks on the quality of provider data submissions. These checks are made prior to data being entered into the PIHP's system. Internal activities specific to the improvement in quality of the data were not evident in documents submitted for review. These audits were discussed under the heading of '"Effectiveness of Services". The reports issued to the provider agencies are evident in the Quality Assessment and Improvement submission from

Item	Rating	Comments
		the PIHP to the WAEQRO, but these documents do not show evidence of discussions about Encounter Validation items and how to improve future outcomes.
6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Met	The PIHP has a policy and procedure that outlines documentation and oversight activities for findings generated from their review activities. Evidence was submitted showing the PIHP requiring the provider agency to submit a corrective action plan to correct deficiencies found in the review. This document was drafted after the PIHP met with the provider agency to fully explain the findings and communicate expectations.
If warranted, evidence of follow-up activity was presented.	N/A	

Summary of Encounter Validation Findings
Score Met _23_%
Met = High confidence/Confidence that PIHP encounter validation process is effective
Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ **Met** ☒ **Partially Met** ☐ **Not Met**

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP fall short of the requirements set forth in the contract between the MHD and the PIHP. The encounter validation review did not include all items specified in the contract, and the sampling method did not meet the requirements agreed upon by the MHD, the WAEQRO, and which are listed in the body of the contract. Having an additional standard in the statement of work attached to the contract caused confusion, which somewhat mitigates this shortcoming. In addition, there were no efforts made to validate other data elements, unless they were a part of the previously-defined clinical record review. Additional steps to ensure that encounters checked actually took place were not made. An analysis of the PIHP's data for the purpose of an encounter validation was not conducted.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 23% of all items meeting a score of Met, 23% at Not Met, and the remaining 52% at Partially Met.

EV Strengths

- The PIHP has developed a strong infrastructure to check data prior to entry to its IT system. This check for accuracy and completeness is comprehensive and understood by both the PIHP and provider IT staff.
- This PIHP fared better than most in last year's comprehensive encounter validation exercise, and this infrastructure contributed greatly to those results.
- The PIHP has also made significant progress in documenting its processes and procedures. Such documentation aids in continued successful completion of related tasks throughout the organization.

EV Challenges

- The PIHP is fine tuning methods for capturing good quality data going forward; however, they are not addressing all of the potential problems with older data, thus their reports that include historical data should not be considered reliable.

- The PIHP did not conduct its own data analysis; therefore, its overall accuracy and completeness could not be determined. The items caught and corrected in the pre-submission process are only opportunities to correct what was specifically found. Such correction does nothing with respect to analyzing the types of errors occurring and developing a method to minimize their occurrence and manifestation elsewhere in the data.

EV Recommendations

1. Completeness standards need to be consistent throughout the various policies and procedures maintained by the PIHP. Having one published standard that other policies reference would be a way to ensure that any changes to the standard are located in only one place.

2. Document network capability studies covering provider capability to produce accurate and complete encounter data. These studies should address everything from systems to processes and forms employed. Such studies should draw conclusions as to the capabilities and potential vulnerabilities associated with the systems evaluated.

3. Conduct analyses on the PIHP's data. Preferably, this would be accomplished on a frozen dataset (a copy of the "live" data held in some other database other than that being used by the RSN and providers). Such analysis needs to be conducted for two reasons: (1) there is no chance for errors being introduced to the data through the analysis process, and (2) the data can be revisited for either further analysis or research.

4. The PIHP's encounter validation reports to the State need to be stand-alone documents that explain its entire encounter validation program. The comments in number 5 in the Encounter Validation tool indicate more specifically what should be included.

5. The PIHP's encounter validation reports to the State should be stand-alone documents that explain its entire encounter validation program. The comments in Standard #5 in the Encounter Validation tool indicate more specifically what should be included.

6. Employ a more system-wide approach to conducting an encounter validation. The errors found were corrected, and potential future errors may have been avoided using the current process. Nonetheless, an increased emphasis placed on systemic issues may yield critical information about wider problems in the PIHP's dataset.

7. Create a cross reference between the complete data set collected and the process for ensuring its accuracy and completeness. This tool would enable the PIHP to ensure that adequate oversight exists for each required data element.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan; organizational charts; Annual Work Plan; minutes of relevant meetings; data and reports submitted to committees involved in QAI activities; the chart review tool (including scoring methods) used in clinical audits and completed review tools; letters, review reports to the providers, and corrective action requests sent to providers; and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a reporting process that is data-driven. The completed tool, with detailed comments can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results are included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. Each standard was then scored separately and the number of Met/Partial/Not Met summed for each. Total percentages are calculated by dividing the number in each category of Met/Partial/Not Met by the total number of items scored. Scores greater than 80% are considered an overall Met score; 65% to 79% is Partially Met, and those below 65% are considered overall as Not Met.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Thurston Mason RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		**3**		• Most recommended elements included in plan • Participation by MIS and Financial personnel included in QMT/not on QAPI Committee • Accountability defined up to Board of County Commissioners • PIP development and implementation process included • Some redundancy in document and lack of clarity about role of specific committees • Indicators described in general terms;

PIHP: Thurston Mason RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				definitions, measurement methods and reporting accountability and frequency difficult to track • Corrective action process not included
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		3		• Plan indicates review annually; lacks detail for process, time frames.
C. Plan includes annual work plan and process for review of associated activities and progress.		1		• Annual work plan referenced in QI plan, but contained in separate document; • Based on previous year's QA results • Work plan is indicator matrix with most of what would be useful for indicator tracking • Does not contain specific focused activities for the year
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		3		• Provider review included • Scope, frequency of review defined • Scoring described – needs more detail • Use for QI not clearly spelled out
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	4			• Specifies committee involvement and avenues for input for providers and consumers at all levels of QAI process • Clinical management staff from providers sit on multiple committees • Allied service system included on QMT as indicated
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		2		• Conducted chart review and fiscal audits for both providers in 2006

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PIHP: Thurston Mason RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• Reports generated for over/under utilization, access, Exhibit N, Parity-Equity, Outpatient Service Hours, and others; most are tables of numbers with no trending or analysis demonstrated • Minutes of QA/PI in early 2006 reflect discussion of key utilization indicators for inpatient and crisis, results of clinical chart audits and request for CA, QRT client satisfaction surveys, PIPs, and EBP development • QMT did not meet during most of year o PIHP convened "Operations Meetings" late summer that included providers; o name of committee in minutes not the same as name of Word document – confusing as to what this group was meant to be addressing
Standard 1 Count (Target 6 Met):	**1**	**5**	**0**	**Target Points: 24 Actual: 16**

Standard

2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.
(2006-7 Contract, Section 7.2)

PIHP: Thurston Mason RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.		3		• Chart reviews conducted for both agencies during review period. • Aggregated Chart review results do not identify agency, date, total score against threshold or possible score. • Categories in chart review tool reflect major categories specified in QI and UM plans.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.			0	• Review tool not detailed/provides little guidance for reviewer. • No explanation of scoring or system to evaluating findings. • Worksheet poorly organized and difficult to score.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		1		• UM plan specifies annual review of review staff by RSN Administrator. • Inter-rater reliability referenced in QAI plan. • No Evidence or description of inter-rater reliability evaluation process.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		2		Evidence submitted includes: • Audit results and requests for Corrective Actions sent to providers • Response from PIHP to CA submission from both providers • Two months elapsed between audit and results sent and follow-up with one provider, o audit in April/May – letter to PIHP in July with request for meeting about

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PIHP: Thurston Mason RSN

Requirement	Met	PM	Not Met	Findings Comments
				multiple problems requested for August • Audit report from another agency for April/May contained no findings or scores. o Letter re: this report dated late August with response due late September.
Standard 2 Count (Target 4 Met):	**0**	**3**	**1**	**Target Points: 16 Actual: 6**
Standard **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		1		Evidence submitted: • Minutes of QA/PI Committee for few months in early 2006; per PIHP and Ombuds, have not been meeting as real QM for awhile because of RFP – more as operations team • Results of chart audit at one provider discussed at meeting, including request for CA, due date, and subsequent submission of the CA; no evidence of review of 2nd provider audit
B. PIHP analyzes and trends individual provider performance.			0	• Trend reports submitted created by provider

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PIHP: Thurston Mason RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
C. PIHP analyzes and trends system-wide performance.			**0**	• No evidence of trend analysis across the 2 agencies
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.			**0**	• Annual report provides financial, utilization, penetration, age, ethnicity, service type information; updates on major changes; • No other evidence of quality results communicated
Standard 3 **Count (Target 4 Met):**	**0**	**1**	**3**	**Target Points: 16 Actual: 1**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**1**		• Grievance policy indicates PIHP will keep records of complaints, grievances, appeals with required information and timeliness information • Documentation not submitted as evidence that PIHP maintains such records • Exhibit N Reports provided re: Appeals
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.		**2**		• 2005-6 bar chart of denial process compliance for BHR for 1 year • Quarterly Complaint/grievance report summarized at QA/PI meetings early in year • Provider states the PIHP regularly reviews

PIHP: Thurston Mason RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				their logs and data • Ombuds states she submits biennial reports to (Exhibit N) Advisory Board, RSN, agencies, NAMI and MHD and QRT • Ombuds and PIHP Administrator are discussing strategies for incorporating her involvement in ongoing changes so she can support change from the bottom up (with consumers)
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	4			• Training conducted on grievances, fraud and abuse 9/28/06 by TRSN for all TRSN staff and "key" provider personnel • Training plan required that providers responsible for ensuring all staff trained o TRSN plan to review agency training records and personnel files o Training conducted just prior to EQR document submission deadline: PIHP had not yet reviewed provider compliance o One provider training calendar for 2006 did not contain this training • Staff at both agencies know what is expected of them or where to find the information • Ombuds well aware of process and role o Stated that it is more difficult to keep up with changes now that out of building – previously would go to staff meetings or

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PIHP: Thurston Mason RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				have casual conversations with staff o WIMRT meets with them 2xyr (used to be 4) to keep them updated – doesn't think that works very well.
Standard 4 Count (Target 3 Met):	**1**	**2**	**0**	**Target Points: 12 Actual: 7**
Grand Totals Count (Target 17 Met): 2				**Target Points: 68 Actual: 30**

Summary Quality Assurance and Improvement Findings
While the PIHP's QAI Plan contains most of the recommended elements, it is somewhat confusing re: lines of decision-making and specifics of reporting, 2 critical elements in an effective process. The PIHP has conducted clinical chart reviews as specified in the QAI Plan; however, the tools used and scoring and reporting methodology would benefit from a fresh look with an eye toward clarity, specificity, and ease of use. Incorporation of Ombuds and provider staff into grievance, appeal, and fair hearing process has progressed significantly: all staff interviewed were well-versed in the requirements and about their respective roles.

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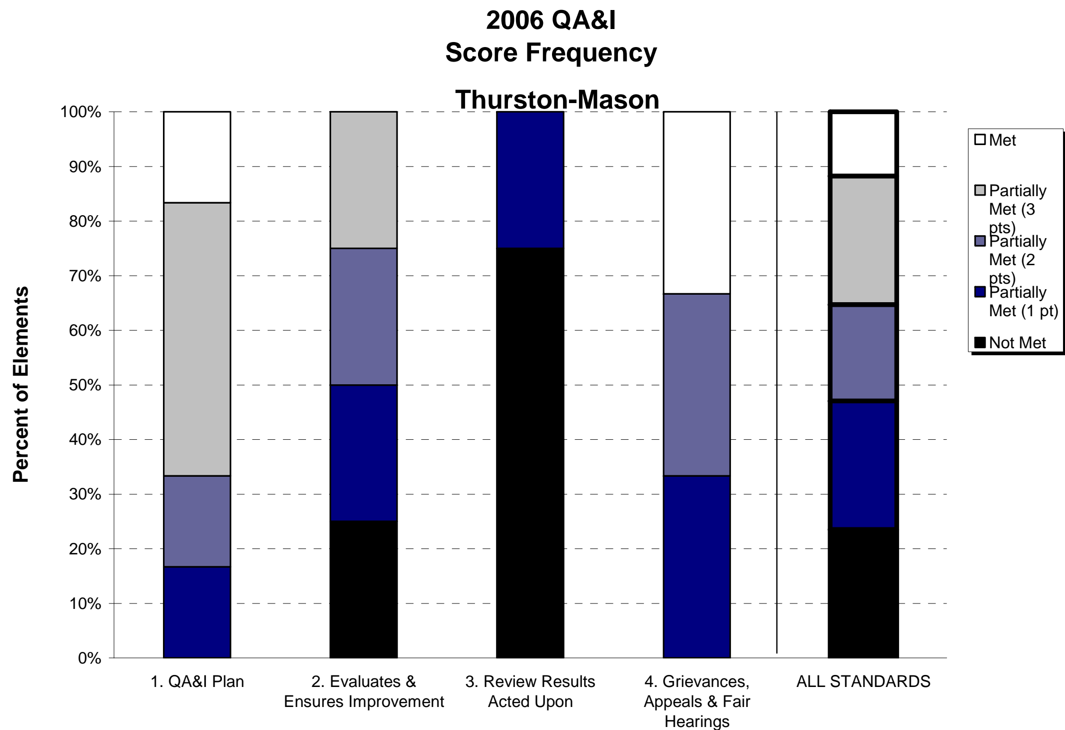

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	1	3	1	1	0
2. Evaluates & Ensures Improvement	4	0	1	1	1	1
3. Review Results Acted Upon	4	0	0	0	1	3
4. Grievances, Appeals & Fair Hearings	3	1	0	1	1	0
ALL STANDARDS	**17**	**2**	**4**	**3**	**4**	**4**

QAI Strengths

- PIHP incorporates Finance and MIS into QAI process – results in all areas of PIHP functions being coordinated and informed
- QA/PI Plan includes most recommended elements and identifies decision-making authority for Plan and system change recommendations
- Record audits conducted per plan for all providers
- Provider staff and Ombuds are knowledgeable about appeals, grievances, and fair hearings

QAI Challenges

- QA/PI Committee has not met regularly during review period
- Reports are tables of data, difficult to interpret or use for monitoring of trends/identification of potential problems
- QA/PI Plan is unclear about specific reporting practices; results in difficulty maintaining focus on key performance indicators
- PIHP's definition of an Annual Work Plan is off the mark (see below)

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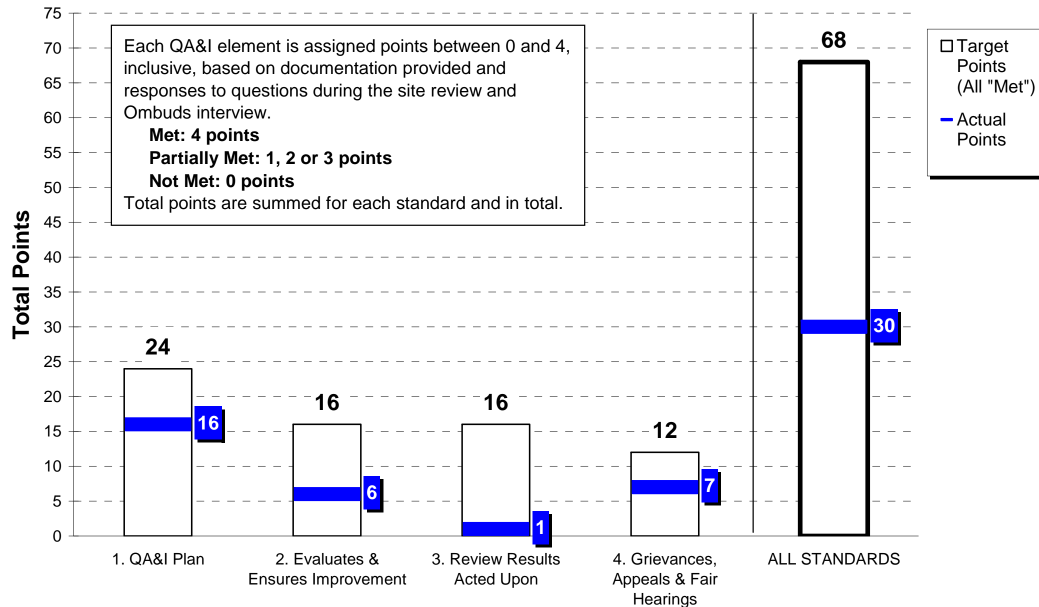

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	16
2. Evaluates & Ensures Improvement	16	6
3. Review Results Acted Upon	16	1
4. Grievances, Appeals & Fair Hearings	12	7
ALL STANDARDS	**68**	**30**

QAI Recommendations

1. Use an indicator matrix in body of QM Plan that specifies indicator, how measured, target or benchmark result, frequency of measurement/reporting, thresholds for action, who responsible for reporting, which committee reviews. Such a tool will improve the PIHP's ability to be clear about what they're measuring and why and to be able to know quickly when something needs attention.

2. Incorporate Annual Work Plan (as attachment) into QM Plan and select 2-4 projects based on previous year's outcomes on key indicators.

3. Include Corrective Action process in QA/PI plan.

4. Streamline and clarify reporting and decision-making channels described in QM Plan.

5. Revise clinical audit tool to facilitate use of consistent standards for each question;

inclusion of requirements for each score in the tool or in a cheat sheet would enhance inter-rater reliability and facilitate training of review staff as well as the clinical staff being reviewed.

6. Revise worksheet for ease of scoring and aggregate tabulation of chart scores.

7. Ensure that audit results are provided in timely fashion and CA requirements addressed expeditiously; create plan to track required time frames for submission, response, implementation; confirm completion in writing to provider.

8. Re-constitute QMC and meet regularly to ensure that quality assurance and improvement activities are prioritized appropriately and implemented effectively.

9. Develop trend reports that display data in manner that facilitates identification of problems or potential problems

V. Recommendations

Following is combined listing of all recommendations in this report, for ease of use and reference.

Subpart Recommendations

1. Create a process to officially approve **revised** policies and procedures. Include dated signatures of PIHP officials or designees, date of revisions, and effective date of policy.

2. Clarify delegated PIHP functions and develop processes related to **all** subcontractor delegation:
   d. Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
   e. Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
   f. Review their related performance on an annual basis.

3. Establish well-defined procedures for analyzing aggregate complaint, grievance and appeal data to identify trends and related quality improvements to enhance care and services.

4. Include monitoring of client access to second opinions and clinical records as part of annual clinical reviews.

5. Develop methods of communication that give equitable consideration to the voice, needs, and contributions of each provider in the PIHP provider network.

6. Continue focused attention to providing organized trainings for PIHP and Provider Network staff to ensure awareness, understanding, skill development, and consistent implementation of new policies, procedures, and mechanisms.

PM Recommendations

1. Develop a policy and procedure to ensure that handling of non-standard codes is handled properly and consistently.

2. Develop a policy and procedure to ensure that staff who work the duplicate member process do so correctly and consistently.

3. Develop a policy and procedure outlining the requirement for data submission when out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

PIP Recommendations

1. Select a study topic based on an analysis of available data from indicators currently being tracked

2. Develop a plan for accomplishing valid sampling methodology (if indicated) and data analysis

3. Devise an intervention that relates to possible barriers to achieving a desired outcome

4. Ensure that all steps in the process are completely developed, defined, and communicated clearly to those involved in data collection and implementation of the proposed intervention

EV Recommendations

1. Completeness standards need to be consistent throughout the various policies and procedures maintained by the PIHP. Having one published standard that other policies reference would be a way to ensure that any changes to the standard are located in only one place.

2. Document network capability studies covering provider capability to produce accurate and complete encounter data. These studies should address everything from systems to processes and forms employed. Such studies should draw conclusions as to the capabilities and potential vulnerabilities associated with the systems evaluated.

3. Conduct analyses on the PIHP's data. Preferably, this would be accomplished on a frozen dataset (a copy of the "live" data held in some other database other than that being used by the RSN and providers). Such analysis needs to be conducted for two reasons: (1) there is no chance for errors being introduced to the data through the analysis process, and (2) the data can be revisited for either further analysis or research.

4. The PIHP's encounter validation reports to the State need to be stand-alone documents that explain its entire encounter validation program. The comments in number 5 in the Encounter Validation tool indicate more specifically what should be included.

5. The PIHP's encounter validation reports to the State should be stand-alone documents that explain its entire encounter validation program. The comments in Standard #5 in the Encounter Validation tool indicate more specifically what should be included.

6. Employ a more system-wide approach to conducting an encounter validation. The errors found were corrected, and potential future errors may have been avoided using the current process. Nonetheless, an increased emphasis placed on systemic issues may yield critical information about wider problems in the PIHP's dataset.

7. Create a cross reference between the complete data set collected and the process for ensuring its accuracy and completeness. This tool would enable the PIHP to ensure that adequate oversight exists for each required data element.

QAI Recommendations

1. Use an indicator matrix in body of QM Plan that specifies indicator, how measured, target or benchmark result, frequency of measurement/reporting, thresholds for action, who responsible for reporting, which committee reviews. Such a tool will improve the PIHP's ability to be clear about what they're measuring and why and to be able to know quickly when something needs attention.

2. Incorporate Annual Work Plan (as attachment) into QM Plan and select 2-4 projects based on previous year's outcomes on key indicators.

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4. Streamline and clarify reporting and decision-making channels described in QM Plan.

5. Revise clinical audit tool to facilitate use of consistent standards for each question; inclusion of requirements for each score in the tool or in a cheat sheet would enhance inter-rater reliability and facilitate training of review staff as well as the clinical staff being reviewed.

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7. Ensure that audit results are provided in timely fashion and CA requirements addressed expeditiously; create plan to track required time frames for submission, response, implementation; confirm completion in writing to provider.

8. Re-constitute QMC and meet regularly to ensure that quality assurance and improvement activities are prioritized appropriately and implemented effectively.

9. Develop trend reports that display data in manner that facilitates identification of problems or potential problems

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Spokane County
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Spokane County PIHP is responsible for managing mental health care and services for Medicaid consumers in Spokane County in the state of Washington. The PIHP is located in Spokane, Washington and is governed by a board comprised of three Spokane County Commissioners. The PIHP Administrator reports to the Governing Board. The PIHP contracts with 29 community mental health centers and specialty providers, which serve approximately 9,600 adult and child consumers on a monthly basis. Total annual Medicaid enrollment in the PIHP is about 75,610. The PIHP contracts for inpatient and outpatient authorization and utilization management with a private healthcare organization, Behavioral Healthcare Options (BHO), Las Vegas, NV.

This report covers the period between February 6, 2006, and February 5, 2007, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;

5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	

Activity	Timeline	Documents/Content
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	January 5, 2007	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	January 22, 2007	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	January 31, 2007	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	February 22, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	February 27, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	March 29, 2007	
4. Debrief conference call	April 12, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	April 19, 2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the

opportunity to submit a response in writing. Spokane County PIHP did submit a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Spokane County PIHP, significant events include:

- The PIHP changed utilization management vendors during the review year and added additional functions to the contract; Behavioral Health Options has taken the lead on several system-change initiatives related to development of community-based alternatives to inpatient hospitalization.

- The PIHP Administrator resigned, as did other PIHP staff; the Community Services Director is currently acting as PIHP Administrator with BHO providing additional operational support, including quality management.

- PIHP reports that focus on addressing high inpatient census and liquidated damages, with assistance from consultants and BHO, has resulted in significant reduction in bed days as well as implementation of community-based alternatives.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- The PIHP initially submitted only new policies and procedures, officially approved and effective as of January 27, 2007. At the request of the WAEQRO, the policies and procedures effective during the majority of the review period (February 5, 2006 through January 26, 2007) were submitted at the end of the site visit. Because those policies were not highlighted as requested, they could not be reviewed within the time period allotted for this PIHP review. Review results, therefore, reflect primarily those policies and procedures implemented at the end of the review year.

- PIHP staff did not submit a 2004 Corrective Action Plan update per the WAEQRO Document Submission Request. Therefore, the WAEQRO had limited information regarding the PIHP's accomplishments related to the implementation of their 2004 Corrective Actions Plan.

4. 2006 Review Results

This report provides results and a summary of Spokane County PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Spokane County PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.106 [Q13]	**Subcontracts ensure enrollee payment liability protections**			
	Liability for Payment-No evidence supplied to demonstrate the PIHP Provider contract has language ensuring enrollees are not charged or held liable for covered services provided to enrollees.	Submit a corrective action plan to the MHD by 4/4/05	CAP submitted 3/23/05	Relevant policies and procedures include all requirements of this provision. PIHP and provider staff were able to articulate basic requirements. PIHP has attained a score of **4-Substantial Compliance**.
438.206 (b)(5) [Q24]	**Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment**			
	Delivery Network – Out-of-Network Providers. No evidence discovered that the	Submit a corrective action plan to the MHD by 4/4/05	CAP submitted 3/23/05	Relevant policies and procedures include all requirements of this provision.

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	PIHP has a mechanism to ensure that cost to enrollees when an out-of-network provider is used is no greater than it would be if the services were furnished within the network.			PIHP and provider staff were able to articulate basic requirements. PIHP has attained a score of **4-Substantial Compliance**.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Spokane County PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

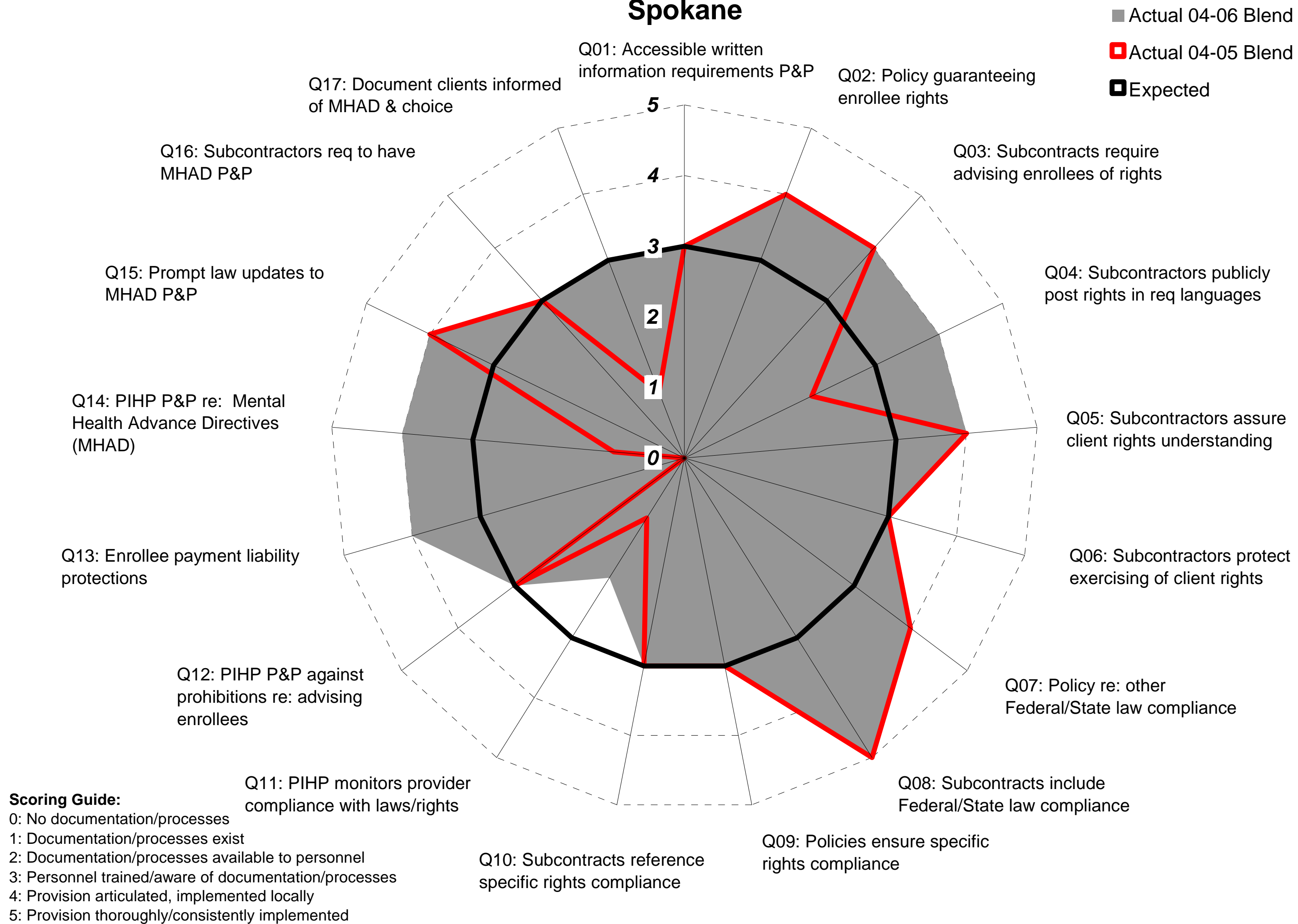
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.


Subpart C: Enrollee Rights & Protections
Spokane
Actual 04-06 Blend
Actual 04-05 Blend
Expected
Q01: Accessible written information requirements P&P
Q02: Policy guaranteeing enrollee rights
Q03: Subcontracts require advising enrollees of rights
Q04: Subcontractors publicly post rights in req languages
Q05: Subcontractors assure client rights understanding
Q06: Subcontractors protect exercising of client rights
Q07: Policy re: other Federal/State law compliance
Q08: Subcontracts include Federal/State law compliance
Q09: Policies ensure specific rights compliance
Q10: Subcontracts reference specific rights compliance
Q11: PIHP monitors provider compliance with laws/rights
Q12: PIHP P&P against prohibitions re: advising enrollees
Q13: Enrollee payment liability protections
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)
Q15: Prompt law updates to MHAD P&P
Q16: Subcontractors req to have MHAD P&P
Q17: Document clients informed of MHAD & choice
5
4
3
2
1
0
Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Spokane

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Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	3		3
Q02: Policy guaranteeing enrollee rights	4		4
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	2	4	4
Q05: Subcontractors assure client rights understanding	4		4
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	4		4
Q08: Subcontracts include Federal/State law compliance	5		5
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	3		3
Q11: PIHP monitors provider compliance with laws/rights	1	2	2
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	0	4	4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	1	4	4
Q15: Prompt law updates to MHAD P&P	4		4
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	1	3	3

Spokane County PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
438.100(b)	**Specific Enrollee Rights**	
[Q4]	**Subcontract requires providers to post client rights in public places in all prevalent languages** Evidence: • New Posting Of Enrollee Rights Policy and Procedures state, "Spokane RSN/PIHP shall require all contract providers to post the enrollee rights in public places in all of the current prevalent languages called out by DSHS (which are Cambodian, Chinese, English, Korean, Laotian, Russian, Spanish and Vietnamese)….Enrollee rights shall be provided in alternative format for enrollees who are blind, and shall be translated in all prevalent languages." • Signed and executed 11-06 thru 6-07 PIHP Provider Contract states, "Post a multilingual notice that advises consumers that all written materials are available in Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese. Provide translations of the mental health consumer rights…readily accessible in public areas and conspicuously marked." • Provider On-Site "Spot Checks" Report –-monitored 8 un-named sites for correctly posted consumer rights and available benefits booklets. Report did not indicate if PIHP monitored for rights in alternative formats. Report stated that with one exception, all sites were compliant. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Poster of client rights translated in all 8 DSHS prevalent languages provided by the PIHP was posted at both provider sites visited by the WAEQRO. • Provider management and direct service staff had knowledge of where client rights were posted and in what languages. (Substantial Compliance)	4
438.100(d)	**Compliance with Other Federal and State law**	

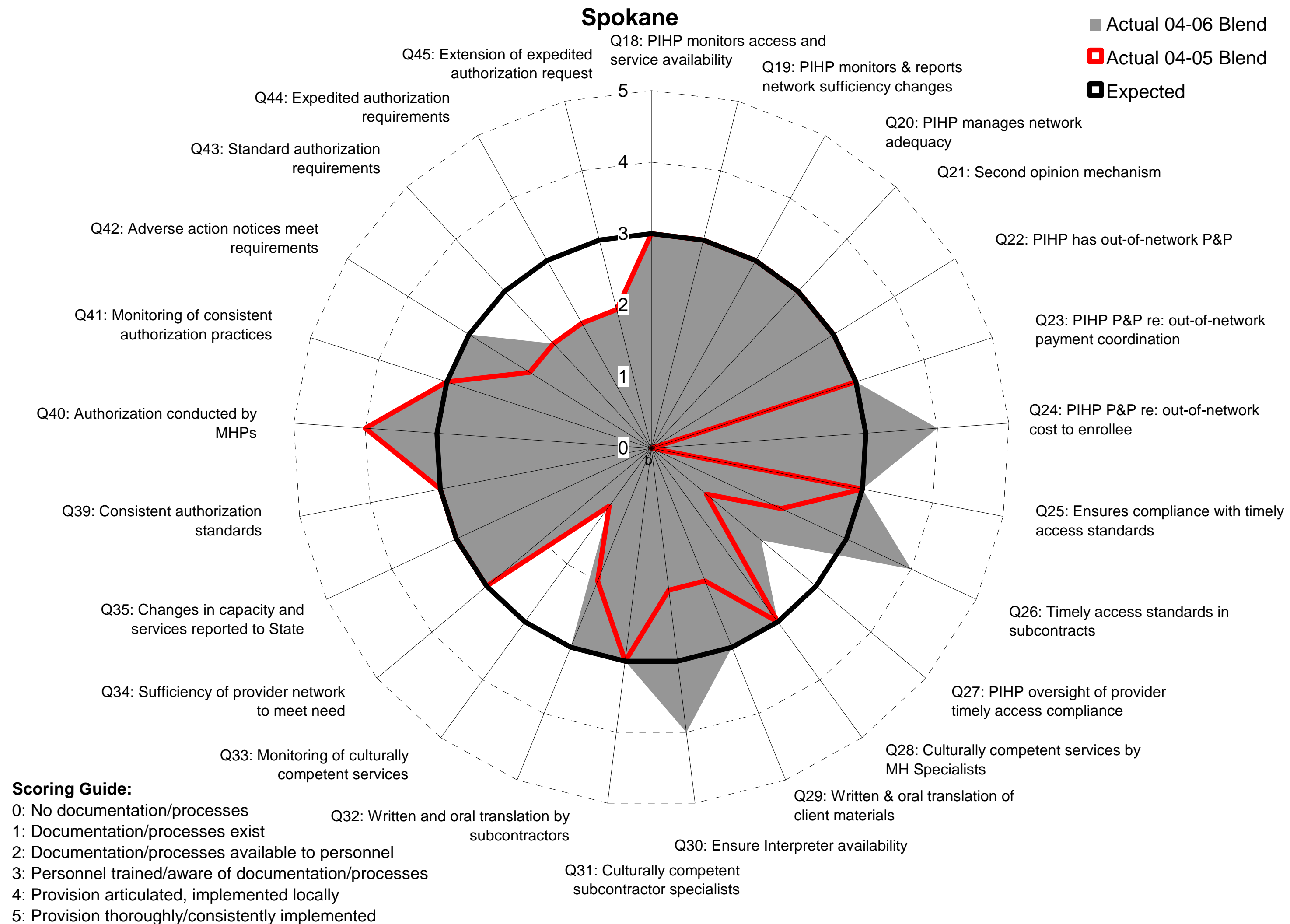
CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
[Q11]	**PIHP monitors subcontractor compliance with Federal and State laws and client rights** Evidence: • New Compliance With Federal and State Laws Policy and Procedures state, "SCRSN/PIHP subcontracts will include compliance with any other applicable Federal or State laws. At a minimum, provider contracts will include compliance with: o the Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; o the Age Discrimination Act of 1965 as implemented by regulations at 45 CFR part 91; o the Rehabilitation Act of 1973; o Titles II and III of the Americans with Disabilities Act; o Other laws regarding privacy and confidentiality; o Right to a second opinion from a qualified health care professional within the network, at no cost to the enrollee (438.206)(b)(3); o Client involvement in decisions about their mental health treatment; and o Client access to clinical records. SCRSN/PIHP will monitor each subcontractor at least annually to ensure compliance with the above regulations." • Signed and executed 11-06 thru 6-07 PIHP Provider Contract includes general requirement to comply with state and federal laws and client rights. References to the majority of the discrimination laws and the 3-rights identified in this provision are specifically called out in the Contract with the exception of the Rehabilitation Act of 1973. • Completed PIHP provider Facility Review Checklist—monitors compliance with ADA Requirements and WA Anti-discrimination Act, access to TDD and verification that staff are trained, policies and procedures related to protection of consumer information. • One signed provider Certification of Compliance with the Civil rights Act of 1964; Rehabilitation Act of 1973; and American Disabilities Act of 1990. • One completed IS Monitoring Tool—monitors protection of PHI—indicates provider compliance with standards. • Completed PIHP Clinical Review Tool showed evidence that client involvement in their mental health treatment decisions is monitored. • PIHP email communication, sent to providers on 1/23/07, asking each agency to notify PIHP of how they document consumer requests to access their medical record. Two emails from agencies responding to PIHP inquiry of how they document	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	consumer requests to access their medical record. No documentation submitted to show evidence of the PIHP monitoring these processes. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • No documentation submitted to show evidence of the PIHP monitoring client's right to a second opinion. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.106	**Liability for Payment**	
[Q13]	**Subcontracts ensure enrollee payment liability protections** Evidence: • New Liability for Payment Policy and Procedures include relevant language meeting the requirements of this provision. • Signed and executed 11-06 thru 6-07 PIHP Provider Contract with language that ensures enrollee liability protections as outlined in this provision. • One PIHP Provider Annual Fiscal Review and Report—evidence of monitoring insurance and consumer billing, denials of coverage, and shows provider cost allocation is generated by the client activity log. • PIHP's Transition Plan and other related documentation regarding the potential insolvency of a residential care subcontractor. Documentation shows evidence of the PIHP's activities of oversight to ensure that consumers had no disruption in care and were not held liable for payment for residential care and services. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Provider management reported that the PIHP monitors to ensure Medicaid enrollees are not held liable for payment during their annual administrative audit by means of reviewing policies and procedures, and review of financial and clinical records.	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	(Substantial Compliance)	4
438.10(g) 438.6(l)	**Advance Directives**	
[Q14]	**PIHP has Mental Health Advance Directive policies and procedures** Evidence: • New Advance Directive Policy and Procedures include all required provisions. • Completed Provider Contract Review Tools—monitor for, "WAC 388-865-0430 (3) Clinical record must contain a copy of any advanced directives, powers of attorney or letters of guardianship provided by the consumer." PIHP monitoring guideline is "Either the record contains a copy of advance directive or evidence that the consumer refused to have an advance directive." • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Provider management reported they are aware of the PIHP's Advance Directive Policy and Procedures and that during their annual contract monitoring, the PIHP reviews their agency advance directive policies and procedures. Management at one provider reported that they are in the process of changing their intake documents to ensure capture and documentation of advance directive information. (Substantial Compliance)	4
[Q17]	**Client informed in writing of Mental Health Advance Directives, and choice is documented** Evidence: • New Advance Directive Policy and Procedures states, "…all adult enrollees must be informed in writing about their right to be advised of Mental Health Advance Directives and the policies as evidenced in their clinical record by a signed statement indicating their choice for a Mental Health Advance Directive or to decline this option." • Signed and executed 11-06 thru 6-07 PIHP Provider Contract states, "The Contractor shall maintain a written Advance Directive policy and procedures that respects enrollees, Advance Directives for psychiatric care. Policy and procedures	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	must comply with RCW 71.32 and the requirements of 42 CFR 422.128, subpart I of part 489, and 42 CFR 438.6 as they pertain to psychiatric care." • Completed PIHP Screen Prints of Advance Directive Field in Raintree software—indicating whether consumer has an advance directive. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Provider network documentation forms inconsistently contained the requirement to document consumer choice related to whether they want an Advance Directive. Management at one provider reported they are in the process of changing their intake documents to ensure capture and documentation of advance directive information. • Provider direct service staff reported they are required to document that Advance Directive information was given to the client and if the client already has an Advance Directive. In addition, staff stated that the client's crisis plan should mimic what is in the Advance Directive. Testimony from direct service staff was inconsistent with respect to whether they are required to document consumer choice relative to executing an Advance Directive. • Recommend that PIHP standardize the method for documenting the provision of Advance Directive information and enrollee choice for the provider network. • Score remains the same as 2005 EQR due to PIHP provider contracts do not contain the requirements of this review element. (Moderate Compliance)	3

Subpart D (Part 1): Access Standards



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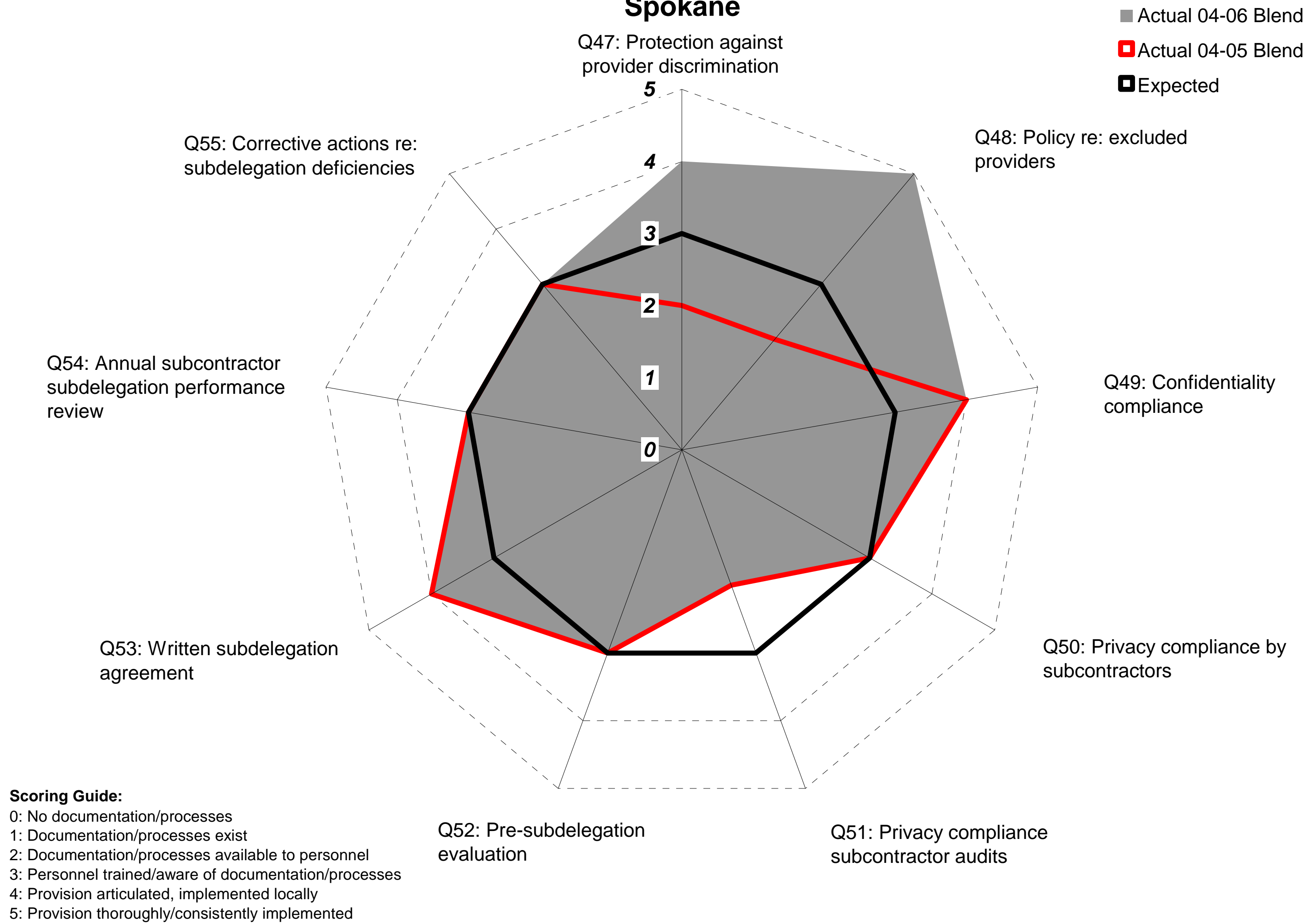
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	3		3
Q24: PIHP P&P re: out-of-network cost to enrollee	0	4	4
Q25: Ensures compliance with timely access standards	3		3
Q26: Timely access standards in subcontracts	2	4	4
Q27: PIHP oversight of provider timely access compliance	1	2	2
Q28: Culturally competent services by MH Specialists	3		3
Q29: Written & oral translation of client materials	2	3	3
Q30: Ensure Interpreter availability	2	4	4
Q31: Culturally competent subcontractor specialists	3		3
Q32: Written and oral translation by subcontractors	2	3	3
Q33: Monitoring of culturally competent services	1	1	1
Q34: Sufficiency of provider network to meet need	3		3
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	3		3
Q40: Authorization conducted by MHPs	4		4
Q41: Monitoring of consistent authorization practices	3		3
Q42: Adverse action notices meet requirements	2	3	3
Q43: Standard authorization requirements	2	2	2
Q44: Expedited authorization requirements	2	2	2
Q45: Extension of expedited authorization request	2	2	2



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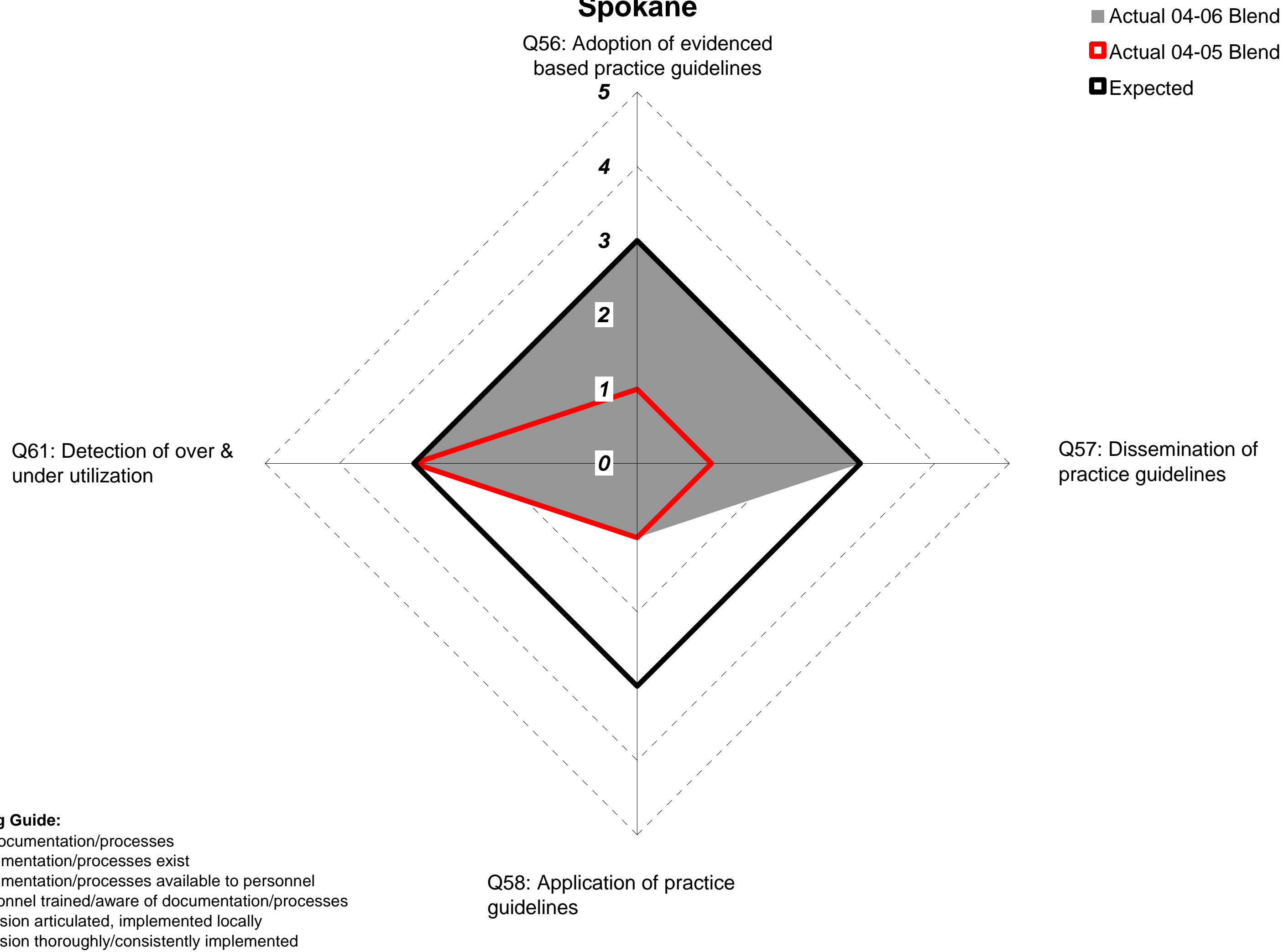
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	2	4	4
Q48: Policy re: excluded providers	2	5	5
Q49: Confidentiality compliance	4		4
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	2	2	2
Q52: Pre-subdelegation evaluation	3		3
Q53: Written subdelegation agreement	4		4
Q54: Annual subcontractor subdelegation performance review	3		3
Q55: Corrective actions re: subdelegation deficiencies	3		3

Subpart D (Part 3): Measurement and Improvement Standards



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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	1	3	3
Q57: Dissemination of practice guidelines	1	3	3
Q58: Application of practice guidelines	1	1	1
Q61: Detection of over & under utilization	3		3

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
438.206 (b)(5)	**Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment**	
[Q24]	**Cost of out-of-network provider is no greater for enrollee than services furnished within network** Evidence: • New Delivery Network: Out-of-Network Provider Policy and Procedures state, "When the payment is sent to the out-of-network provider, it is accompanied by a statement that the out-of-network provider must accept the SCRSN/PIHP payment as "payment in full" and may not balance bill the enrollee." • Sample copy of RSN Out-of-Network Finance Agreement Statement—accompanies payment to out-of-network provider and stipulates provider must accept the PIHP payment and consumers cannot be balance billed for services. PIHP staff reported form letter has not yet been used due to no out-of-network provider requests. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Provider management are aware of out-of-provider network policy and able to articulate basic purpose and process for referral and payment. • Other than reviewing consumer complaints and grievances, no monitoring methods outlined in policy and no examples of monitoring mechanisms employed by PIHP to monitor this provision were submitted for review. (Substantial Compliance)	4
438.206 (c)(1)	**Furnishing of Services**	
[Q26]	**Subcontracts require providers to meet timely access standards and specify each standard** Evidence: • Signed and executed 11-06 thru 6-07 PIHP Provider Contract requires providers to meet timely access standards and	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	stipulates each standard. • New Timely Access To Care Policy and Procedures state, "SCRSN/PIHP subcontracts shall require network providers to meet the standards for timely access and shall specify each standard….SCRSN/PIHP shall have mechanisms for oversight of subcontractor compliance with standards for timely access." • Monthly Access Reporting Forms—show number of intakes completed within/outside 10 working days, and explanation; and number of routine services offered within/outside 14 calendar days, and explanation. Sample reports are for only one provider. Reviewer requested that PIHP provide access reports from 2-3 providers, including their largest provider. • 2006 Access to Care Average Monthly Totals by Agency—annual aggregate data of intakes completed within/outside 10 working days, and number of routine services offered within/outside 14 calendar days for each network provider. One provider shows over 25% of intakes are outside the 10 working day requirement. PIHP reported that they have not yet established thresholds related to timely access requirements and have not issued any quality improvements or corrective actions related to provider noncompliance with timely access. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • In addition to the monthly access to care reports, provider management reported that the PIHP conducts annual chart audits which include review for compliance with timely access. • Provider direct service staff accurately articulated the timely access standards. Staff at one provider reported that a percentage of their intakes regularly fall outside of the 10 working day requirement. They described strategies they are implementing to correct this situation. (Substantial Compliance)	4
[Q27]	**PIHP oversight of subcontractor compliance with timely access standards** Evidence: • New Timely Access To Care Policy and Procedures state, "SCRSN/PIHP will implement the following mechanisms for oversight of subcontractor compliance with standard for timely access to care. o Providers are required to submit an Access to Care Report with each monthly bill submitted to SCRSN/PIHP.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	Providers will receive training annually and upon request on how to accurately complete this report. o Once SCRSN/PIHP receives the report, a spreadsheet is created which shows individual provider compliance with access standards and overall network trends. o Any provider who does not meet access standards will: ▪ Develop a corrective action plan for coming into compliance with access standards, and ▪ Receive additional training to ensure the form is completed correctly. o SCRSN/PIHP will review provider performance regarding access standards on a quarterly basis." • Monthly Access Reporting Forms—show number of intakes completed within/outside 10 working days, and explanation; and number of routine services offered within/outside 14 calendar days, and explanation. Sample reports were submitted for only one provider. • 2006 Access to Care Average Monthly Totals by Agency—annual aggregate data of intakes completed within/outside 10 working days, and number of routine services offered within/outside 14 calendar days for each network provider. One provider shows over 25% of intakes are outside the 10 working day requirement. PIHP staff were unable to articulate oversight requirements as outlined in their policy under bullet one, above. PIHP reported that they have not yet established thresholds related to timely access requirements and have not issued any quality improvements or corrective actions related to provider noncompliance with timely access. • In addition to the monthly access to care reports, provider management reported that the PIHP conducts annual chart audits which include review for compliance with timely access. • Provider direct service staff accurately articulated the timely access standards. Staff at one provider reported that a percentage of their intakes regularly fall outside of the 10 working day requirement. They described strategies they are implementing to correct this situation. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.206 (c)(2)	**Furnishing of Services Continued**	
[Q29]	**Written and oral translation of client materials** Evidence: • New Culturally Competent Services Policy and Procedures	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	contain requirements for written and oral translation of client materials. • Signed and executed 11-06 thru 6-07 PIHP Provider Contract has relevant language that requires written and oral translation of client materials. In addition, the provider contract states, "ensure that mental health professionals and MHCPs have effective methods of communication with enrollees who have sensory impairments." • Invoices for AT&T Language Line Services (August '06)—show use of language line for Spanish and Russian-speaking clients. • Invoice for Interpreter Services (July '06)—shows use of Bosnian, Croatian interpreters for client services. • DSHS Public Mental Health System Benefits Booklet in 8 DSHS-required languages. • Enrollee Rights in 8 DSHS-required languages. • "Symptoms Of Mental Illness" in 8 DSHS-required languages. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Direct service staff were able to articulate languages that must be available in oral translation and how to access interpreters, including those for American Sign Language. • At one provider, management reported that they have the DSHS Public Mental Health System Benefits Booklet for Medicaid enrollees available in 13 languages and in Braille. • There remain inconsistencies among provider management staff as to the specific client materials required to be translated in all seven prevalent languages and made available in alternative formats for persons with sensory impairments. Recommend that PIHP identify, in provider contracts, specific client materials to be translated and identify the required languages and formats in which materials are to be made available. (Moderate Compliance)	3
[Q30]	**Ensure Interpreter availability** Evidence: • Signed and executed 11-06 thru 6-07 PIHP Provider Contract and new Culturally Competent Services Policy and Procedures jointly contain requirements to ensure interpreter availability, including effective methods of communication with enrollees who have sensory impairments. • Invoices for AT&T Language Line Services (August '06)—show	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	use of language line for Spanish and Russian-speaking clients. • Invoice for Interpreter Services (July '06)—shows use of Bosnian, Croatian interpreters for client services. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Direct service staff were able to articulate languages that must be available in oral translation and how to access interpreters including those for American Sign Language. • PIHP staff reported that they ensure interpreter services are being utilized when needed by looking in clinical records for cultural consults at intake, and for translator services documentation throughout the clinical record. PIHP submitted clinical record reviews showing evidence of monitoring for cultural consults. No examples of monitoring mechanisms employed by the PIHP to ensure use of interpreters were submitted for review. (Substantial Compliance)	4
[Q32]	**Client materials translated according to WAC 388-865-0330 requirements related to language thresholds** Evidence: • New Culturally Competent Services Policy and Procedures contain requirements for written and oral translation of client materials. • Signed and executed 11-06 thru 6-07 PIHP Provider Contract has relevant language that requires written and oral translation of client materials. In addition, the provider contract states, "ensure that mental health professionals and MHCPs have effective methods of communication with enrollees who have sensory impairments." • Invoices for AT&T Language Line Services (August '06)—show use of language line for Spanish and Russian-speaking clients. • Invoice for Interpreter Services (July '06)—shows use of Bosnian, Croatian interpreters for client services. • DSHS Public Mental Health System Benefits Booklet in 8 DSHS-required languages. • Enrollee Rights in 8 DSHS-required languages. • "Symptoms Of Mental Illness" in 8 DSHS-required languages • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Direct service staff were able to articulate languages that must be available in oral translation and how to access interpreters including those for American Sign Language. • At one provider, management reported that they have the DSHS Public Mental Health System Benefits Booklet for Medicaid enrollees available in 13 languages and in Braille. • There remain inconsistencies among provider management staff as to the specific client materials required to be translated in all seven prevalent languages and made available in alternative formats for persons with sensory impairments. Recommend that PIHP identify in provider contracts specific client materials to be translated and identify the required languages and formats in which materials are to be made available. (Moderate Compliance)	3
[Q33]	**Mechanisms for oversight of culturally competent service standards** Evidence: • New Culturally Competent Services Policy and Procedures states, "SCRSN/PIHP shall develop mechanisms for oversight of culturally competent service standards." • The one oversight mechanism listed in the above-mentioned policy states, "Each provider is expected to submit to SCRSN/PIHP a document showing their mental health care providers, clinical specialties and languages spoken, pursuant to the PIHP/Provider contract. This information is updated at least annually and provided to enrollees on request." The PIHP did not submit an example of this monitoring mechanism; therefore, Reviewer unable to determine if it has been implemented. • PIHP submitted highlighted sections of clinical chart reviews related to oversight of cultural competent services. However, this monitoring mechanism is not listed in the policy referenced in bullet one, above. • Diversity Task Force Minutes (July 17, 2006)—evidence of discussions related to purpose of group, sporadic attendance with a core group of 4-5 participants, training strategies and needs, and staff recruitment strategies to build a multicultural work force. • Registration data base showing evidence that PIHP and provider staff attended the January 28th, 2006 Incorporating Cultural Competency into the Mental Health Service System training.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Brochure for "Creating Futures, Transforming Lives" for the 2006 Behavioral Health Conference—no specific training curriculum or attendance rosters were submitted. • Recommend the PIHP establish congruency between the oversight/monitoring mechanisms related to cultural competency employed by the PIHP and their Culturally Competent Services Policy and Procedures. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • New Notification Of Action Policy and Procedures incorporate the Notice of Action (NOA) requirements of this provision. • Upon review of several copies of NOAs, reviewer unable to determine if the required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs were submitted for review. • Information Service Workgroup Minutes (4-19-06 and 6-15-06)—show decision to add to the PIHP authorization screen the date NOA letter is printed to allow for better tracking. • PIHP electronic authorization screens show date authorization screen is created and date NOA is printed. Does not give date enrollee requested service or date NOA was mailed, which are needed to determine whether required timeframes were met. • PIHP Authorization and Denial Report/Analysis—shows number of authorizations and denials per month and number of days between the provider request for authorization and BHO authorization/denial. This report also does not provide the information needed to ensure that required NOA timeframes are being met. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Network providers receive notification of denials, reductions, suspensions, or terminations as part of the PIHP electronic authorization/denial notification process. Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Differing reports as to whether the provider receives copy of NOA. PIHP's	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	policies and procedures do not address if provider is notified of NOA. Recommend clarifying provider notification of NOA procedure in policies. (Moderate Compliance)	3
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • New Timely Access to Authorizations Policy and Procedures contain the requirements for standard authorization decisions and extensions. However, the policy does not stipulate the procedures related to implementing these requirements. • PIHP staff reported that they have not developed a process for BHO, their delegated UM subcontractor, to request any needed authorization extensions. • Provider management and direct service staff reported that, at times, intakes and authorizations extend beyond the required 14-calendar day requirement, and no extensions are requested. • No evidence of authorization extension requests were submitted by the PIHP. • PIHP Authorization and Denial Report/Analysis—shows number of authorizations and denials per month and how many days between the provider request for authorization and BHO authorization/denial. Report does not provide the information needed to ensure that standard authorization timeframes are being met (i.e., date of enrollee request for service, date of provider authorization request, date of BHO authorization/denial, and date enrollee notified of authorization decision). • No evidence was submitted of PIHP utilization management oversight to ensure that required subcontractor timeframes are met. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q44]	**Procedures for expedited authorization decisions** Evidence: • New Timely Access to Authorizations Policy and Procedures contain the requirements for expedited authorization decisions and extensions. However, policy does not stipulate the procedures related to implementing these requirements. • The above policy stipulates that the "PIHP Provider" makes the decision for the expedited authorizations and related	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	extensions. PIHP staff reported that this was a typo and that expedited authorizations would be conducted by BHO, their delegated UM subcontractor. • BHO staff reported that there is no need for an expedited authorization request process because they treat all authorization requests as expedited. Reviewer found no evidence of the stated expectation in the PIHP-BHO service agreement. • PIHP Authorization and Denial Report/Analysis—shows number of authorizations and denials per month and number of days between the provider request for authorization and BHO authorization/denial. Report did not contain data related to expedited authorization requests and decisions. • Provider management and direct service staff were able to articulate purpose of expedited authorization requests; however, they were unfamiliar with related timeframes and procedures associated with making such a request. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q45]	**Extension of expedited authorization request** Evidence: • New Timely Access to Authorizations Policy and Procedures contains the requirements for expedited authorization decisions and extensions. However, policy does not stipulate the procedures related to implementing these requirements. • The above policy stipulates that the "PIHP Provider" makes the decision for the expedited authorizations and related extensions. The PIHP staff reported that this was a typo and that expedited authorizations would be conducted by BHO, their delegated UM subcontractor. • BHO staff reported that there is no need for an expedited authorization request process because they treat all authorization requests as expedited. Reviewer found no evidence of the stated expectation in the PIHP-BHO service agreement. • PIHP Authorization and Denial Report/Analysis—shows number of authorizations and denials per month and number of days between the provider request for authorization and BHO authorization/denial. Report did not contain data related to expedited authorization or extension requests and decisions. • Provider management and direct service staff were not consistently certain as to whether extensions could be granted for expedited authorization requests. Also, they had variable knowledge with respect to related timeframes and procedures.	

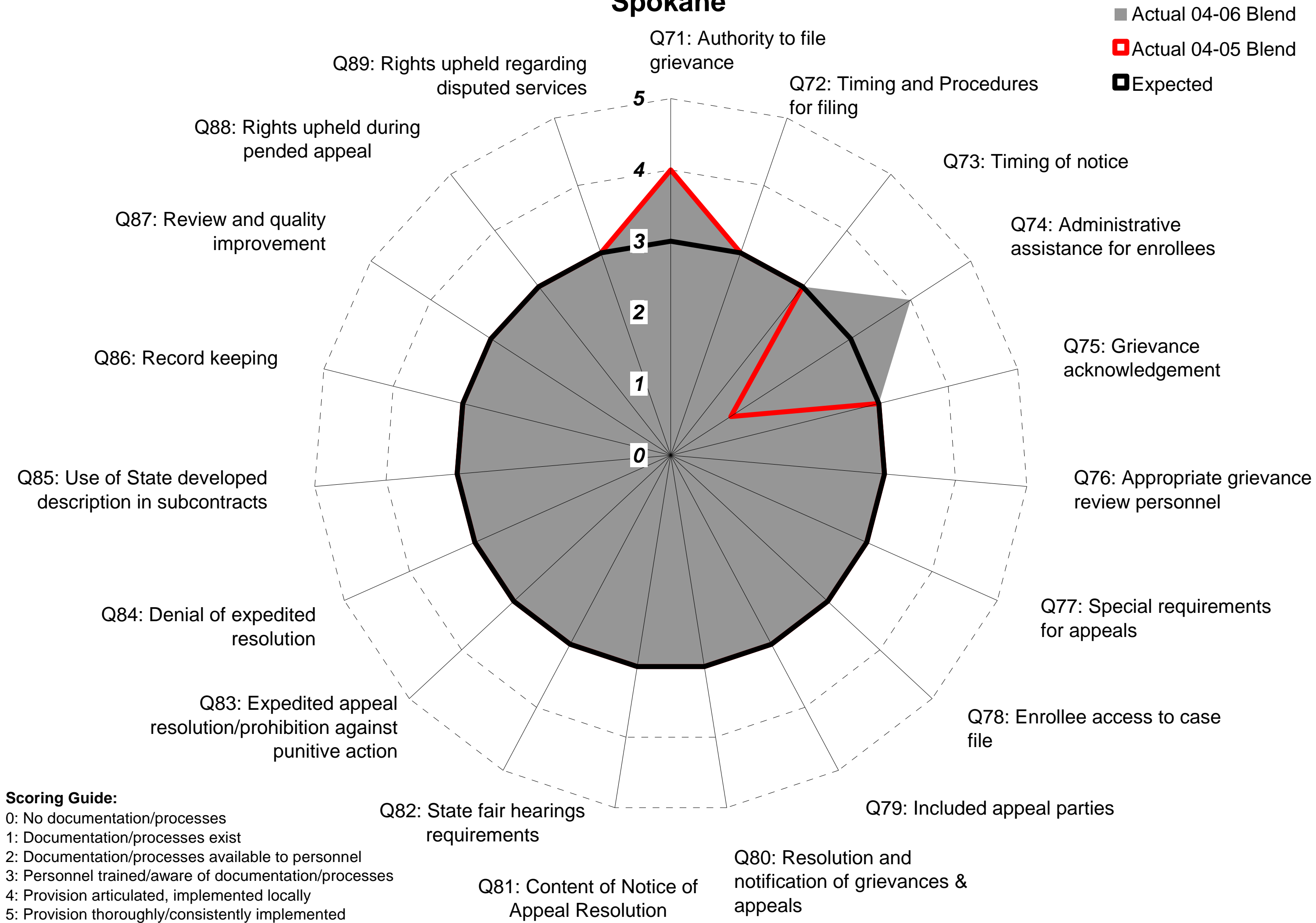
CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.214(c)	**Nondiscrimination**	
[Q47]	**Protection against provider discrimination** Evidence: • New Provider Non Discrimination Policy and Procedures, states, "SCRSN/PIHP provider selection shall be consistent with 438.12, and shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment." • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Provider network management reported there has been no discrimination by PIHP. (Substantial Compliance)	4
438.12	**Excluded Providers**	
[Q48]	**No contracts with providers excluded from participation in Federal Health Care Programs** Evidence: • New Excluded Providers Policy and Procedures contains the requirements of this provision. Policy states, "SCRSN/PIHP and its contracted providers shall check the 'Excluded Database' at http://www.oig.hhs.gov and the 'Excluded Parties Listing System' at http://epls.gov before offering employment or a contract for services. A copy of the search results indicating 'no results found' shall be placed in the personnel record, or contract file." • Documents showing evidence of PIHP and one provider monitoring for excluded local organizations and practitioners on Federal website. • In addition, the above policy states, "SCRSN/PIHP shall require its contracted providers to sign a 'Certification Regarding Debarment, Suspension, and Other Responsibility Matters' form annually to affirm that they, their employees and their contractors are not excluded from participation." • 3-signed and executed provider Certifications of Debarment. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Network provider management articulated intent and practice of this provision and the PIHP's mechanism established to meet the requirements. (Maximum Compliance)	5
438.224	**Confidentiality**	
[Q51]	**PIHP audits subcontractors for privacy compliance** Evidence: • New Confidentiality Policy and Procedures, states, "SCRSN/PIHP shall ensure, through its contracts, that (consistent with Subpart F of part 431 of 42 CFR 438.244), for medical records and any other health and enrollment information that identifies a particular enrollee, SCRSN/PIHP and its providers uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable." • Above policy does not include procedures related to PIHP oversight and monitoring to ensure that clinical records contain enrollee rights associated with confidentiality, PHI-informed consents, release of information documentation, or review of provider procedures related to client access to clinical record. • PIHP ensures through audits of their subcontractors using the Spokane County Agency IS Monitoring / Audit Tool that procedures are in place that protects privacy according to the provisions of 45 CFR (audit of one provider submitted as evidence). • 2006- 2007 Complaint Log and most recent Ombuds Exhibit N show no complaints or grievances related to breach of confidentiality or related issues. • Completed Provider Contract Review Tool (09-07-06) – indicates clinical record complies with clinical record confidentiality standards (which are not identified in the policy in bullet one, above). • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Provider management reported that their last PIHP annual	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	audit included the IS Monitoring Audit Tool and a clinical record review of confidentiality practices. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.236	**Practice Guidelines**	
[Q56]	**Adoption of practice guidelines meets established requirements** Evidence: • New Practice Guidelines Policy and Procedures include the basic requirements of this provision. • Adopted Clinical Practice Guidelines, generated by The American Psychiatric Association: o Treating Major Depressive Disorder o Psychiatric Evaluation Of Adults • Quality Improvement Committee (QIC) minutes (1-19-07)—show evidence of some provider reps in attendance, as well as approval and adoption of practice guidelines by the QIC, per policy requirement. Minutes didn't provide evidence of provider participation in the selection of the practice guidelines. • Provider management had differing reports as to whether the PIHP elicited staff participation in the selection and adoption of the practice guidelines. • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • No evidence submitted by the PIHP indicating that provider staff received training specifically related to the implementation of the practice guidelines. • Provider management and direct service staff were able to identify the adopted practice guidelines. In addition, staff reported that they had not yet received training on the practice guidelines and were not using them at the time of the review. (Moderate Compliance)	3
[Q57]	**Dissemination of practice guidelines to providers and enrollees upon request** Evidence: • New Practice Guidelines Policy and Procedures include the basic requirements of this provision. • Adopted Clinical Practice Guidelines, generated by The	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	American Psychiatric Association: o Treating Major Depressive Disorder o Psychiatric Evaluation Of Adults • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. Practice guidelines were distributed with the training notebooks. • No evidence was submitted by the PIHP indicating that provider staff received training specifically related to implementation of the practice guidelines. • Provider management and direct service staff were able to identify the adopted practice guidelines. In addition, staff reported that they had not yet received training on the practice guidelines and were not using them at the time of the review. (Moderate Compliance)	3
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • New Practice Guidelines Policy and Procedures does not include how the PIHP will monitor to ensure that decisions for utilization management, enrollee education, coverage of services, and other processes of care are consistent with the practice guidelines. • Adopted Clinical Practice Guidelines, generated by The American Psychiatric Association: o Treating Major Depressive Disorder o Psychiatric Evaluation Of Adults • PIHP Training the Trainers-January 25, 2007—submitted provider attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers for each provider will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. Practice guidelines were distributed with the training notebooks. • No evidence was submitted by the PIHP indicating that provider staff received training specifically related to implementation of the practice guidelines. • Provider management and direct service staff were able to identify the adopted practice guidelines. In addition, staff reported that they had not yet received training on the practice guidelines and were not using them at the time of the review. • No monitoring mechanisms related to this provision were submitted by the PIHP for review.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

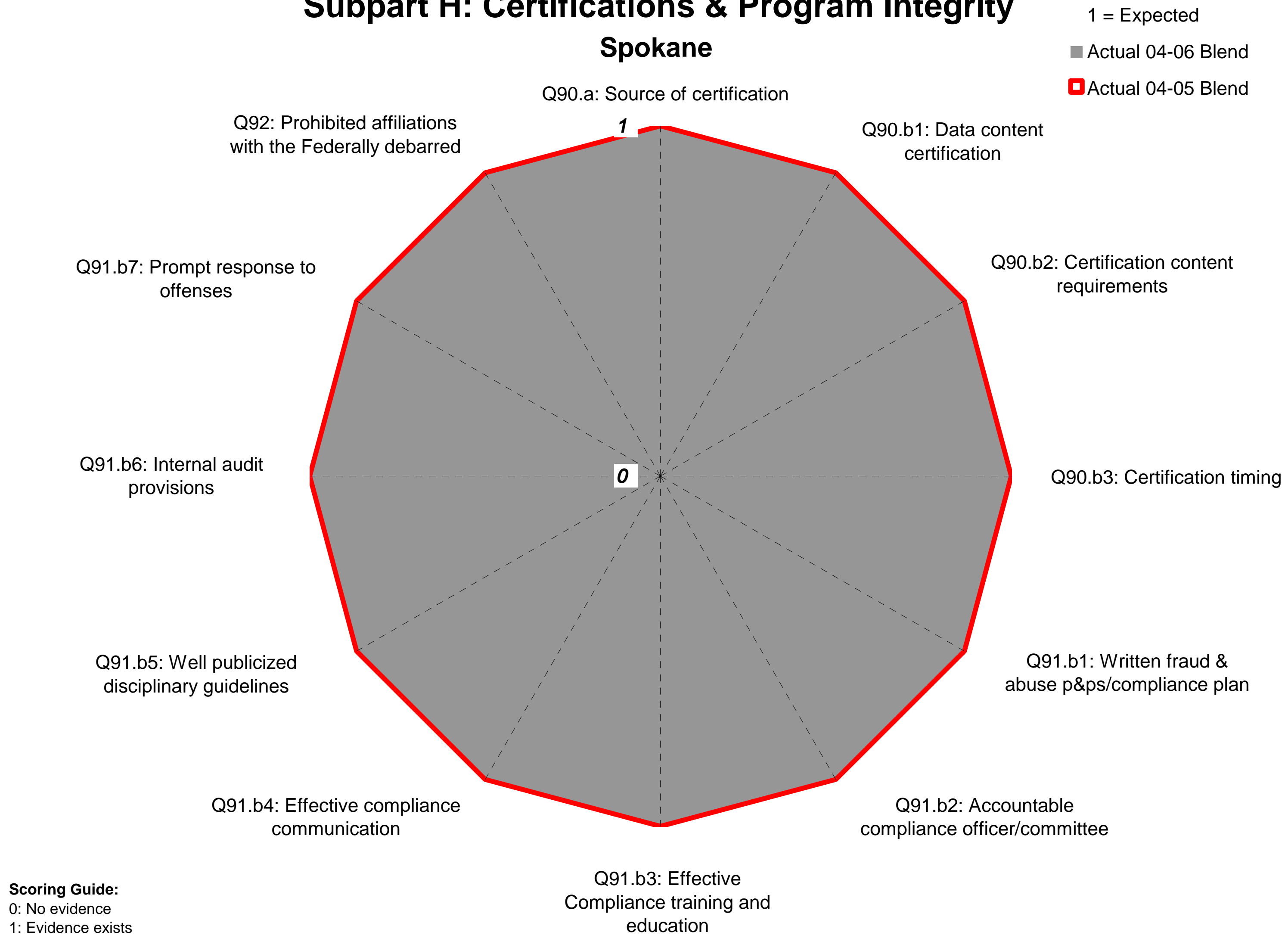
2004-2006 Subpart Scoring Trend and Detail for Spokane

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	4		4
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	3		3
Q74: Administrative assistance for enrollees	1	4	4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	3		3
Q87: Review and quality improvement	3		3
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
438.406	**Handling of Grievances and Appeals**	
[Q74]	**PIHP ensures enrollees are provided assistance in completing forms and taking procedural steps** Evidence: • New Grievance and Appeals Policy and Procedures incorporate language that ensures enrollees are provided reasonable assistance in completing forms and taking other procedural steps related to grievances and appeals. • Training the Trainers-January 25, 2007—submitted attendance roster, PowerPoint, trainer instructions and notebooks, and sample training test and answers. Trainers will then have 45 days to complete training with their agency staff. PowerPoint and training notebooks included material relevant to this review element. • Provider direct service staff able to articulate basic understanding assistance available to enrollees • No related QA&I activities submitted for review. (Substantial Compliance)	4



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for Spokane

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	1		1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

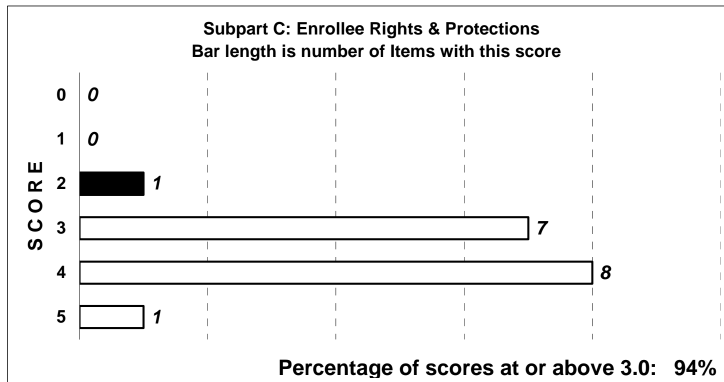
CFR Reference	Compliance Determination Report *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness and truthfulness of the data. (Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State. (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (Compliance)	1

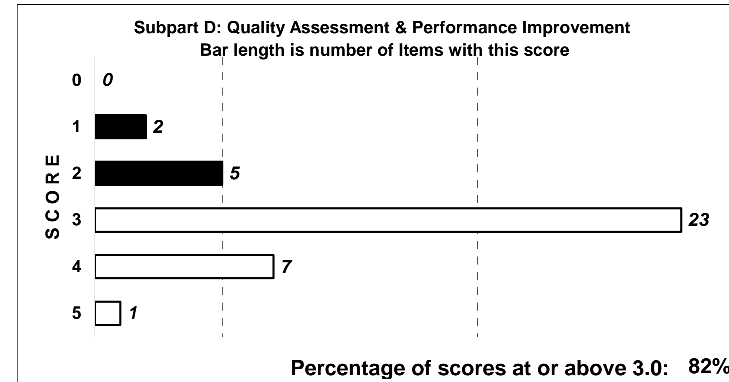
Scoring Frequency Overview

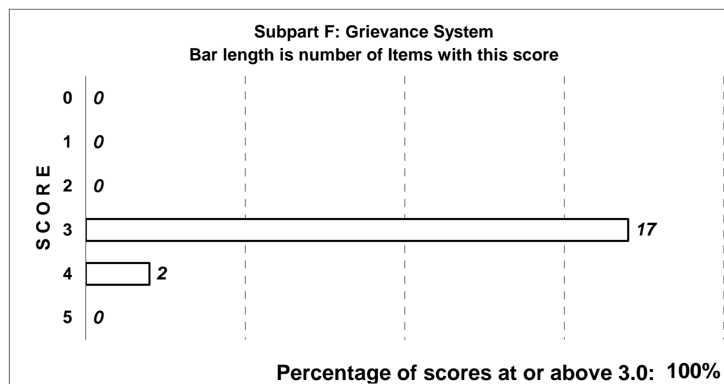
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Spokane

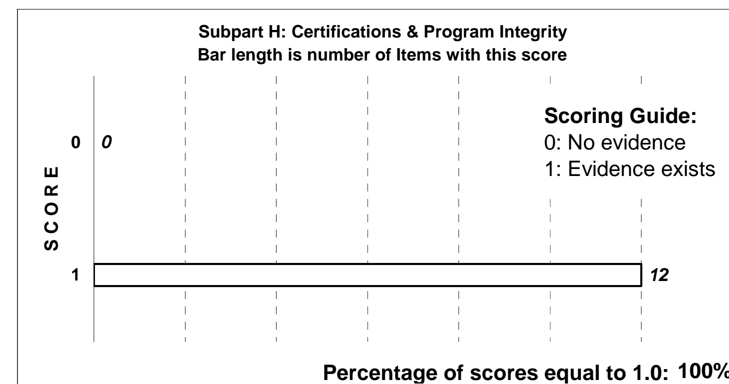
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The above charts depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 94%
Subpart D: 82%
Subpart F: 100%
Subpart H: 100%

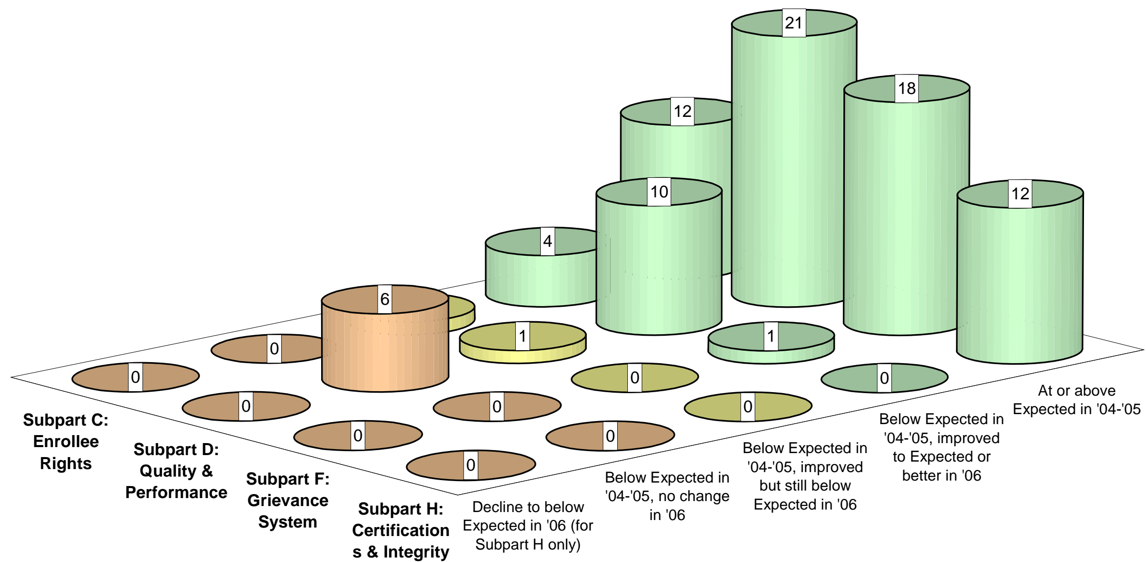
By prioritizing Certifications and Program Integrity, Spokane County PIHP achieved Expected compliance for Subpart H in 2005, and again in 2006. SCPIHP has also achieved Expected compliance for all review elements in Subpart F-Grievance Systems.

The PIHP continues to make progress with respect to Subpart C-Enrollee Rights and Protections, and Subpart D-Quality Assessment and Performance Improvement. However, relevant policies and procedures remain underdeveloped and are missing key requirements. Specific areas that remain a challenge include, but are not limited to, elements related to oversight of timely access standards, authorization standards and timeframes, oversight of culturally competent service standards, and implementation of practice guidelines. In addition, the Spokane County PIHP needs to increase the knowledge and application of Subparts C and D requirements at the level of network providers and their staff.

Score Trend Summary for:
Spokane

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Percent	Subpart D: Quality & Performance Item Count	Percent	Subpart F: Grievance System Item Count	Percent	Subpart H: Certifications & Integrity Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	6	15.8%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved but still below Expected in '06	1	5.9%	1	2.6%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	4	23.5%	10	26.3%	1	5.3%	0	0.0%
At or above Expected in '04-'05	12	70.6%	21	55.3%	18	94.7%	12	100.0%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, Spokane County PIHP performance relative to Subpart C (*Enrollee Rights*) showed 12 out of 17 items (70.6%) already at or above the Expected level of performance. After the 2006 review, 16 items (94.1%) are at the Expected level, reflecting improvement in 4 out of 5 elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), Spokane County PIHP entered the 2006 review with 18 of 19 items (94.7%) already at or above Expected. After the 2006 review, 19 items (100%) meet the Expected level of performance, again indicating improvement in all elements that scored below Expected in 2005.

The improvement Spokane County PIHP has made in all four (4) Subparts reflects focused efforts on continuous quality improvement during 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- In collaboration with BHO, PIHP staff developed a Training the Trainers protocol and related materials to ensure training and implementation of new PIHP policies and procedures throughout the provider network.
- The PIHP IS Monitoring Audit Tool includes a thorough review of policies, procedures, and work station security practices to ensure that sensitive data and personal health information are protected per HIPAA regulations.
- The PIHP produced and supplied their entire provider network with a poster of enrollee rights translated into the 8 required DSHS languages.
- The PIHP has effectively improved provider network relations over the past year.

Subpart Challenges

- Procedures and protocols are deficient with respect to implementation of requirements stipulated in policies and procedures.
- PIHP policies and procedures lack effective monitoring mechanisms as well as quality assurance and improvement activities related to a majority of Subpart review elements. The primary method of PIHP oversight is listed as the monitoring of complaints and grievances; by itself, this method is an inadequate means of management oversight.

Subpart Recommendations

1. Develop an effective process for monitoring provider network compliance with timely access. Establish thresholds related to timely access requirements and, when appropriate, issue quality improvements or corrective actions for noncompliance.

2. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

3. Develop implementation procedures for Standard Authorization and Expedited Authorization decisions and requests for extensions. Ensure that appropriate controls are in place for authorization processes and develop monitoring mechanisms to ensure adherence to required timeframes.

4. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, and date Notice of Action (NOA) was sent.

5. Include monitoring of client access to second opinions and clinical records as part of annual clinical reviews.

6. Develop effective oversight mechanisms for culturally competent service standards.

7. In provider contracts, stipulate specific client materials to be translated and identify the required languages and formats in which materials are to be made available.

8. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services,

treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

9. Expand privacy compliance audits of subcontractors to incorporate medical record review of protected personal health information practices and confidentiality requirements.

10. Modify current monitoring tools and develop effective monitoring mechanisms that incorporate review elements related to BBA requirements and the PIHP's standards outlined in their new and yet-to-be revised policies and procedures.

11. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The PIHP has only one provider agency that uses non-standard codes; this provider maintains their own crosswalk to the State codes. The PIHP system only accepts the State's standard codes; other codes return to the submitter as an error.

2. Unique member ID
   The PIHP searches for duplicate member IDs; suspected duplicates are entered into a duplicate member list. This list is used to eliminate duplicate member IDs in the data system.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The system employed by the PIHP tracks individuals across product lines and through enrollment, disenrollment, and re-enrollment.

4. Calculating member months
   With their new membership database, PIHP staff calculate per member per month statistics.

5. Member database
   PIHP staff report that they now store membership data in their IT system, Raintree. They also keep a local copy of the most recent data for analysis and management report purposes.

6. Provider Database
   PIHP staff report that they are in the process of developing a provider database to manage development of a fee-for-service like reimbursement model.

7. Data easily under-reported
   The PIHP does not have a policy or procedure to capture easily under-reported outpatient data; e.g., outpatient services provided by a non-network provider. They report having a policy and procedure to capture out-of-network inpatient services.

PM Summary

Spokane County PIHP does pre-submission screening of its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. The PIHP's efforts in this year's encounter validation review (described below) met the basic requirements. The overall score of Partially Met in the 2006 encounter validation review has some impact on the general state of the PIHP's performance measure accuracy, but their review results showed few problems. The general state of the PIHP's data is evaluated as "fair" (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- Moving data storage and analysis back into the County system has given them increased awareness of their system's metrics and an ability to conduct their own analyses and make informed decisions.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs whenever possible.

APS reviewed one of two submitted PIPs for Spokane County PIHP: Continuity Planning, which was identified by the PIHP as clinical. Included in the document request were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006. (See, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

For validated PIPs ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

The PIP summary submitted for Continuity Planning was a new study topic for 2006. The summary indicates that the PIHP attempted to create a PIP based on their ongoing system redesign efforts, which were focused on addressing severe financial penalties related to inpatient utilization. Minutes of redesign meetings starting in November 2006 were submitted; however no mention was made of PIP activity per se. The summary did not provide detailed information related to each element of the PIP protocol. In discussion at the site visit, the PIHP indicated that the only attendee at the September 2006 training is no longer employed, and that no one attended the follow-up training. In addition, BHO reported that the information gleaned from that training was confusing relative to State expectations of PIP development, which resulted in the PIHP continuing to await further direction rather than moving ahead with PIPs of their own. Due to the abbreviated nature of the submission and the discussion at the site visit, the WAEQRO was not able to complete the formal validation process. Recommendations are provided below.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

PIP validation tool was not completed.

Activity 2: Evaluate Overall Validity and Reliability of Study Results

PIP validation tool was not completed.

PIP Strengths

- EQRO unable to assess

PIP Challenges

- PIHP has not moved forward in developing PIPs related to data produced about system performance.
- PIHP staff have not attended State-sponsored training and will need to educate themselves about the intricacies of compliance with CMS protocols.

PIP Recommendations

1. Ensure that development of PIPs is conducted according to State contract requirements.

2. Assign responsibility for PIP development to an appropriate staff person, and ensure availability of design and data analysis expertise.

3. Develop new PIPs from analysis of system performance; select study topics based on most critical system improvements needed related to clinical outcomes, processes of care, and/or consumer satisfaction.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	SCRSN uses the State Reporting Manual (2006 and 2007 editions) plus the State's data dictionary as the standard for their data requirements. This information is unaltered from the state and provides a clean foundation for their collection practices. The PIHP does not have a data completeness standard.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The PIHP provided copies of sign-in sheets for training on the State Reporting Manual as evidence of communicating their data requirement standards. They distribute the State's data dictionary and reporting instructions to their provider network and the method of implementing any changes is well-documented.

Item	Rating	Comments
2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Met	The PIHP uses an IS Audit tool to document a set of parameters in their providers' IT environment. They review operating environment (hardware), clinical software, access to Raintree, HIPAA, backup, recovery and contingency plans, and policies and procedures. The PIHP uses a standardized tool to collect this information, which enhances usefulness to both the PIHP and their provider network.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Not Met	The PIHP does not conduct an Encounter Validation-specific data analysis for the purpose of validating its completeness and accuracy. Efforts to verify such data prior to transmission are excellent, but do not provide the views needed to calculate actual completeness values necessary for this analysis.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Not Met	Data analysis specific to an encounter validation is not done.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data analysis specific to an encounter validation is not done.
4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of	Partially Met	The process used by the PIHP is not documented in a policy and/or procedure. Review of the documents submitted shows the PIHP using what appears to be a standardized process that meets the basic EV requirements outlined in their contract with the State. Contracts between the PIHP and their providers provide the EV requirement, but in no more detail than stated in the State's contract with the PIHP. The process needs

PIHP Encounter Validation
Process Review

Item	Rating	Comments
service, and service provider.		to be fully defined in a policy and procedure to ensure that the process is carried out in a consistent manner.
PIHP includes additional data elements in matching exercise.	Not Met	There was no evidence submitted showing that the PIHP checks additional data elements in their EV process.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Not Met	No tools for the encounter validation process were submitted.

5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Met	The report to the state describes the encounter validation efforts taken by the Spokane County PIHP. The description is high level but does provide a good basic picture of their results. More specific details of their process would enhance the usefulness of their report. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s);

PIHP Encounter Validation Process Review

Item	Rating	Comments
		• Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	PIHP provided evidence with respect to the practice of sharing review exercise results with their providers.
PIHP regularly reports internally for quality improvement activities.	Met	The PIHP works closely with their provider network in communicating specifics about their IT systems as well as issues concerning system implementation and data collection.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Not Met	The PIHP did not submit a policy outlining their handling of corrective actions should such become necessary in the encounter validation process.
If warranted, evidence of follow-up	N/A	

PIHP Encounter Validation
Process Review

Item	Rating	Comments
activity was presented.		

Summary of Encounter Validation Findings

Score Met _39_ %

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ Met ☒ Partially Met ☐ Not Met

Summary of encounter validation findings:

Spokane County's encounter validation efforts met the basic requirements set forth in the contract between the MHD and the PIHP. The encounter validation review included the items specified in the contract, and the sampling method met the requirements agreed upon by the MHD and the WAEQRO, which are listed in the contract. The PIHP's evaluation of their provider network's

risks (step 2 in the tool above) is an excellent example of a modified Information Systems Capability Assessment (ISCA) that meets the specific needs of the PIHP. An analysis of the PIHP's data for the purpose of an encounter validation was not conducted.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. Had the entire tool been used in computing the score, the PIHP would have fared equally well, with 39% of all items meeting a score of Met, 46% at Not Met, and the remaining 15% at Partially Met.

EV Strengths

- The IS Audit Tool developed and used by the PIHP is an excellent amalgam of subjects that helps the PIHP evaluate the capability of their provider agencies to submit timely, accurate, and complete encounter data while ensuring that necessary security measures are in place to protect the Personal Health Information held within that data.
- The Encounter Validation report issued to the State requires only minor modifications (to enhance descriptions of some of the process details used by the PIHP in their Encounter Validation efforts) to meet the model defined in the EV Tool.

EV Challenges

- Undocumented processes in an environment with staff turnover increases the risk that validation processes could not be repeatable agency to agency or year to year.

EV Recommendations

1. Develop, document and communicate data completeness standards for the entire data set.

2. Begin an analysis of the encounter data. When analyzing the data set for an encounter validation, use a frozen data set for the time frame of the validation.

3. Define Encounter Validation processes in a policy and procedure.

4. Develop method and tools to analyze and validate other data in the data set.

5. Document corrective action processes in a policy.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		2		• The PIHP did not submit the QM Plan that was in effect for the full review year. A document with the electronic file name "QM Plan 1/17/06" was submitted for review; however, the actual document does not contain the date it is applicable/effective. While the minutes of the January 2007 QMC reflect approval of this plan, its effective date is unclear. • The QM Plan includes many components sufficient for a comprehensive plan, such as goal, scope, annual review, and performance

PIHP: Spokane				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				improvement projects; however, the Plan does not contain the date it is applicable/effective. • The Plan does not clearly state who is responsible for its approval; however, the PIHP Executive Director stated that the Quality Management Committee (QMC) approves the plan. • The Plan clearly describes the roles of Board of Commissioners (BOC), the Executive Director, and the QMC. • Senior management staff are members of the QM committee. The Executive Director and MIS Director are on the QM Committee; the Chief Financial Officer is an ad hoc member. • The Chart of Subcommittees indicates a Quality Director role; however, duties of this position are not defined in the QM Plan. • Three committees comprise the QA Program: quality, utilization, and children's resources. The relationship between the QA/QI committees is not clearly described. • Performance measures indicators, monitoring methods, and reporting processes are not adequately described.

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PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
				• QM Plan states that an annual review will be done; however, it does not specify the review's scope. • In describing and diagramming the conceptual model, PI activities appear to overlap with RSN operations only partially. In a comprehensive QI process, PI activities would inform all aspects of RSN operations and therefore be an overlay rather than an overlap. • Also missing is: o A quality-of-care vision that is consumer-focused; o The population served; and o An annual work plan of 3-4 specific quality improvement activities.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		**2**		• QM Plan states that an annual review will be done; however, it does not specify the review's scope.
C. Plan includes annual work plan and process for review of associated activities and progress.		**1**		• PIHP submitted "Spokane RSN Clinical Flow" document under a cover page, "Annual Plan." While not formally designated as an annual work plan, the redesign flow document does provide a roadmap for the key improvement initiatives that were addressed during the review year.

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PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
				• Redesign Flow document does not specify PIHP implementation plan, accountability, or review and reporting process. • An Annual Work Plan is not referenced in the QM Plan submitted.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		2		• Care Management Section states that regular formal contractor audits and clinical reviews are conducted. • QM Plan includes general reporting frequency for most major reporting categories (see, Attachment 14, QAI Process Requirements for details). • No monitoring frequency provided for several activities defined in the QM Plan (see, Attachment 14, QAI Process Requirements for details). • The QM Plan does not discuss corrective action as part of a comprehensive review and follow-up process. • Missing is a description of clinical chart review goals in several key areas: o No frequency or number of charts to be reviewed is provided; o No detail is shown of how reviews are conducted; o No detail is present related to data collection methods or analysis.

PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.		**3**		• The Consumer Consultation Panel (CCP) is not referenced in the QM Plan or the Chart of Subcommittees. The CCP routinely reports to the MHAB. • Inclusion of providers and consumers on quality-related committees is defined in the QM Plan: o QA/QI committee membership includes Advisory Board representative, Ombuds, and at least 3 provider staff; o Representation from each provider agency is not expected on the QMC.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**2**		• Evidence submitted of quality management activities described in the QM Plan: o Behavioral Health Options (BHO) representative reported that he is acting as Quality Director, which is supported by the contract amendment dated 2/15/07 retroactive to 1/1/07. o The Quality Director reported several specific quality improvement initiatives specified in the redesign document. o Provider management staff reported involvement with the redesign clinical work group.

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PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
				○ Minutes of MHAB reflect routine reporting by Ombuds of consumer complaints and grievances. ○ Provider management staff reported that the QA/QI committee includes provider staff and consumer representatives. • Implementation is not effective in the following ways: ○ PIHP Executive Director stated at site visit that the quality improvement team, (QIT) was poorly attended, and that its functions were moved to the Mental Health Advisory Board (MHAB). MHAB minutes do not reflect QA/QI functions. ○ Jan – April 2006 QIT minutes did not reflect discussion of QA and I activities. ○ General outline of QM Plan was presented at QMC 1/07, where it was verbally approved without addressing questions and concerns reflected in minutes.
Standard 1 Count (Target 6 Met):	**0**	**6**	**0**	**Target Points: 24 Actual: 12**

PIHP: Spokane				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			• Evidence provided that clinical chart reviews were conducted: o Chart review schedule for 2006-2007 including the number of charts reviewed in 2005 and 2006, accounting for all providers. o Nine completed chart reviews for adults and children. o Several narrative provider reports providing results of reviews and recommended or necessary actions. o One corrective action follow-up report from a provider. o Ombuds confirmation that both RSN and provider staff conduct clinical chart reviews.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**2**		• Contract Review Tool identifies some standards and provides a general interpretive guide for scoring assessments, treatment plans, case management, and psychiatric services. • Missing components include: Tool items to track quality of on-going care for services that are not

PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
				medically focused or case managed. o Items related to BBA compliance, such as consumer choice, and access to interpreters, second opinions, and clinical records. o Documentation of thresholds for scoring, subtotal by section or total score for chart and a methodology for aggregating scores. • Completed tools provided for review reflect inconsistent scoring. For example, some elements are marked N/A for no obvious reason, some sections are routinely left blank, and comments boxes rarely used.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**1**		• No documentation was provided to address reliability of scores between reviewers or the overall analysis of scores; however, it was stated at the PIHP interview that Dr. Bell trained staff on expectations of score thresholds prior to each site visit.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**3**		• Documentation and site visit interviews provided evidence that corrective action policy is implemented. • Thresholds for corrective action are described by both RSN and provider management as contractual; however, the contract, QAI Plan, and policies do

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PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
				not specify thresholds for corrective actions or required improvements related to quality of care review results.
Standard 2 Count (Target 4 Met):	**1**	**3**	**0**	**Target Points: 16 Actual: 10**
<u>Standard</u> **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.			**0**	• Jan-April 2006 QIT minutes did not address clinical chart reviews. QA/QI minutes in November, 2006 and 1/07 referenced chart review requirements; however, there was no discussion of review results. • No other minutes provided for review discussed clinical chart review findings or corrective action oversight.
B. PIHP analyzes and trends individual provider performance.		**1**		• Several clinical monitoring narrative reports for individual providers: o Provided an overview of process and specific corrections; o Stated trends with recommendation for changes; and o Indicated follow-up from the previous

PIHP: Spokane				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				audit year. • No documentation was provided to support collection and reporting of aggregate data from chart reviews. • No reports were provided related to longer term analysis of individual provider chart review performance.
C. PIHP analyzes and trends system-wide performance.			**0**	• No documentation was provided to support system-wide reporting or analysis of aggregate chart review data.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		**1**		• Provider staff reported that data related to their agency's service utilization is shared at IT meetings. Staff interviewed attend these meetings only occasionally. • No other reports and meeting notes submitted for review by the PIHP relate to communicating results of clinical chart reviews.
Standard 3 Count (Target 4 Met):	**0**	**2**	**2**	**Target Points: 16 Actual: 2**

<u>Standard</u>
4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)

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PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		3		• Complaint Log (6/06-1/07) provides tracking of timeliness and resolution of calls made directly to the PIHP. • Exhibit N for April-September, 2006 supported the near-zero reports of grievances and appeals. • Evidence was provided showing that the PIHP maintains logs of appeals and grievances. • Notice of Action Policy and annual report of approved/denied authorizations were provided for review. One appeal of NOA occurred during the year. o Comparison of the appeal tracking form and the tracking log revealed that the dates were different on each and that the required timeframes were not met.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.	4			• Evidence was submitted that confirms incorporation of grievance and appeal activity into analysis of QAI: o The QM Plan discusses grievances and appeals in the functions of the QMOC; the Care Management section includes discussion of Ombuds services. o The Ombuds stated that her quarterly reports are distributed to RSN, BOCC, providers, MHAB,

PIHP: Spokane

Requirement	Met	PM	Not Met	Findings Comments
				QRT, NAMI, allied systems, MHD, RSN staff, and the community development staff director. o Meeting minutes support Ombuds Participation at MHAB, QA/QI, and QIT. o The Ombuds stated that she submits Exhibit N twice/year. Because they are not required on the Exhibit N, complaints are not reported. o The Ombuds described reporting a problematic trend in residential care to QRT, which they jointly resolved.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	**4**			• Ombuds reported attendance at policy training in February 2007 and State-wide Ombuds training September 2006. Ombuds accurately explained the grievance system. • Provider staff accurately reported the complaints/grievances and appeals process. • Provider staff reported that the RSN conducted training for all agencies on the grievance and appeal system during the review year. • PIHP reported that the standard method is “train the trainer” at RSN committee meetings, and that material is then shared with agency staff.

PIHP: Spokane					
Requirement		Met	PM	Not Met	Findings Comments
Standard 4	Count (Target 3 Met):	2	1	0	Target Points: 12 Actual: 11
Grand Totals	Count (Target 17 Met):	3	12	2	Target Points: 68 Actual: 35

Summary Quality Assurance and Improvement Findings
Spokane County Regional Support Network (SCRSN) achieved the highest score possible (Met = 4 points) on 3 out of 17 possible items. Another 12 items were Partially Met and, of these, 3 items were nearly met. Two (2) items were unmet related to regular committee review of provider clinical quality reviews and evidence of system-wide analysis of results of providers' performance. SCRSN achieved a total score of 35 points (51%) for this first review of Quality Assurance and Improvement Plan and activities. These findings reflect a system that lost focus on routine oversight of the existing quality management structure while undergoing major redesign. The WAEQRO recommends that specific measurable indicators be reviewed and analyzed on a scheduled basis under the leadership of a full-time Quality Manager. Continued development of analytic and reporting tools related to data collected at the provider and system levels is encouraged to effectively trend, analyze, and report well-defined indicators. Accomplishing these tasks will produce consistent focus on critical performance measures and desired improvements.

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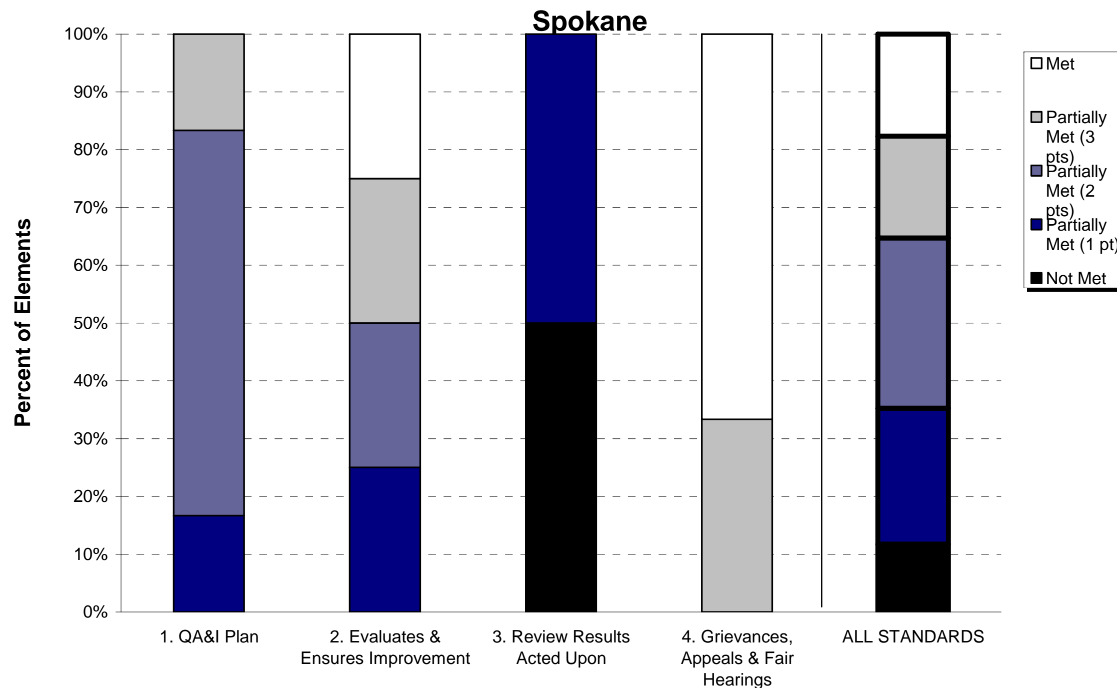

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	0	1	4	1	0
2. Evaluates & Ensures Improvement	4	1	1	1	1	0
3. Review Results Acted Upon	4	0	0	0	2	2
4. Grievances, Appeals & Fair Hearings	3	2	1	0	0	0
ALL STANDARDS	**17**	**3**	**3**	**5**	**4**	**2**

QAI Strengths

- Although the QM Plan was not the organizing tool used in the past year, the Clinical Redesign provided the framework for important systemic changes and quality improvement activities for the year.
- The commitment of existing staff is clearly reflected in the number and depth of changes described.
- It was evident from provider and PIHP interviews that frequent communication is occurring as a result of the redesign efforts.
- The Mental Health Advisory Board provided a consistent forum for routine communication and reporting for system issues during the redesign effort.

QAI Challenges

- The quality improvement team leader position was vacant for much of the year. Other key leadership positions were also vacant during the year, and remaining staff filled the roles as best they could.
- Management Information Systems staff are not participating routinely on the Quality Management Committee; development of

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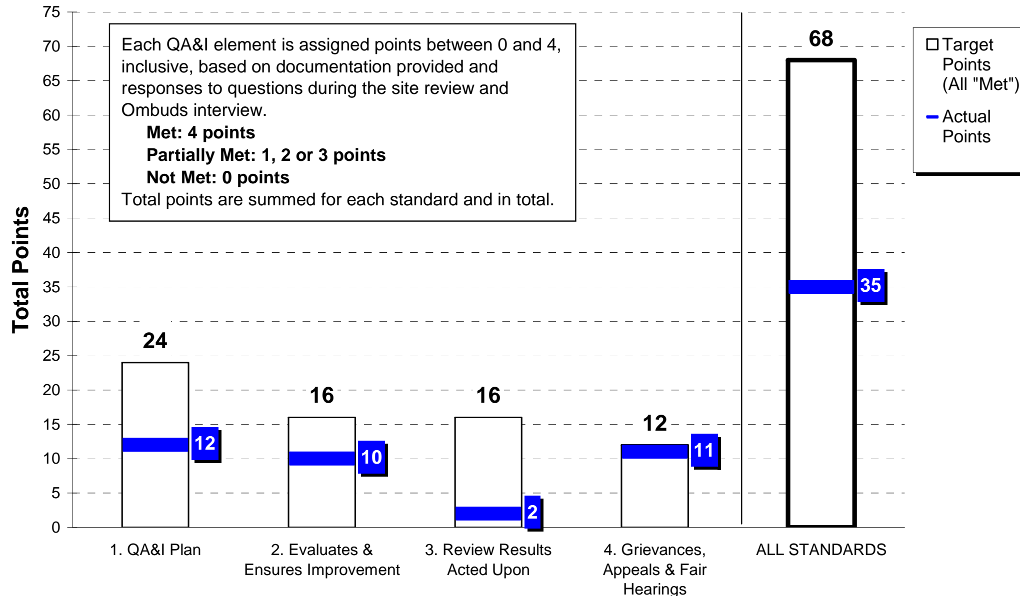

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	12
2. Evaluates & Ensures Improvement	16	10
3. Review Results Acted Upon	16	2
4. Grievances, Appeals & Fair Hearings	12	11
ALL STANDARDS	**68**	**35**

relevant electronic reports and tools necessary to effectively implement the QM Plan would thus be hampered.

- The Quality Management Plan does not provide an effective roadmap to accomplish the required oversight and improvement activities. Specifically, the conceptual model is confusing, and performance indicators are not well-developed.

QAI Recommendations

1. Consider development of a full time Quality Manager position within the PIHP, with responsibility for management of the QA&I program.
2. Develop data-based reports for all indicators, including graphs and charts that support trending for each provider and for the system as a whole over time.
3. The QM Plan would benefit from an initial discussion of the mission/vision and principles that guide the quality management program. The mission seems best described by a phrase under governing structure: “To ensure that Quality Management is an active consideration in all aspects of SCRSN business, and that

members of the SCRSN Provider Network and consumers of public mental health services are involved in the Program's processes."

4. Clarify reporting and decision-making relationships of all quality-related committees. Establish and maintain a reporting schedule, and document results of discussion, including plans and responsibility for any follow-up activities.
5. Include in the Plan oversight of delegated functions for utilization management and quality assurance in the QM Plan.
6. Include in the matrix of indicators the definition of the performance measures, data sources, calculation methods, targets, performance thresholds for further action, and reporting frequency and responsibility.
7. Ensure that all indicators in the Plan related to chart reviews are reflected in the chart review tool.
8. Ensure that BBA-required monitoring by the PIHP is included in provider administrative and/or clinical chart audit tools.

Recommendations

Subpart Recommendations

1. Develop an effective process for monitoring provider network compliance with timely access. Establish thresholds related to timely access requirements and, when appropriate, issue quality improvements or corrective actions for noncompliance.

2. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

3. Develop implementation procedures for Standard Authorization and Expedited Authorization decisions and requests for extensions. Ensure that appropriate controls are in place for authorization processes and develop monitoring mechanisms to ensure adherence to required timeframes.

4. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, and date Notice of Action (NOA) was sent.

5. Include monitoring of client access to second opinions and clinical records as part of annual clinical reviews.

6. Develop effective oversight mechanisms for culturally competent service standards.

7. In provider contracts, stipulate specific client materials to be translated and identify the required languages and formats in which materials are to be made available.

8. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

9. Expand privacy compliance audits of subcontractors to incorporate medical record review of protected personal health information practices and confidentiality requirements.

10. Modify current monitoring tools and develop effective monitoring mechanisms that incorporate review elements related to BBA requirements and the PIHP's standards outlined in their new and yet-to-be revised policies and procedures.

11. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. Ensure that development of PIPs is conducted according to State contract requirements.

2. Assign responsibility for PIP development to an appropriate staff person, and ensure availability of design and data analysis expertise.

3. Develop new PIPs from analysis of system performance; select study topics based on most critical system improvements needed related to clinical outcomes, processes of care, and/or consumer satisfaction.

EV Recommendations

1. Develop, document and communicate data completeness standards for the entire data set.

2. Begin an analysis of the encounter data. When analyzing the data set for an encounter validation, use a frozen data set for the time frame of the validation.

3. Define Encounter Validation processes in a policy and procedure.

4. Develop method and tools to analyze and validate other data in the data set.

5. Document corrective action processes in a policy.

QAI Recommendations

1. Consider development of a full time Quality Manager position within the PIHP, with responsibility for management of the QA&I program.

2. Develop data-based reports for all indicators, including graphs and charts that support trending for each provider and for the system as a whole over time.

3. The QM Plan would benefit from an initial discussion of the mission/vision and principles that guide the quality management program. The mission seems best described by a phrase under governing structure: "To ensure that Quality Management is an active consideration in all aspects of SCRSN business, and that members of the SCRSN Provider Network and consumers of public mental health services are involved in the Program's processes."

4. Clarify reporting and decision-making relationships of all quality-related committees. Establish and maintain a reporting schedule, and document results of discussion, including plans and responsibility for any follow-up activities.

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5. Include in the Plan oversight of delegated functions for utilization management and quality assurance in the QM Plan.

6. Include in the matrix of indicators the definition of the performance measures, data sources, calculation methods, targets, performance thresholds for further action, and reporting frequency and responsibility.

7. Ensure that all indicators in the Plan related to chart reviews are reflected in the chart review tool.

8. Ensure that BBA-required monitoring by the PIHP is included in provider administrative and/or clinical chart audit tools.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Southwest
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Southwest PIHP is responsible for managing mental health care and services for Medicaid consumers in Cowlitz County in the state of Washington. The PIHP is located in Longview, Washington and is governed by a board comprised of three (3) Cowlitz County Commissioners. The PIHP Administrator reports to the Board of County Commissioners. The PIHP contracts with three (3) community mental health centers and specialty providers, which serve approximately 1,500 adult and child consumers on a monthly basis. Total annual Medicaid enrollment in the PIHP is about 18,600. The PIHP does not delegate any functions.

This report covers the period between September 23, 2005, and September 22, 2006, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:
1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical

oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments with respect to change over the last two review years in areas that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings

Activity	Timeline	Documents/Content
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	August 22 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	September 11 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	September 22 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	October 11, 2006	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	October 20, 2006	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	November 9, 2006	
4. Debrief conference call	November 22, 2006	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	November 30, 2006	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the

opportunity to submit a response in writing. Southwest PIHP submitted a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Southwest PIHP, significant events include:

- The RSN Administrator left in July 2006, and the Quality Manager has been in the Acting position; a new Administrator will be hired.
- The PIHP changed Medical Directors in June 2006 and has added several new positions to better meet BBA and State requirements.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- PIHP monitoring tools submitted with documentation materials were not highlighted as requested and relevant information could not be readily located. Therefore, it was difficult to determine if pertinent review elements were included in the PIHP's monitoring and review activities.

- The PIHP submitted very little documentation related to PIPs, and the summary provided did not include the detail necessary to evaluate the methodology. Attachments referred to in the summary were not included in the submission.

- While specific agency chart audit reports were submitted for review, the PIHP did not provide copies of any aggregated, longitudinal reports discussed at the Quality Management Committee, making it difficult to verify that they are tracking and trending performance on their indicators.

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4. 2006 Review Results

This report provides results and a summary of Southwest PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Southwest PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.210 (b) [Q52]	**Evaluation of Subcontractor ability to perform delegated functions**			
	No evidence provided by the PIHP to demonstrate that before any delegation of enrollee information, initial assessment, determination of medical necessity and management information services functions, the PIHP evaluated the prospective subcontractor's ability to perform the	Submit a corrective action plan to the MHD	CAP submitted 5/10/05	Relevant policies and procedures include all requirements of this provision. PIHP implementing provider credentialing and clinician profiling procedures. No pre-delegation evaluation of Netsmart Technologies (PIHP's MIS vendor). Unable to determine if Sub contractual Relationships and Delegation policy is applied to all subcontractors performing delegated functions. PIHP has attained a score of **2-Partial Compliance.**

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	identified activities to be delegated.			
438.210 (b) [Q54]	**Annually monitor subcontractor performance related to delegated functions**			
	No evidence discovered that the PIHP currently monitors the Network Providers' performance associated with enrollee information, initial assessment and determination of medical necessity.	Submit a corrective action plan to the MHD	CAP submitted 5/10/05	Relevant policies and procedures include all requirements of this provision. PIHP reviews performance of network providers annually. Unable to determine if PIHP is monitoring the performance of Netsmart Technologies on an annual basis. No review submitted. PIHP has attained a score of **2-Partial Compliance.**
438.210 (b) [Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions**			
	No evidence discovered that the PIHP has conducted reviews and incorporated Network Provider quality improvements and corrective actions in their reports.	Submit a corrective action plan to the MHD	CAP submitted 5/10/05	Relevant policies and procedures include all requirements of this provision. PIHP reviews performance of network providers annually and requires provider quality improvements and corrective action plans as needed. No annual review of Netsmart Technologies submitted, unable to determine if the PIHP has imposed any quality improvements or corrective actions. PIHP has attained a score of **2-Partial Compliance.**
438.242	**Health Information Systems**			
	Limited	Submit a	CAP submitted	The PIHP has since replaced their

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	evidence exisits that the PIHP works to verify the accuracy and timeliness of the data. The PIHP and its providers do not have evidence of reports that are used to verify the accuracy of the data submitted.	corrective action plan to the MHD by 5/10/05.	5/10/05	software. A series of reports were developed for this new software to check data accuracy and timeliness. Presently, the PIHP checks data accuracy and timeliness with these reports.
438.242	**Health Information Systems**			
	The PIHP does screen the data for consistency, but at the time of our visit they were not yet transmitting data to the state. It is not possible to state that the PIHP screens their data for completeness and consistency since their data is admittedly in an incomplete state.	Submit a corrective action plan to the MHD by 5/10/05.	CAP submitted 5/10/05	The PIHP screens its data for consistency prior to entry into its system. There was no evidence that the PIHP conducts data consistency checks. This is a recommendation in the 2006 report.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);

- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);
- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Southwest PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

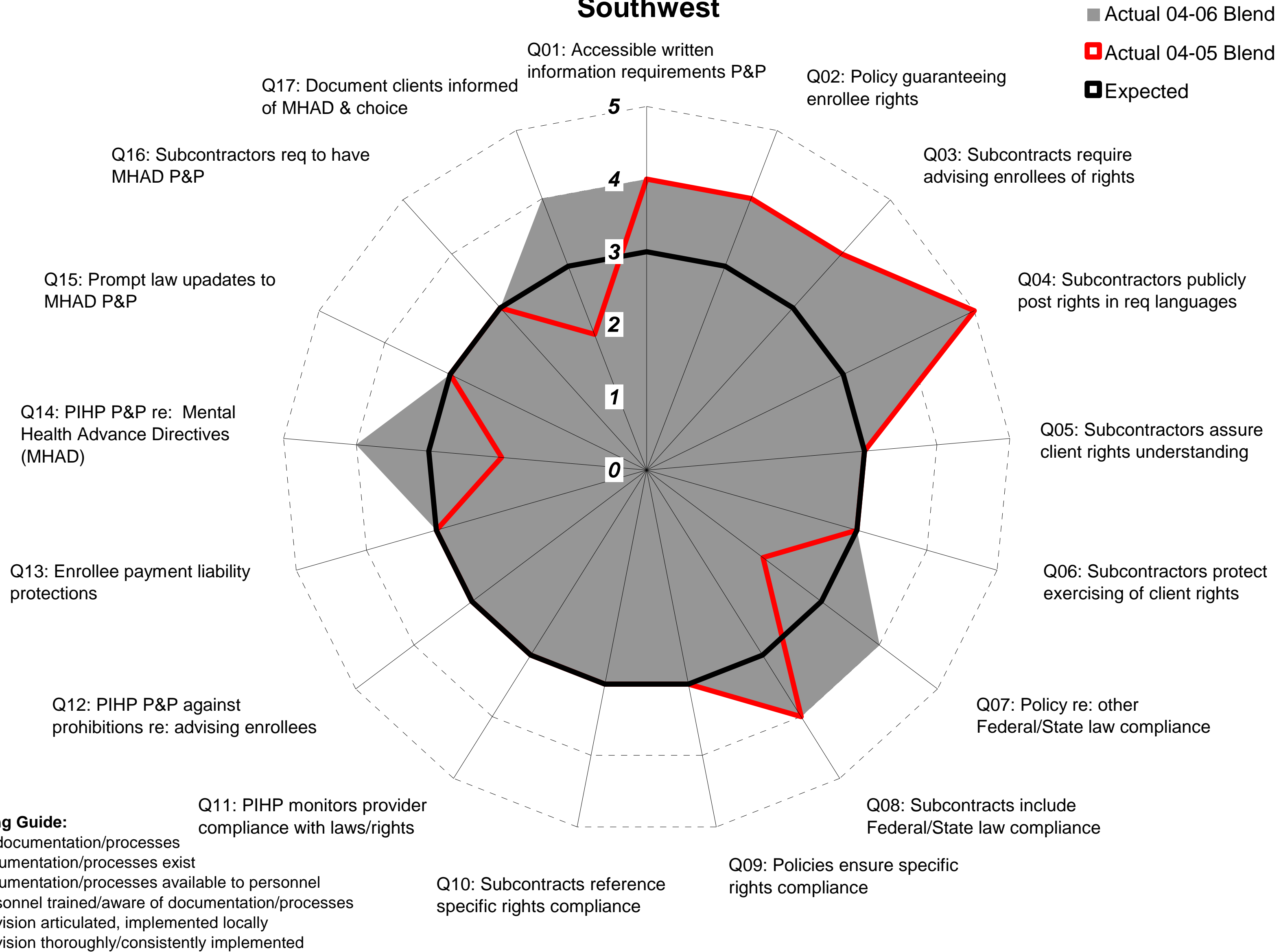
The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.

Subpart C: Enrollee Rights & Protections

Southwest



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Southwest

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	4		4
Q02: Policy guaranteeing enrollee rights	4		4
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	5		5
Q05: Subcontractors assure client rights understanding	3		3
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	2	4	4
Q08: Subcontracts include Federal/State law compliance	4		4
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	3		3
Q11: PIHP monitors provider compliance with laws/rights	3		3
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	3		3
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	2	4	4
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	2	4	4

Southwest PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

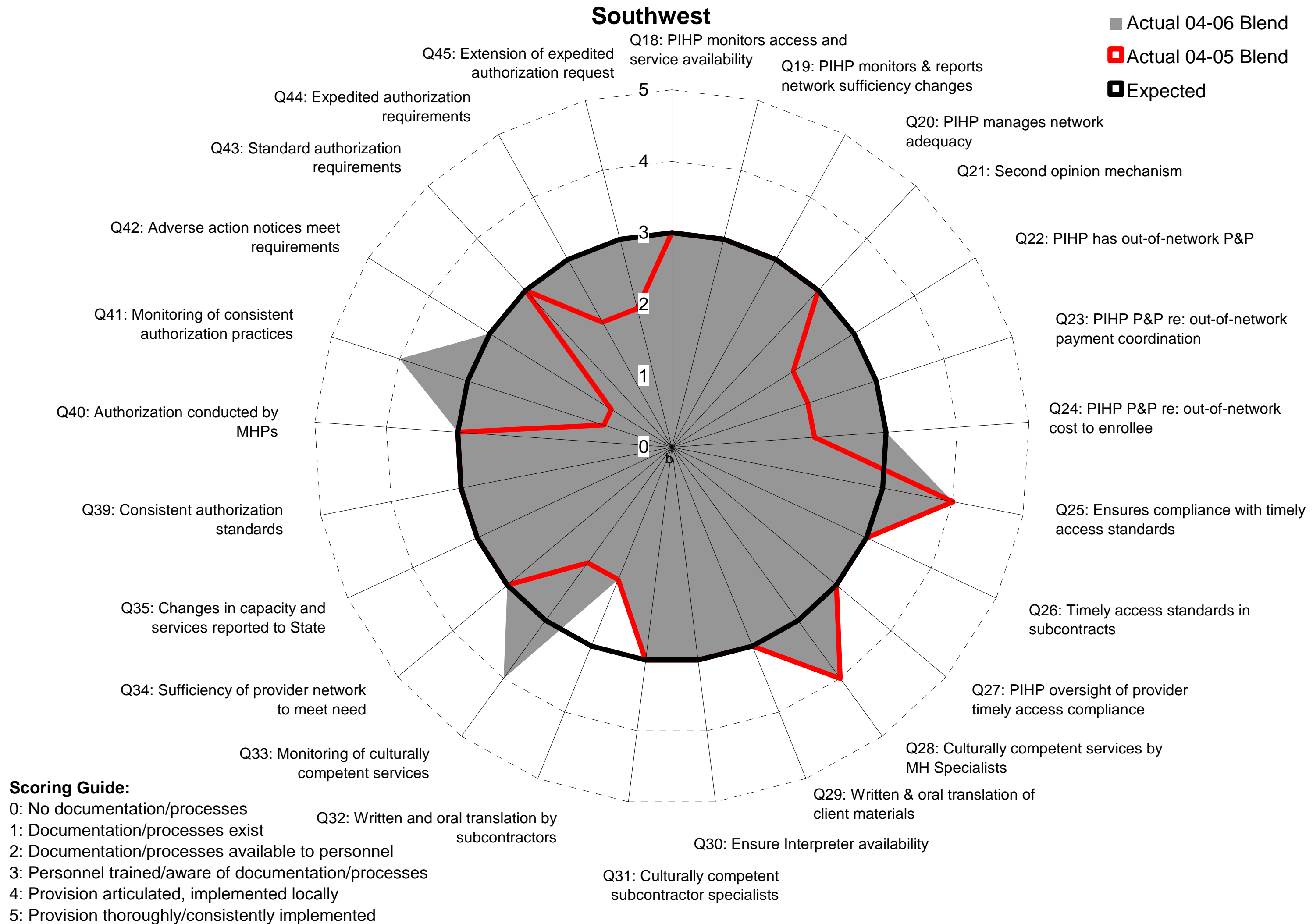
CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
438.100(d)	**Compliance with Other Federal and State law**	

[Q7]	**Compliance with other Federal and State laws is reflected in policies**
	Evidence:
	• 607 Nondiscrimination policy and procedures includes adherence to all State and Federal laws and includes all nondiscrimination laws identified in this provision.
	• Network provider policies and procedures reflect compliance with Federal and State laws including the nondiscrimination laws.
	• Acknowledgement of Receipt and Understanding forms signed by provider network staff for policy 607.
	• Network provider management did not know if PIHP monitors their compliance with the nondiscrimination laws except by reviewing their applicable policies and procedures.
	• PIHP annual 2006 PIHP Consumer Survey results show the following inquiries and their responses:
	  o *Staff are sensitive to my cultural background and /or disability.*
	    yes: 87% somewhat: 2% no: 11%
	  o *I feel the staff are open to my questions, concerns, complaints.*
	    yes: 83% somewhat: 4% no: 13%
	• 2006 PIHP Consumer Survey results were shared at the September 14, 2006 QMC Meeting, and provider directors were requested to share the results with provider staff.
	(Substantial Compliance)
		4

438.10(g) **438.6(l)**	**Advance Directives**	
[Q14]	**PIHP has Mental Health Advance Directive policies and procedures** Evidence: • Revised 605 Advance Directive policy and procedures includes all required provisions. • Network provider Advance Directive policies and procedures. • Acknowledgement of Receipt and Understanding forms signed by provider network staff for policy 605.	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	• DSHS "Advance Directives" brochure; MHPs are required to provide this brochure to adult enrollees at intake. • Network provider management reported their last clinical chart review was conducted by the PIHP in May/June. PIHP specifically reviewed for evidence that Advance Directive information was given to consumers at time of intake. • Provider direct service staff reported they have received training on Advance Directive procedures related to required information to be provided to consumers. Direct service staff articulated the procedures accurately. • Completed Outpatient Record Review Tool indicates PIHP reviews enrollee clinical records for a copy of any Advance Directive, Power of Attorney, or letters of guardianship. Recommend that review tool also capture documentation indicating clients have been provided required Advance Directive information materials, and consumer choice as to whether to have an Advance Directive. • PIHP annual 2006 PIHP Consumer Survey results show: o *I understand what an advance directive is.* yes: 61% somewhat: 13% no: 26% Survey results show need for continued emphasis of assisting consumers with understanding Advance Directives. • 2006 PIHP Consumer Survey results were shared at the September 14, 2006 QMC Meeting, and provider directors were requested to share the results with provider staff. • (Substantial Compliance)	4
[Q17]	**Client informed in writing of Mental Health Advance Directives, and choice is documented** Evidence: • Revised 605 Advance Directive policy and procedures, an attachment to PIHP Provider Contracts, requires that all adult enrollees be informed in writing of their right to be advised of Mental Health Advance Directives. • The policy also requires, "Each [PIHP] agency provider will ensure that upon intake evaluation, adult consumers will be asked whether or not they want to have an advanced directive. The consumer's clinical record will be documented to reflect the consumer's response and provider's action based upon the response. This will be measured by the presence of a consumer signed statement indicating their choice for a Mental Health Advance Directive." • DSHS "Advance Directives" brochure; MHPs are required to	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	provide this brochure to adult enrollees at intake. • Acknowledgement of Receipt and Understanding forms signed by provider network staff for policy 605. • Network provider management reported their last clinical chart review was conducted by the PIHP in May/June. PIHP specifically reviewed for evidence that Advance Directive information was given to consumers at intake. • Provider direct service staff reported they have received training on Advance Directive procedures related to required information to be provided to consumers. Direct service staff articulated the procedures accurately. • Mental Health Advance Directive Information Sheet; signed by consumer at intake, documents consumer choice as described above. • Copies of completed Consent for Treatment form from one network provider does not include documentation of consumer choice as described above; only verifies that Advance Directive information has been provided. • Completed Outpatient Record Review Tool indicates PIHP reviews enrollee clinical records for a copy of Advance Directive, Power of Attorney, or letters of guardianship provided by the consumer. Recommend that review tool also capture documentation indicating clients have been provided required Advance Directive materials, and documentation of consumer choice related to whether they want an Advance Directive. • PIHP annual 2006 PIHP Consumer Survey results show: o *I understand what an advance directive is.* yes: 61% somewhat: 13% no: 26% Survey results show a need for continued emphasis on assisting consumers with understanding an Advance Directive. • 2006 PIHP Consumer Survey results were shared at the September 14, 2006 QMC Meeting, and provider directors were requested to share the results with provider staff. (Substantial Compliance)	4


Subpart D (Part 1): Access Standards
Southwest
Actual 04-06 Blend
Actual 04-05 Blend
Expected
Q18: PIHP monitors access and service availability
Q19: PIHP monitors & reports network sufficiency changes
Q20: PIHP manages network adequacy
Q21: Second opinion mechanism
Q22: PIHP has out-of-network P&P
Q23: PIHP P&P re: out-of-network payment coordination
Q24: PIHP P&P re: out-of-network cost to enrollee
Q25: Ensures compliance with timely access standards
Q26: Timely access standards in subcontracts
Q27: PIHP oversight of provider timely access compliance
Q28: Culturally competent services by MH Specialists
Q29: Written & oral translation of client materials
Q30: Ensure Interpreter availability
Q31: Culturally competent subcontractor specialists
Q32: Written and oral translation by subcontractors
Q33: Monitoring of culturally competent services
Q34: Sufficiency of provider network to meet need
Q35: Changes in capacity and services reported to State
Q39: Consistent authorization standards
Q40: Authorization conducted by MHPs
Q41: Monitoring of consistent authorization practices
Q42: Adverse action notices meet requirements
Q43: Standard authorization requirements
Q44: Expedited authorization requirements
Q45: Extension of expedited authorization request
5
4
3
2
1
0
Scoring Guide:
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1: Documentation/processes exist
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4: Provision articulated, implemented locally
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2004-2006 Subpart Scoring Trend and Detail for
Southwest

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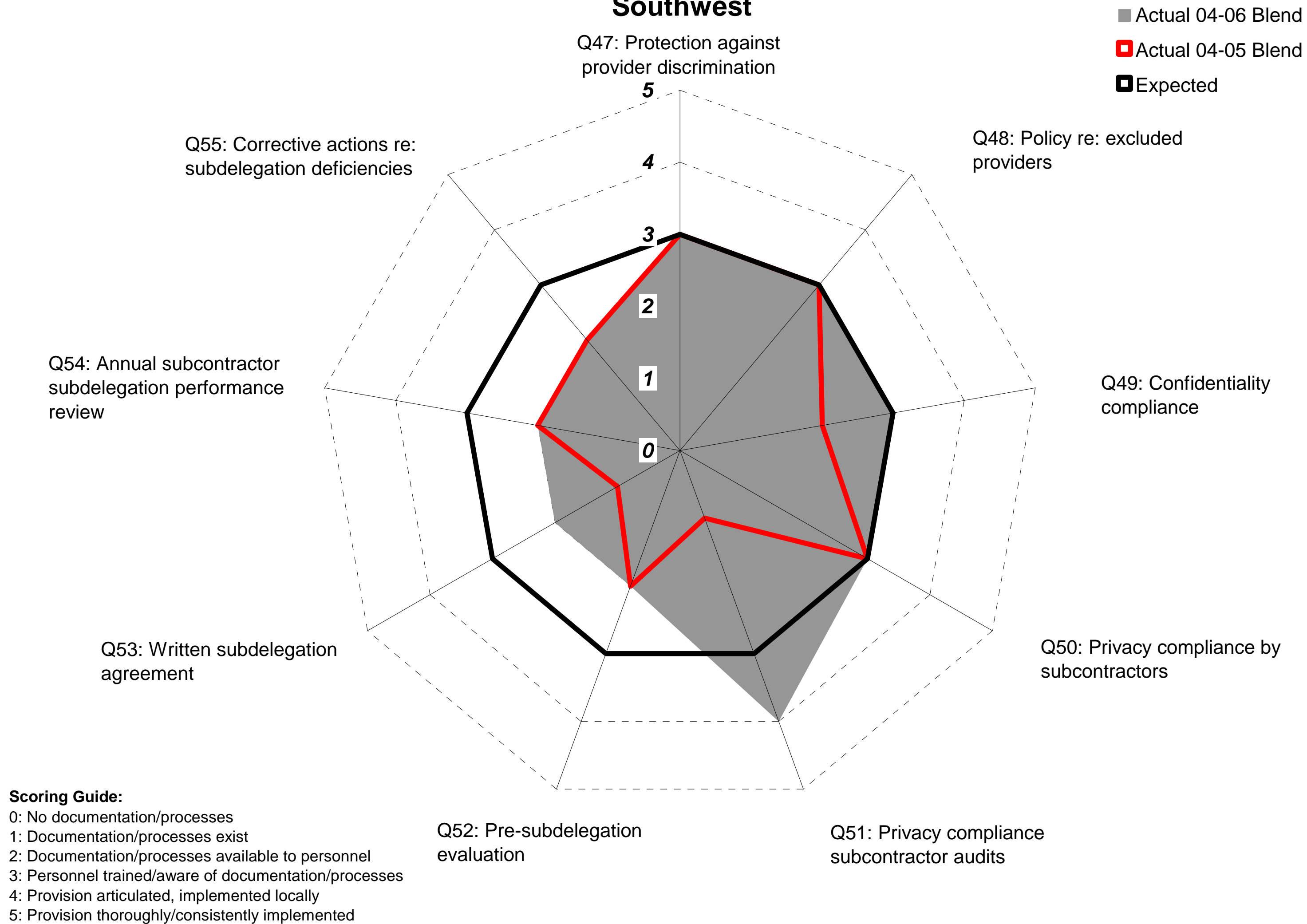
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	2	3	3
Q23: PIHP P&P re: out-of-network payment coordination	2	3	3
Q24: PIHP P&P re: out-of-network cost to enrollee	2	3	3
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	3		3
Q28: Culturally competent services by MH Specialists	4		4
Q29: Written & oral translation of client materials	3		3
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	3		3
Q32: Written and oral translation by subcontractors	2	2	2
Q33: Monitoring of culturally competent services	2	4	4
Q34: Sufficiency of provider network to meet need	3		3
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	3		3
Q40: Authorization conducted by MHPs	3		3
Q41: Monitoring of consistent authorization practices	1	4	4
Q42: Adverse action notices meet requirements	1	3	3
Q43: Standard authorization requirements	3		3
Q44: Expedited authorization requirements	2	3	3
Q45: Extension of expedited authorization request	2	3	3



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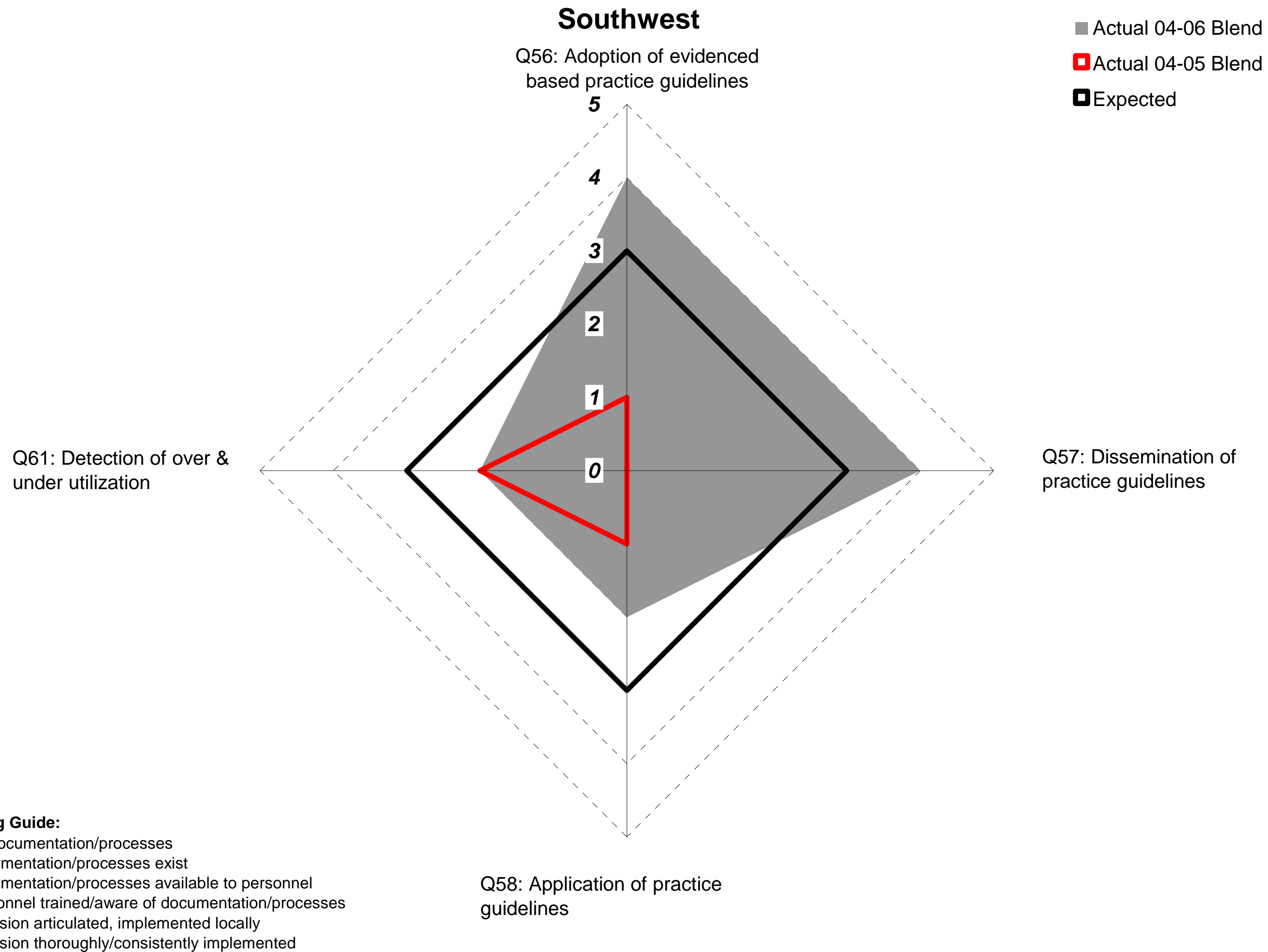
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	2	3	3
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	1	4	4
Q52: Pre-subdelegation evaluation	2	2	2
Q53: Written subdelegation agreement	1	2	2
Q54: Annual subcontractor subdelegation performance review	2	2	2
Q55: Corrective actions re: subdelegation deficiencies	2	2	2

Subpart D (Part 3): Measurement and Improvement Standards



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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	1	4	4
Q57: Dissemination of practice guidelines	0	4	4
Q58: Application of practice guidelines	1	2	2
Q61: Detection of over & under utilization	2	2	2

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (b)(4)	**Delivery Network—Out-of-Network Providers**	
[Q22]	**PIHP has out-of-network policy and procedures, and subcontractors are making referrals as needed** Evidence: • <u>321 Out of Provider Network Referrals</u> policy and procedures contains requirements related to out-of-network providers. • Descriptions of 2 actual Out-Of-Network Provider scenarios and supporting documentation including: <u>Continuity of Care Review Overview and Purpose</u> and meeting minutes, <u>Working Agreements</u> between PIHP and Out-Of-Network Providers, <u>LOS extension requests</u>, <u>Referral Logs</u> <u>and Requests</u>, <u>Case Notes</u>, and <u>Out-of-Network Provider Billing Invoices</u>. • <u>Acknowledgement of Receipt and Understanding</u> forms signed by provider network staff for policy 321. • Provider management aware of out-of-provider network policy and able to articulate basic purpose and processes for referral and payment. Reviewer noted discrepancy in provider management description and policy relating to responsible party for payment. Recommend that PIHP further clarify payment responsibilities in policy and trainings. • Direct Service staff reported having conversations with supervisors on how to make referrals to psychiatrists. Staff knew where to locate PIHP policy and procedure for reference when needed. (Moderate Compliance)	3
438.206 (b)(5)	**Delivery Network--Out-of-Network Providers Coordination with PIHP with Respect to Payment**	
[Q23]	**Out-of-network policy and procedures include coordination with respect to payment** Evidence: • <u>321 Out of Provider Network Referrals</u> policy and procedures stipulates that network providers are contractually obligated to pay for a consumer's medically necessary services outside of the service area in a timely manner and at no additional cost to the consumer. Additionally, the policy states, the provider shall continue to pay for services outside the service area until the consumer is no longer in need of such service(s).	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Descriptions of 2 actual Out-Of-Network Provider scenarios and supporting documentation including: Continuity of Care Review Overview and Purpose and meeting minutes, Working Agreements between PIHP and Out-Of-Network Providers, LOS extension requests, Referral Logs and Requests, Case Notes, and Out-of-Network Provider Billing Invoices. • Invoices from out-of-network providers showing accounts received and paid. • Descriptions and documentation show evidence of PIHP paying for out-of-network services rather than providers, as required in the policy (see, bullet one, above). • Acknowledgement of Receipt and Understanding forms signed by provider network staff for policy 321 • Provider management aware of out-of-provider network policy and able to articulate basic purpose and processes for referral and payment. Reviewer noted discrepancy in provider management description and policy relating to responsible party for payment. Recommend that PIHP further clarify payment responsibilities in policy and trainings. • Direct Service staff reported having conversations with supervisors on how to make referrals to psychiatrists. Staff knew where to locate PIHP policy and procedure for reference when needed. (Moderate Compliance)	3
[Q24]	**Cost of out-of-network provider is no greater for enrollee than services furnished within network** Evidence: • 321 Out of Provider Network Referrals policy and procedures stipulates that network providers are contractually obligated to pay for a consumer's medically necessary services outside of the service area in a timely manner and at no additional cost to the consumer. Additionally, the policy states, the provider shall continue to pay for services outside the service area until the consumer is no longer in need of such service(s). • Descriptions of 2 actual Out-Of-Network Provider scenarios and supporting documentation including: Continuity of Care Review Overview and Purpose and meeting minutes, Working Agreements between PIHP and Out-Of-Network Providers, LOS extension requests, Referral Logs and Requests, Case Notes, and Out-of-Network Provider Billing Invoices. • Invoices from out-of-network providers showing accounts received and paid. • Descriptions and documentation show evidence of PIHP paying for out-of-network services rather than providers as required in the policy (see, bullet one, above).	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Acknowledgement of Receipt and Understanding forms signed by provider network staff for policy 321. • Provider management aware of out-of-provider network policy and able to articulate basic purpose and processes for referral and payment. Reviewer noted discrepancy in provider management description and policy relating to responsible party for payment. Recommend that PIHP further clarify payment responsibilities in policy and trainings. • Direct Service staff reported having conversations with supervisors on how to make referrals to psychiatrists. Staff knew where to locate PIHP policy and procedure for reference when needed. (Moderate Compliance)	3
438.206 (c)(2)	**Furnishing of Services Continued**	

[Q32]	**Client materials translated according to WAC 388-865-0330 requirements related to language thresholds**
	Evidence:
	• PIHP marketing materials:
	    o Recognizing Mental Illness translated into (Cambodian, Chinese, English, Korean, Laotian, Russian, Spanish, and Vietnamese),
	    o Community Resources translated into (English, Spanish),
	    o Mental Health Services & Information Booklet in English with some Spanish subtitles.
	• No policy and procedures or PIHP Provider Contract language submitted for review as required by Scoring Guide 1.
	• No reference or indication that marketing/education materials are available in Braille, audio or other alternative methods for individuals who may be visually impaired or have limited comprehension of written or spoken English, or who are unable to read per WAC 388-865-015.
	• Marketing distribution list contains log of where marketing materials have been distributed throughout the region.
	• PIHP staff reported that they are not certain as to the available languages or formats of their providers' marketing/educational materials.
	• Provider management reported that they have the DSHS Public Mental Health System Benefits Booklet for people enrolled in Medicaid available in all 8 required prevalent languages. Also reported that Braille or audio formats are currently unavailable.
	• Score remains the same as 2005 EQR due to insufficient	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q33]	**Mechanisms for oversight of culturally competent service standards** Evidence: • Revised 903 Clinical and Administrative Record Review, 906 Provider Agency Credentialing and Clinical Profiling and 311 Cultural Competence policy and procedure contain requirements applicable to this provision. • Sample Clinical Record Review Tool-completed, monitors for involvement of mental health specialist participation as appropriate, cultural history assessed during intake and age, culture and disabilities addressed in plan of care. • Sample Personnel Record Review tool-incomplete; monitors for clinician experience and culturally specific specialty training, assist PIHP in determining if their provider network is able to meet the cultural needs of their Medicaid enrollee population. • PIHP staff reported they are not sure how they are currently monitoring the Cultural Competence Standards outlined in their 311 Cultural Competence policy and procedures. Recommend that PIHP incorporate their Cultural Competence Standards into their Clinical Record Review Tool. • Network provider management reported the PIHP monitors for mental health specialist consults and inclusion of enrollee's culture in treatment plans. One provider provides quarterly trainings and one in the past year was focused on how culture expands beyond race. (Substantial Compliance)	4
438.210(b)	**Authorization of Services**	
[Q41]	**PIHP audits subcontractors for consistent authorization practices and evidence of policy** Evidence: • Revised 205 Intake Authorization, 200-Outpatient Authorizations-Adult, 201-Outpatient Authorizations-Child, 328-Residential Level of Care Authorization, 402 Inpatient Services Authorization, 402B Admission Triage Worksheet, 402C Certification for Admission to Psychiatric Inpatient Care Acute and Long Term Facilities, 402D Request for Inpatient or Crisis Support Unit Authorization, 402E Extensions Request for Hospitalization, 403 Inpatient Services Appeal of Denial, and 405 Use of Single Bed Certification policies and procedures collectively include the PIHP's authorization practices. • PIHP staff conduct all authorizations and certifications for	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	payment for all levels of care as outlined in their policies and procedures. • Authorizations and certifications are processed via fax and electronically concurrently. PIHP is working toward conducting all authorizations and certifications electronically in the near future. • Pre-Intake Evaluation Screening and Authorization/Denial form, completed. • One Eligibility Requirement Criteria Form-Child. • ITA Authorization Numbers tracking form. • Intake Request tracking Form. • One completed Outpatient Record Review Tool, monitors intake evaluations and treatment plans conducted and developed by providers; includes criteria to determine appropriate diagnosis and level of care. • Provider management and direct service staff able to consistently articulate authorization processes. Reported that PIHP recently provided training on the different authorization junctures and related procedures. (Substantial Compliance)	4
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • Revised 109-Medicaid only-Denial or Limit of a Request for Service or Reduction, Suspension or Termination of an Existing Service-Adult/Child, 600-Consumer Rights and Responsibilities, 601-Ombuds Services, 602-Consumer Complaint, Grievance Appeal (Title XIX), and Fair Hearing General Policy Requirements, 602A-Consumer Complaint and Grievance System, 602B-Notice Requirements Title XIX, 602C-Appeal Policy, 602D-Fair Hearing policies and procedures; collectively, they contain the requirements of this provision. • Notice of Action Binder Page employee sign off, Notice of Action Binder Page Steps, Notice of Action Denial Letter Log, Notice of Action Letter, PIHP Mental Health Consumer Survey, and the PIHP Consumer Handbook further define the written processes pertaining to Notice of Action requirements and procedures. • Procedures for Inpatient denial and authorization of services are found in the 402 Inpatient Services Authorization and 403 Inpatient Services Appeal of Denial policy and procedures. For inpatient, the PIHP utilizes a "Denial of Authorization" letter rather than an NOA. The PIHP sends the consumer the PIHP appeal process with the "Denial of Authorization" letter.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• As evidenced in the Notice of Action (NOA) log and steps, denials, reductions, suspensions, and terminations of services are conducted by utilization management at the PIHP. • Employee training sheets indicate PIHP that staff have been trained on how to complete a Notice of Action, the NOA log, and the log location. PIHP tracks which consumers were denied, received reduction, suspension, or termination due to lack of medical necessity in the Notice of Action log. • Notice of Action Log, date of request for service, or service requested not included in log. As a result, it appears the PIHP starts the 14-day clock when the network provider requests authorization rather than the enrollee's initial request for service. Reviewer unable to determine if process and timeframes for NOAs meet requirements. Timeframes for enrollee requests for services, authorizations & denial dates, and NOAs must be tracked to ensure timeframe requirements are being met. • Upon review of a copy of an NOA, reviewer is unable to determine what type of service or point of service was being denied (i.e., intake, outpatient, residential, inpatient, etc.). • Definition of denial in the PIHP's P&Ps and NOA letter differs significantly. Recommend utilizing the same definition in all policies, procedures and related documents. • Providers receive notification of denials, reductions, suspensions, or terminations as part of the authorization/denial notification process. Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Differing reports as to whether the provider receives copy of NOA. PIHP's policies and procedures do not address if provider is notified of NOA. Recommend clarifying provider notification of NOA procedure in policies. (Moderate Compliance)	3
438.210(d)	**Timeframe for decisions**	
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Revised 200-Outpatient Authorizations-Adult and 201-Outpatient Authorizations-Child policies and procedures contain procedures for expedited authorization decisions and extensions. • PIHP provided Authorization policies and procedures training for network provider staff on March 21 and 22, 2006. Documentation included training agenda, PowerPoint, intake case scenarios, attendance rosters, training test, and training evaluations.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• PIHP documented that "as a result of the March 2006 trainings, 95% of attendees reported a better understanding of the 'Authorization Process' and 86% of attendees reported that they felt all elements of Authorizations had been discussed. No attendees reported Expedited Authorizations as a topic that needed further clarification." • Provider direct service staff unfamiliar and unable to articulate purpose and related procedures of an Expedited Authorization. (Moderate Compliance)	3
[Q45]	**Extension of expedited authorization request** Evidence: • Revised 200-Outpatient Authorizations-Adult and 201-Outpatient Authorizations-Child policies and procedures contain procedures for expedited authorization decisions and extensions. • PIHP provided Authorization policies and procedures training for network provider staff on March 21 and 22, 2006. Documentation included training agenda, PowerPoint, intake case scenarios, attendance rosters, training test, and training evaluations. • PIHP documented that "as a result of the March 2006 trainings, 95% of attendees reported a better understanding of the 'Authorization Process' and 86% of attendees reported that they felt all elements of Authorizations had been discussed. No attendees reported Expedited Authorizations as a topic that needed further clarification." • Provider direct service staff unfamiliar and unable to articulate purpose and related procedures for extensions of Expedited Authorizations. (Moderate Compliance)	3
438.224	**Confidentiality**	
[Q49]	**PIHP has HIPAA Confidentiality policies and procedures** Evidence: • PIHP has a comprehensive set of HIPAA policies and procedures which contain the requirements of this provision. • '05-'06 Provider Agreement shows contract language requiring adherence to State and Federal laws, including HIPPA. • Network provider policy and procedure pertaining to confidentiality, collateral information, and access to records. • Letters to network providers distributing PIHP HIPAA P&Ps on 9/08/05; requests that providers review and incorporate policies into their own PIHP Policy and Procedure Manual. • One completed Clinical Record Review Tool monitors for	

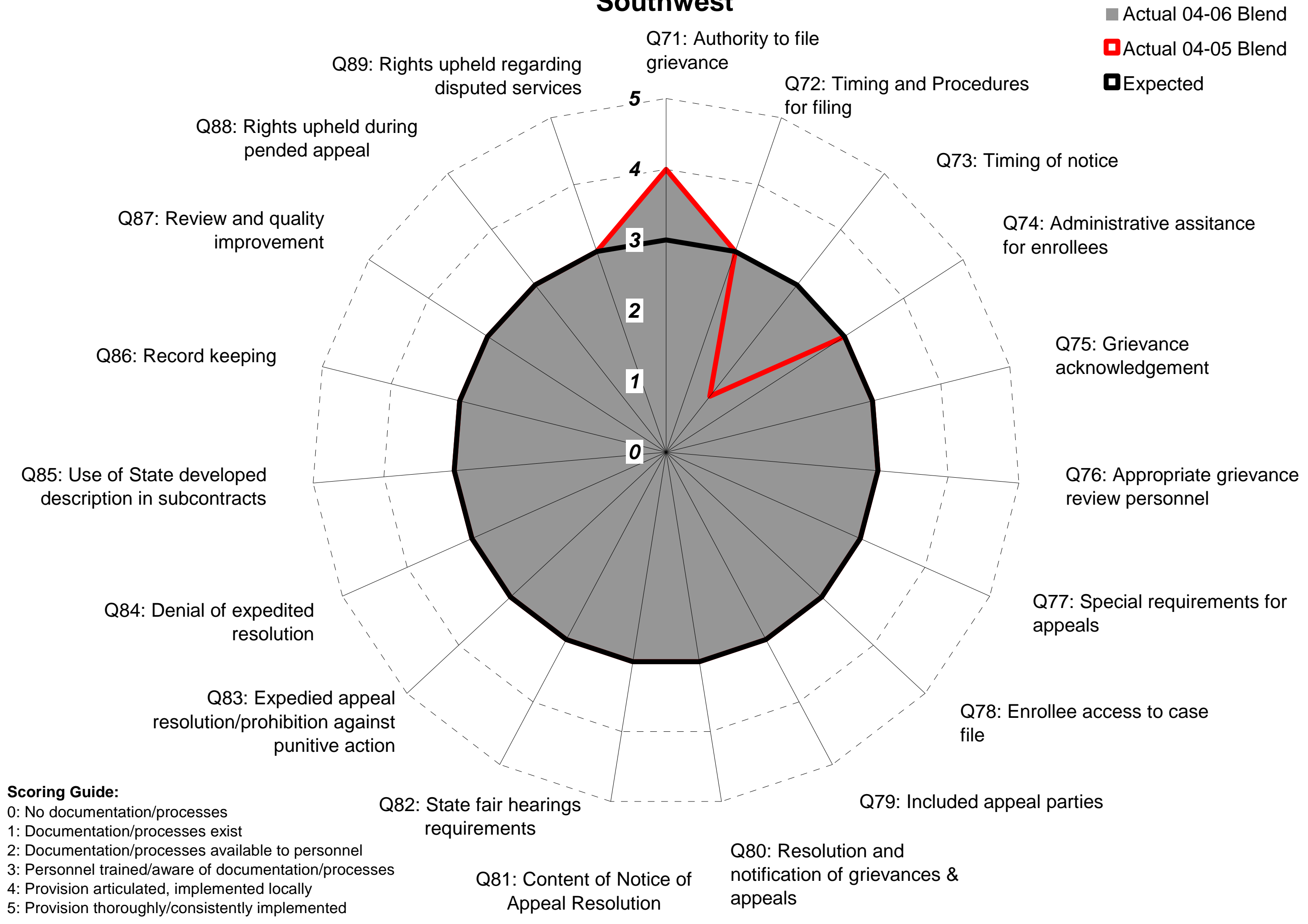
CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	signed Client Authorization to Release Information. • Provider management reported no HIPAA training provided by PIHP since last review; however, they have provided their own internal HIPAA-related trainings for direct service staff. (Moderate Compliance)	3
[Q51]	**PIHP audits subcontractors for privacy compliance** Evidence: • PIHP has a comprehensive set of HIPAA policies and procedures which contain the requirements of this provision. • '05-'06 Provider Agreement shows contract language requiring adherence to State and Federal laws, including HIPPA. • Network provider policy and procedure pertaining to confidentiality, collateral information, and access to records. • Letters to network providers distributing PIHP HIPAA P&Ps on 9/08/05; requests that providers review and incorporate into their own PIHP Policy and Procedure Manual. • One completed Clinical Record Review Tool monitors for signed Client Authorization to Release Information. • Provider management reported no HIPAA training provided by PIHP since last review; however, they have provided their own internal HIPAA related trainings for direct service staff. • PIHP staff and provider management reported that the PIHP conducted a review of personnel records, confidentiality practices, security, PHI, consumer access to records, and 3rd party records during this year's annual review. PIHP reported they "found out enough to know they need to do more training." • No evidence showing how HIPAA audit results are aggregated and incorporated into quality assurance and improvement activities. (Substantial Compliance)	4
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • Revised 917 Sub contractual Relationships and Delegation policy and procedure includes process for evaluating prospective subcontractor ability to perform PIHP-delegated functions. • Revised 906-Provider Agency Credentialing and Clinician Profiling policy and procedures stipulate that contracted mental health providers will complete the credentialing application and clinician profiling, along with the additional documentation listed	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	as required. • Provider credentialing applications and clinician profiling for period of 2005-2006 contract period. • No other pre-delegate audits for additional sub-delegates were submitted for review. • Unable to determine if 917 Sub contractual Relationships and Delegation policy has been implemented with Netsmart Technologies (PIHP's MIS vendor), which houses PIHP data and submits it to MHD. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • Revised 917 Sub contractual Relationships and Delegation policy and procedures contain basic requirements for written delegation agreements. • Revised 906-Provider Agency Credentialing and Clinician Profiling policy and procedures stipulate that contracted mental health providers will complete the credentialing application and clinician profiling, along with the additional documentation listed as required. • PIHP Provider Contract requires compliance with any duties or responsibilities delegated to the Contractor, as identified in Attachment 11. The attachment outlines duties and responsibilities delegated to all providers contracting with the PIHP; delineates the expectations of completeness and competence of implementing these duties and responsibilities, as well as the intent of the PIHP to impose corrective actions, revoke delegated function, or take other remedial actions up to and including termination of the provider contract. • Acknowledgement of Receipt and Understanding forms signed by provider network staff for policy 917. However, there were no signed acknowledgements of receipt and understanding forms from Netsmart employees. • No written agreement between the PIHP and Netsmart Technology was submitted for review; therefore. unable to determine if agreement meets requirements of this provision. (Partial Compliance)	2
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • Documents listed in [Q52] and [Q53]	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Completed Clinical Review Tool and Administrative Audit Tool reviews conducted during review period include provider performance related to delegated functions outlined in Attachment 11. • No annual performance review or other monitoring activities of Netsmart Technologies was submitted for review; thus, unable to determine if PIHP is monitoring the performance of Netsmart on a regular basis. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • Documents listed in [Q52] and [Q53]. • Completed Clinical Review Tool and Administrative Audit Tool reviews conducted during review period include provider performance related to delegated functions outlined in Attachment 11. • 903-Clinical and Administrative Record Review policy and procedures. • Network Provider Audit Exit Letter with recommended quality improvements. • Provider Response Letter with explanation of steps taken and projected to address recommended quality improvements. • No annual performance review or other monitoring activities of Netsmart Technologies was submitted for review; thus, unable to determine if PIHP is monitoring this subcontractor's performance on a regular basis. Also unable to determine if the PIHP has imposed any quality improvements or corrective actions. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.236	**Practice Guidelines**	
[Q56]	**Adoption of practice guidelines meets established requirements** Evidence: • Revised 331-Best Practice Implementation policy and procedures include the basic requirements of this provision. • PIHP selected 4 evidence based practices from SAMSHA to adopt: Illness Management and Recovery, Assertive Community Treatment, Family Psycho education, Co-Occurring	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	Disorders: Integrated Dual Disorders Treatment. These best practices have been based on valid and reliable clinical evidence, and, according to the PIHP, consider the needs of its enrollees. • 9/14/06 QMC minutes indicate that revised policy 331-Best Practices was distributed with the expectation that provider staff would be trained to the changes. • PIHP has ordered the complete manuals for these practice guidelines from SAMSHA, and manuals are available to the providers on a check out basis. • Provider management and direct service staff are able to identify the adopted practice guidelines. • Provider management reported that internal training has occurred on the practice guidelines they have selected to implement from those adopted by the PIHP. (Substantial Compliance)	4
[Q57]	**Dissemination of practice guidelines to providers and enrollees upon request** Evidence: • Revised 331-Best Practice Implementation policy and procedures include the basic requirements of this provision. • PIHP selected 4 evidence-based practices from SAMSHA to adopt: Illness Management and Recovery, Assertive Community Treatment, Family Psycho education, Co-Occurring Disorders: Integrated Dual Disorders Treatment. These best practices have been based on valid and reliable clinical evidence, and, according to the PIHP, consider the needs of the PIHP's enrollees. • 9/14/06 QMC minutes indicate that revised policy 331-Best Practices was distributed with the expectation that provider staff would be trained to the changes. • PIHP has ordered the complete manuals for these practice guidelines from SAMSHA, and manuals are available to the providers on a check out basis. • Provider management and direct service staff are able to identify the adopted practice guidelines. • Provider management reported internal training has occurred on the practice guidelines they have selected to implement from those adopted by the PIHP. (Substantial Compliance)	4
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • Revised 331-Best Practice Implementation policy and procedures stipulate that for each new practice adopted, the	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	UM team must create tools and methods by which the PIHP can monitor fidelity to such practices and provide oversight to ensure their full utilization in clinical services. • No tools and methods of monitoring the adopted practice guidelines were submitted for review. • PIHP and provider staff reported that the PIHP has not begun clinical monitoring of adopted practice guidelines. (Partial Compliance)	2
438.240	**Quality Assessment and Performance Improvement Program**	
[Q61]	**Effective mechanisms to detect under and over utilization** Evidence: • Reviewed 101A-Adult Mental Health Services Enrollment Criteria Form, 202-Authorization Data Requirements, 203-Functional Data Requirements, 400-Inpatient Data Requirements, 403 Inpatient Data Form, 2005 Inpatient Community Hospital Utilization Table-By Age, and SLS Pending Authorization Return Report, and Quality Management Committee Activity Schedule; over and under utilization monitoring processes are not described in these policies and procedures or tables. • PIHP gathers a wide range of utilization data on a variety of populations; however, there was no data analysis describing trends of utilization, and no information on related QA&I activities. • Reviewer was unable to determine how submitted evidence demonstrates mechanisms for detecting over and under utilization. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2



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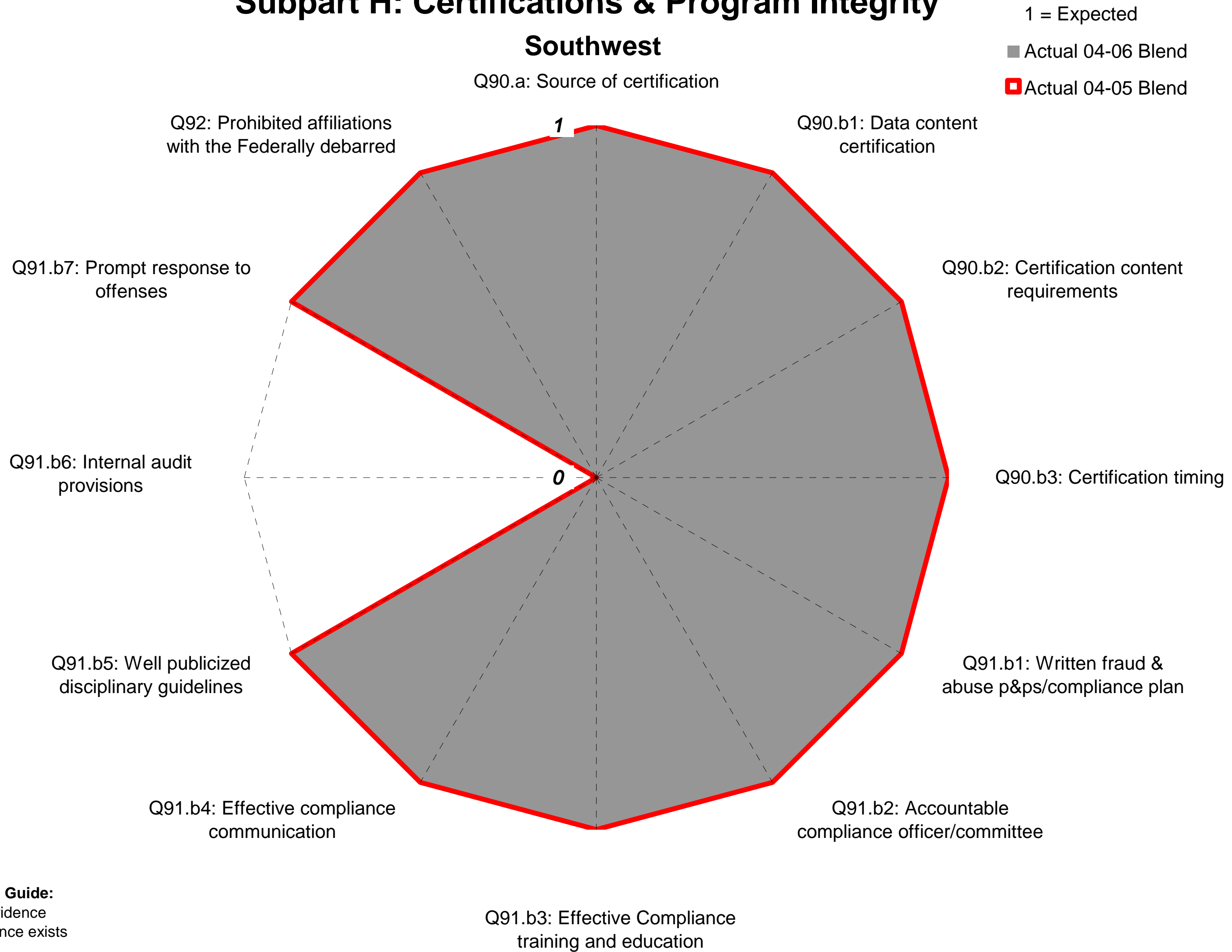
Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	1	3	3
Q74: Administrative assistance for enrollees	3		3
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	3		3
Q87: Review and quality improvement	3		3
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3
0.00	3	3	3

Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.404	**Notice of Action-Timing of Notice**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • Revised 109-Medicaid only-Denial or Limit of a Request for Service or Reduction, Suspension or Termination of an Existing Service-Adult/Child, 600-Consumer Rights and Responsibilities, 601-Ombuds Services, 602-Consumer Complaint, Grievance Appeal (Title XIX), and Fair Hearing General Policy Requirements, 602A-Consumer Complaint and Grievance System, 602B-Notice Requirements Title XIX, 602C-Appeal Policy, 602D-Fair Hearing policies and procedures; collectively, they contain the requirements of this provision. • Notice of Action Binder Page employee sign-off, Notice of Action Binder Page Steps, Notice of Action Denial Letter Log, Notice of Action Letter, PIHP Mental Health Consumer Survey, and the PIHP Consumer Handbook further define the written processes pertaining to Notice of Action requirements and procedures. • Procedures for Inpatient denial and authorization of services are found in the 402 Inpatient Services Authorization and 403 Inpatient Services Appeal of Denial policy and procedures. For inpatient, the PIHP utilizes a "Denial of Authorization" letter rather than an NOA. The PIHP sends the consumer the PIHP appeal process with the "Denial of Authorization" letter. • As evidenced in the Notice of Action (NOA) log and steps, denials, reductions, suspensions, and terminations of services are conducted by utilization management at the PIHP. • Employee training sheets indicate that PIHP staff have been trained on how to complete a Notice of Action, the NOA log, and the log location. PIHP tracks which consumers were denied, received reduction, suspension, or termination due to lack of medical necessity. • Notice of Action Log, date of request for service, or service requested are not included in log. As a result, it appears that the PIHP starts the 14-day clock when the network provider requests authorization, rather than using the enrollee's initial request for service. Reviewer was unable to determine if process and timeframes for NOAs meet requirements. Timeframes for enrollee requests for services, authorizations & denial dates, and NOAs must be tracked to ensure that timeframe requirements are being met. • Upon review of a copy of an NOA, reviewer was unable to	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	determine what type of service or point of service was being denied (i.e., intake, outpatient, residential, inpatient, etc.). • Definition of denial in the PIHP's P&Ps and NOA letter differs significantly. Recommend utilizing the same definition in all policies, procedures and related documents. • Providers receive notification of denials, reductions, suspensions, or terminations as part of the authorization/denial notification process. Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Differing reports as to whether provider receives copy of NOA. PIHP's policies and procedures do not address if provider is notified of NOA. Recommend clarifying provider notification of NOA procedure in policies. (Moderate Compliance)	3



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for Southwest

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse P&Ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well-publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	0	0	0
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1
0.00	1	1	1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification. (1) To the accuracy, completeness, and truthfulness of the data. (Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness, and truthfulness of the documents specified by the State. (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification. (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b6]	**Provisions for internal monitoring** Evidence: • Revised Attachment 1-909 Compliance - Business Ethics and Regulatory Compliance Program and 909C-Internal Fraud and Abuse Employee Requirements policies and procedures (no approval date or signatures) focus on the PIHP's provider monitoring and auditing procedures to detect potential fraud and abuse. Policies do not address the PIHP's internal monitoring practices related to fiscal management, resource, and utilization management, conduct, conflict of interests, etc., to prevent and detect potential fraud and abuse. One procedure addresses screening of PIHP employees to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation as verified through the United States Health and Human Services website at http://exclusions.oig.hhs.gov., and the Excluded Parties Listing System at http://www.epls.gov. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.	

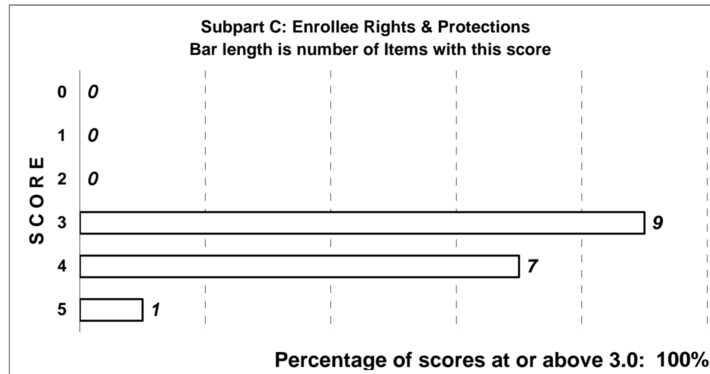
(No Compliance)	0

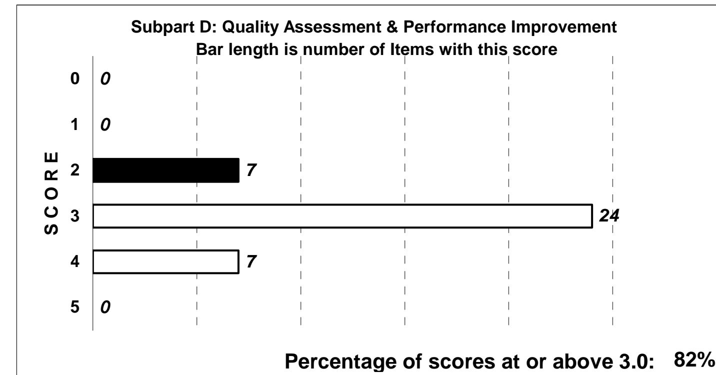
Scoring Frequency Overview

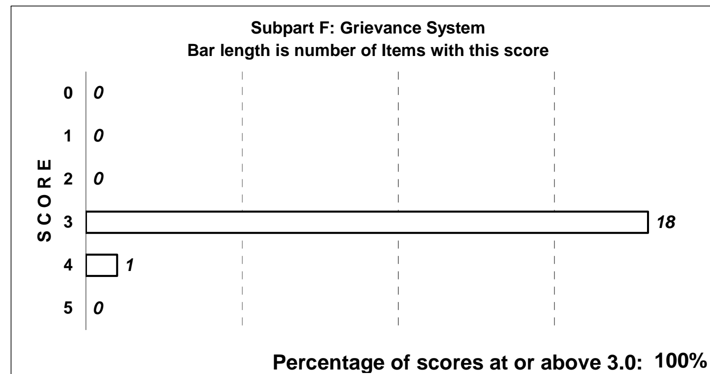
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Southwest

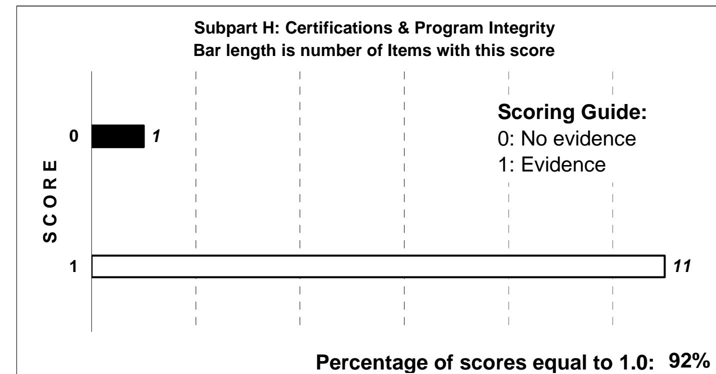
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

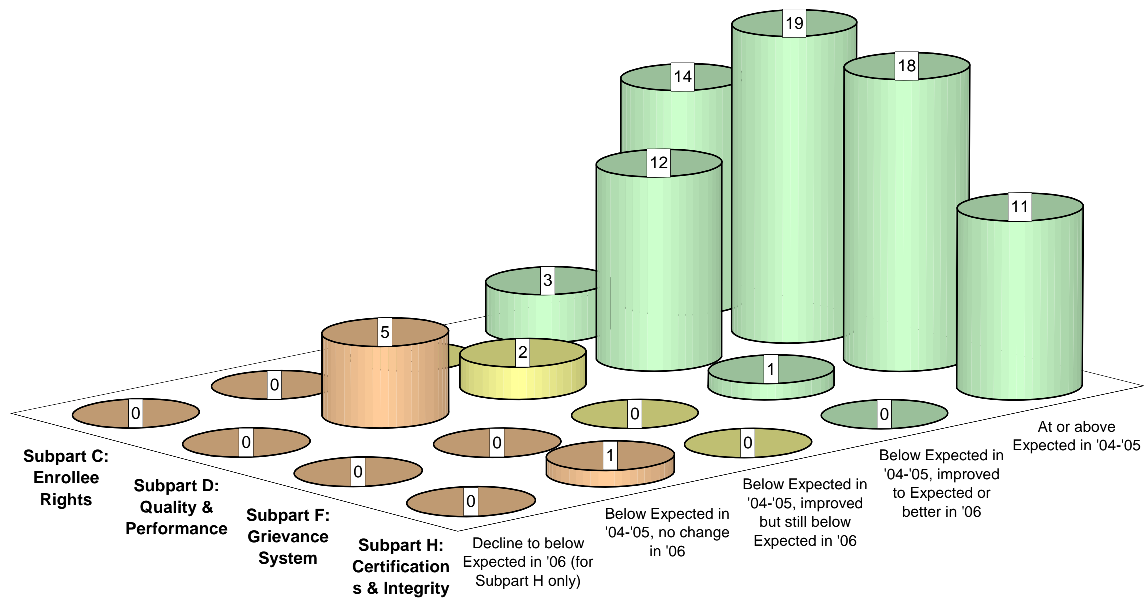
The above charts depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 100%
Subpart D: 82%
Subpart F: 100%
Subpart H: 92%

Southwest PIHP meets the minimum standard for all the specific requirements in Subparts C and F. The PIHP has prioritized Subpart C by ensuring that direct service staff are knowledgeable about rights and protections and provide this information to consumers. With respect to Subpart F, PIHP staff have prioritized ensuring that their network providers have access to grievance system policies and procedures, and have provided basic training in this area. PIHP staff have also met nearly all of the minimum standards of Subpart H by ensuring that all data certifications meet source, content, and timing requirements, and that all but one of the required elements for program integrity are in place.

The Southwest PIHP continues to make progress with respect to Subpart D. Specific areas that remain a challenge include elements related to delegation of PIHP functions, implementation of practice guidelines, and monitoring over and under utilization. In addition, the Southwest PIHP needs to increase the knowledge and application of Subpart D requirements at the level of network providers and their staff.



Score Trend Category	Subpart C: Enrollee Rights Item Count	Percent	Subpart D: Quality & Performance Item Count	Percent	Subpart F: Grievance System Item Count	Percent	Subpart H: Certifications & Integrity Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	5	13.2%	0	0.0%	1	9.1%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	2	5.3%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	3	17.6%	12	31.6%	2	10.5%	0	0.0%
At or above Expected in '04-'05	14	82.4%	19	50.0%	17	89.5%	10	90.9%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**11**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of generalizations or summaries.

Prior to the 2006 review, Southwest PIHP performance relative to Subpart C (*Enrollee Rights*) showed 14 out of 17 items (82.4%) already at or above the Expected level of performance. After the 2006 review, 17 items (100%) are at the Expected level, reflecting improvement in all elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), Southwest PIHP entered the 2006 review with 17 of 19 items (89.5%) already at or above Expected. After the 2006 review, 19 items (100%) meet the Expected level of performance, again indicating improvement in all elements that scored below Expected in 2005.

The improvement Southwest PIHP has made in all four (4) Subparts reflects focused efforts on continuous quality improvement during 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- Evidence of many revised policies and procedures pertaining to the Subpart requirements demonstrates the PIHP's efforts to document, standardize, and operationally define processes to effectively manage care throughout the region.
- The PIHP has a distribution and accountability process for policies and procedures that requires provider network staff to sign and submit an Acknowledgement of Receipt and Understanding.
- The PIHP's adopted practice guidelines/evidence-based practices are relevant to the needs of the region's enrollee population, and are of value and interest to the provider network.

Subpart Challenges

- The PIHP lacks quality assurance and improvement activities related to a majority of Subpart review elements. Monitoring tools are outdated and require revision to incorporate BBA requirements and the PIHP's revisions to their policies and procedures.
- PHIP staff are challenged in effectively using the data they generate for aggregate data analysis and formulating quality improvements.
- PIHP staff are unclear as to which PIHP functions require the application of subcontractor delegation conditions.

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Clarify definition of denial, 14-day start point for enrollee request for services, and provider receipt of Notice of Action in grievance system policies and procedures and NOA letter.

3. Establish well-defined procedures for collecting and analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

4. Clarify delegated PIHP functions and develop processes related to sub-delegation:
    - Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    - Review their related performance on an annual basis.

5. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

6. Develop and incorporate into policy specific client marketing and educational material requirements. Emphasize procedures related to translation of materials into all prevalent languages and alternative formats, and define particular client materials expected to be made regularly available.

7. Revise and update monitoring tools incorporating review elements related to the BBA and the PIHP's new and revised policies and procedures.

8. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate measures evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited to a technical assistance review and, as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which, if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   This item remains unchanged from the 2005 review status. The PIHP plans to formalize this activity.

   IT staff indicate that their new system transmits only State-specified codes. They attempt to have providers use only these codes. For items that require a special code, providers need to enter the new code into the system, then crosswalk to the State-specified codes. The crosswalk is maintained by the Southwest RSN. Because this is a new system, IT staff do not yet have a written crosswalk process and procedure.

2. Unique member ID
   The new system uses a data query to search for duplicate member IDs. Once potential duplicates are flagged, the IT manager checks the data to determine whether flagged IDs are indeed duplicates. If so, the information is merged into the original member ID.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   Their system can track individuals across product lines, enrollment, disenrollment, and re-enrollment.

4. Calculating member months
   This item remains unchanged from the 2005 review. PIHP staff stated that their new system has the capability to track member months. They also reported that they are developing methods to calculate member months.

5. Member database
   The PIHP uses data made available by MHD for its member database. This data

is imported into an SQL database and maintained for use in financial eligibility checks.

6. Provider Database
   The PIHP maintains provider data as part of an effort to move their payment system to a "fee for service" model. Staff also track provider credentials with this database.

7. Data easily under-reported
   As part of their fiscal accounting system, PIHP staff state that they track services provided by out-of-network providers. They state they capture this data for entry into their encounter system. PIHP staff did not submit a policy and procedure for this process.

Performance Measurement Summary

Southwest PIHP has strong pre-submission screening processes on its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. Unfortunately, their efforts fell short in this year's analysis and encounter validation review (described below). The overall score of Partially Met in the 2006 encounter validation review has a negative impact on the general state of the PIHP's performance measure accuracy. Therefore, the general state of their data is evaluated as "fair", despite being aided by the 2005 performance. Unfortunately, no steps are being taken to help bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- This PIHP has strong pre-submission processes to identify errors before data is entered into their system. These processes are largely responsible for the fairly positive results in last year's encounter validation.

PM Challenges

- All areas discussed in the encounter validation review later in this report are relevant here.
- The PIHP has done little to reconcile data already in their system. This data could provide much useful information in a variety of QA/QI areas.
- Since the last review cycle, the PIHP has made little, if any, progress on the topical items listed above .

PM Recommendations

1. Develop a policy and procedure outlining the requirement for data submission when out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two submitted PIPs for Southwest PIHP: Hospital Diversion/Inpatient Utilization, which was identified by the PIHP as clinical. Included in the desk review were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and to evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006 (see, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

The PIP reviewed was titled, "Hospital Diversion/Inpatient Utilization" and was identified as a clinical PIP. The PIHP submitted a brief summary of their activities, a self-validation, and various reports covering admissions and readmissions for the community hospital and the state hospital between 2001 and the end of 2005. The PIHP also submitted a report of "liquidated damages" (money paid to the State for over utilization of State Hospital beds) between late 2003 and February 2006.

Southwest had determined that, in general, their inpatient utilization was more than twice the rate of the state; thus, the PIHP developed some community-based alternatives in an attempt to reduce inpatient use. Their study question stated: "*Can a strategic investment of approximately $1.2 million in 2004 in new hospital diversion programs be sufficient to reduce our inpatient utilization rate to the extent that the hospital diversion programs could generate enough cost savings to become self-sustaining over time?"* The PIHP developed three community-based alternatives – a crisis unit, some managed and cluster housing, and a Program of Assertive Community Treatment (PACT) team. The PIHP also evaluated the cost of these services against their hospital costs, though their methodology lacked considerable detail and specificity. These programs were implemented in 2004 and 2005. While all programs are generating "activity", inpatient use at Western State Hospital has not diminished, and the PIHP is considering other

alternatives.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).		X			Use of inpatient care, if not clinically warranted but rather reflects the only alternative to minimal community options, can be deleterious to consumers' long term recovery.
1.2. Is selected following collection and analysis of data (or was selected by the State).		X			Based on data indicating excessively high admission and readmission rates to community and state hospital, compared to rest of state
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	
1.4 Includes all eligible populations that meet the study criteria.			X		Developing criteria for "eligible population" was part of study – did not sufficiently address the comparison
1.5 Has the potential to affect member health, functional status, or satisfaction.		X			Yes, although this was not the focus of the PIP
Totals for Step 1:	**0**	**3**	**1**	**1**	
Number of shaded critical evaluation elements met for Step 1: 0/1					
Step 2: Clearly Defined, Answerable Study Questions					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
The written study question or hypothesis:					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.			X		Convoluted question related to financial savings resulting from development of inpatient alternatives
2.2 Is answerable/provable.				X	Question too convoluted
Totals for Step 2:	**0**	**0**	**1**	**1**	
Number of shaded critical evaluation elements met for Step 2: 0/2					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.			X		Indicators and methods for measurement not defined; time frames for measures not defined
3.2. Are based on practice guidelines, with sources identified.		X			Cite work related to PACT teams
3.3 Allow for the study question/hypothesis to be answered or proven.		X			Can see trend of some indicators; e.g. number of admissions
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.		X			
3.5 Have available data that can be collected on each indicator.		X			Data is available; however, indicators need to be further defined and source of data is not identified
3.6 Include the basis on which each indicator was adopted, if internally developed.			X		Not addressed
Totals for Step 3:	**0**	**4**	**2**	**0**	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Number of shaded critical evaluation elements met for Step 3: N/A					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					
4.1. Is accurately and completely defined.			X		Never clarify counting of involuntary admits; never get back to distinguishing between 1st admissions and readmissions
4.2. Includes requirements for the length of a member's enrollment in the MCP.			X		
4.3 Captures all members to whom the study question applies.			X		Not clear – does not describe how they will distinguish between those who could benefit from community alternative and those who could not.
Totals for Step 4:	**0**	**0**	**3**	**0**	
Number of shaded critical evaluation elements met for Step 4: 0/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).			X		Have retrospective numbers but no projections
5.2. Identify the sample size (or use the entire population).			X		Specifics of population not described, but the PIHP intended to use the entire population
5.3. Specify the confidence interval to be used (or use the entire population).				X	
5.4 Specify the acceptable margin of error (or use the entire population).				X	
5.5 Ensure a representative sample of the eligible population.				X	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.			x		
Totals for Step 5:	**0**	**0**	**3**	**3**	
Number of shaded critical evaluation elements met for Step 5: 0/1					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.					None of the data collection methods or tools were provided.
6.2. Identification of specified sources of data.					
6.3. A defined and systematic process for collecting baseline and remeasurement data.					
6.4. A timeline for collection of baseline and remeasurement data.					
6.5. Qualified staff and personnel to abstract manual data.					
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.					
6.7 A manual data collection tool that supports inter-rater reliability.					
6.8 Clear and concise written instructions for completing the manual data collection tool.					
6.9 An overview of the study in written instructions.					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
6.10 Automated data collection algorithms that show steps in the production of indicators.					
6.11 An estimated degree of automated data completeness.					
Totals for Step 6:	**0**	**0**	**0**	**11**	
Number of shaded critical evaluation elements met for Step 6:					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.		X			Multiple major interventions undertaken – made intuitive sense in addressing the problem
7.2 System changes that are likely to induce permanent change.				X	
7.3 Revised if original interventions are not successful.				X	
7.4 Standardized and monitored if interventions are successful.				X	
Totals for Step 7:	**0**	**1**	**0**	**3**	
Number of shaded critical evaluation elements met for Step 7: 0/1					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					
8.1. Is conducted according to the data analysis plan in the study design.			X		Data analysis plan not provided; a set of indicators was identified, but then was confused with “data they wanted to look at”; none were defined with any detail; no numerators/denominators to assist in

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					assessing result
8.2. Allows for generalization of the results to the study population if a sample was selected.				X	
8.3. Identified factors that threaten internal or external validity of findings.					
8.4. Includes an interpretation of findings.				X	
8.5 Is presented in a way that provides accurate, clear, and easily understood information.				X	
8.6 Identifies initial measurement and remeasurement of study indicators.				X	
8.7 Identifies statistical differences between initial measurement and remeasurement.				X	
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.				X	
8.9 Includes the interpretation of the extent to which the study was successful.				X	
Totals for Step 8:	**0**	**0**	**1**	**8**	
Number of shaded critical evaluation elements met for Step 8: 0/2					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.		X			Used same data system to count inpatient admits and days
9.2. There is documented improvement in processes or outcomes of care.		X			Demonstrate decline in # of admissions and days; savings calculated, but methodology not

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					provided
9.3. The improvement appears to be the result of planned intervention(s).			X		No way to tell
9.4. There is statistical evidence that observed improvement is true improvement.			X		Not calculated
Totals for Step 9:	**0**	**2**	**2**		
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.		X			General trend of decreasing numbers of initial admissions and readmissions and calculation of savings; no statistical analysis
Totals for Step 10:	**0**	**1**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 10: N/A					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS
***Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported**
**** Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported**
***** Not Met = Reported PIHP PIP results or plan/activities not credible**
Summary of Aggregate Validation Findings
* ☐ **Met**   * * ☐ **Partially Met**   *** ☒ **Not Met**
Summary of PIP validation findings: The PIHP organized this PIP around financial considerations rather than clinical outcomes, despite significant efforts to develop alternatives to inpatient care. In addition, this PIP appeared to have been created to reflect work that was taking place before PIPs were required and reflects only a rudimentary understanding of the PIP protocol. Nevertheless, the PIHP appears to understand the need for an intervention to study and for data to evaluate pre-and post intervention. APS expects that next year, having attended the State training and with a clear understanding of the protocols, Southwest PIHP will be able to develop and proceed with two PIPs that more closely adhere to the protocol. Doing so will provide them with greater confidence that their efforts are having the desired impact on the outcomes and/or processes of care for consumers.

PIP Strengths

- The PIHP understands the basic concepts of the PIP protocol and recognizes the necessity of studying the results of an intervention
- The study topic addressed a critical aspect of consumer care

PIP Challenges

- As submitted, the PIP is too complicated, with too many data elements and interventions to gain reliable understanding of the outcomes of their efforts.
- The study question is convoluted, making it difficult to understand the task and goals.

PIP Recommendations

1. Use existing data from indicators to identify areas of greatest need and/or potential impact around which to develop new PIPs.

2. Keep the plan simple, and focus on developing details of the intervention and data analysis.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, with minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements (see, Attachment #10, Encounter Validation Document Request). A desk review of submitted documents was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and, in some cases, a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding); identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHP's encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with all documentation requirements, but, during interviews, staff are unable to consistently articulate processes. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	The PIHP thoroughly documents their data requirements. These requirements are set forth in an RSN-specific Data Dictionary that features State requirements as a base with RSN-specific requirements added. Timelines for data submission are consistent between policies and are clearly identified for each type of data specified. No completeness standards were included in the documents submitted and reviewed.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The PIHP communicates data requirements to its provider network.

Item	Rating	Comments
2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Met	The PIHP made some effort to evaluate its provider network capabilities and vulnerabilities. No specific documentation was submitted relative to processes employed by provider agencies. Documenting provider agency processes for entering data into two systems, for example, could help ensure consistency or demonstrate vulnerability.

3. Analysis of provider agencies' data for accuracy and completeness

PIHP Encounter Validation
Process Review

Item	Rating	Comments
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Not Met	The PIHP does not conduct a specific data analysis for the purpose of validating its entire data set for completeness and accuracy. Efforts to verify such data prior to transmission are excellent, but do not provide the views needed to calculate actual completeness values for purposes of this analysis.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Not Met	No tools were submitted for this type of data analysis.
Data is evaluated in a frozen state and archived for future possible use.	Partially Met	Although the entire data set is not subjected to an analysis, the PIHP archives its data at the beginning of each month's reporting cycle. Reports and future analyses can be checked against this archived data.

4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Partially Met	The PIHP has an encounter validation policy that does not specifically meet requirements set forth in the contract between MHD and the PIHP. In part, the contract states (paragraph 6.7): At a minimum, the PIHP will conduct encounter validation checks using the following method. The PIHP must review 1% of all encounters or 250 encounters which ever is least during the first 6 months of the Agreement period. This will include checking the clinical record against the PIHP encounter data for agreement in type of service, date of service and service provider. This review will also verify that the

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		service reported actually occurred. The PIHP's policy on their encounter validation process specifies a similar sampling size and includes provision to check the service type and date; however, it does not include a provision to check the provider, nor a check with respect to validity of the encounter.
PIHP includes additional data elements in matching exercise.	Partially Met	The PIHP does note that they also check programs, credentials, and financial variables. The PIHP does not have a system to check other data elements. If the PIHP had a method to identify such elements, this data could be added to reviews on a rotating basis to ensure eventual scrutiny.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Not Met	The tools used by the PIHP for their EV review were not submitted to APS. A spreadsheet with data was submitted, but the source of this information was unclear.

5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report to the State lists numbers of encounters per chart audited, numbers of encounters matching, numbers of encounters missing, number of charts missing, and percentage of compliance. An audit summary is also provided. Ideally, the report would contain information requested by this tool. At a minimum, documentation should contain:

PIHP Encounter Validation Process Review

Item	Rating	Comments
		• A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Partially Met	PIHP submitted evidence regarding the practice of sharing review exercise results with their providers. Although errors were identified in these reports, requests for corrections were not evident in the documentation provided.
PIHP regularly reports internally for quality improvement activities.	Not Met	No evidence was submitted of encounter validation results being shared or used for any internal quality improvement activities. The documents provided did not detail any improvements processes required due to issues identified during the encounter validation exercise.

6. Follow-up activities

PIHP Encounter Validation
Process Review

Item	*Rating*	*Comments*
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Not Met	The policies submitted did not provide any details of oversight of the follow-up activities.
If warranted, evidence of follow-up activity was presented.	N/A	

Summary of Encounter Validation Findings

Score Met _15.5_ %

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings					
	Met		Partially Met		Not Met

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP fall short of requirements set forth in the contract between MHD and the PIHP. The encounter validation review did not include all items specified in the contract. Some efforts were made to validate other data elements, but more needs to be done to make this process comprehensive. Additional steps were not made to ensure that encounters checked actually took place. An analysis of the PIHP's data for the purpose of an encounter validation was not conducted.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. Had the entire tool been used in computing the score, the PIHP would have fared equally well, with 15.5% of all items meeting a score of Met, 38.5% at Not Met, and the remaining 46% at Partially Met.

EV Strengths

- Process details are comprehensive in the new policies and procedures.
- Pre-submission screening of provider data prior to transmission helps keep their data clean.

EV Challenges

- Verification of encounters while staff are engaged in software implementation is not ideal.

EV Recommendations

1. Document in a policy the completeness standards the PIHP is going to use for its data.

2. Conduct analyses of the PIHP's data. Preferably, this would be accomplished on a frozen dataset (a copy of the "live" data held in a database other than that being used by the RSN and providers). Such analysis needs to be conducted for two reasons: (1) there is no chance for errors being introduced to the data through the analytical process, and (2) the data can be revisited for further analysis or research.

3. Modify the existing encounter validation policy to meet requirements of the contract the PIHP has with the State.

4. The PIHP's encounter validation reports to the State need to be stand-alone documents that explain its entire encounter validation program. The comments in number 5 in the Encounter Validation tool indicate more specifically what should be included.

5. Employ a more system-wide approach to conducting an encounter validation. The current approach assumes that errors found were corrected, and potential errors may have been avoided. Nonetheless, an increased emphasis placed on systemic issues may yield critical information about wider problems in the PIHP's dataset.

6. Create a cross-reference between the complete data set collected and the process for ensuring its accuracy and completeness. This tool would enable the PIHP to ensure that adequate oversight exists for each required data element.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. Each standard was then scored separately and the number of Met/Partial/Not Met summed for each. Total percentages are calculated by dividing the number in each category of Met/Partial/Not Met by the total number of items scored. Scores greater than 80% are considered an overall Met score; 65% to 79% is Partially Met, and those below 65% are considered overall as Not Met.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Southwest RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		2		• The QAI plan needs to document the involvement of Finance and IT to have a comprehensive process; • Missing some key elements; e.g., an Annual Work Plan, PIPs, indicator detail that would define methods of measurement, targets, reporting schedules.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.	4			• Yes, the plan is reviewed in January or March and implemented throughout the year.
C. Plan includes annual work plan and process for review of associated activities and progress.		3		• No mention of Annual Work Plan in QM Plan;

PIHP: Southwest RSN

Requirement	Met	PM	Not Met	Findings Comments
				• Work Plan appears to be a separate document and includes a process for developing plans, implementing and reviewing; subcommittees established for each of 9 identified activities. • Topics for work plan were selected by Quality Manager based on results of EQRO, RFQ requirements, and minutes from QMC. Topics were not selected based on analysis of data from previous year. • Elements of plan include some QI activities plus exploration of some administrative activities for possibility of improvement. Appears to describe wide range of tasks for the coming year, not all of which could be considered true QI.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		**2**		• The description of provider review is unfocused and includes no discussion of specifics with respect to the follow-up/Corrective Action process. • PIHP provided annual schedule of provider review reports to QMC.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	**4**			• Plan identifies multiple venues for meaningful input from providers and consumers and their families.

PIHP: Southwest RSN

Requirement	Met	PM	Not Met	Findings Comments
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		2		• PIHP staff submit that the committee is supposed to meet every other month, but has not done so in the last year due to other tasks (RFQ) and staffing changes; this is in conflict with Plan which requires monthly meetings. • Staff state that they are considering monthly meetings. • QM meeting minutes are very brief with little information about results of reviews, data from reports (which were not provided), or content of narrative reports from Subcommittees; little evidence of analysis and/or action to be taken as a result of any discussions. • Documents submitted confirming provider visits/exit letters, requests for CA; providers confirm visits, feedback as evidenced. • Provider states RSN audits personnel files annually – were there in June for full annual audit. • Providers report having input on development of Practice Guidelines.
Standard 1 Count (Target 6 Met):	**2**	**4**	**0**	**Target Points: 24 Actual: 17**

PIHP: Southwest RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			• September 2005 review results letters (provided for 3 agencies) indicate chart reviews covering some of the elements in the tool; • Completed individual chart reviews provided spanning various providers and time frames from late 2005 through March 2006. • PIHP states they review 10% of charts annually; get out to providers almost every month and conduct chart reviews; • Conducted personnel and clinical record reviews in May, 2006, per letters to EDs; did not include actual review documents, so no information about content covered. • Providers confirm almost monthly site visits with feedback to staff and written summaries/requests for Corrective Actions, if indicated.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**2**		• Provided sample (not filled out) "Voluntary and Involuntary Outpatient Record Review Tool"; • Tool addresses everything in QM Plan;

PIHP: Southwest RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• Scoring methodology not apparent from review of tool; does not have method or place to document total score for each record. • Tool is long and redundant; scoring standards not articulated for "underdeveloped, standard, etc.", although does have an "interpretive guide" for each question • Tool is outdated and does not accurately reflect BBA or WAC standards and requirements
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.			**0**	• RSN states they do not do this, though they have developed a policy and are waiting for participation of their Medical Director. • Tool includes an interpretive guide for each item being scored, but no standards for each possible rating.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**3**		• No documented evidence provided that CAs referenced in letters to providers were submitted or tracked for implementation. • RSN does not have an internal tracking system to ensure that all activities related to requested CAs are occurring within required timeframes and that loops are closed regarding completion of planned/accepted corrective action

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PIHP: Southwest RSN

Requirement	Met	PM	Not Met	Findings Comments
				plans. • RSN states that, by policy an agency has 30 days to get CA plan to them; RSN then follows up on problematic cases during next review and documents completion in the relevant exit report. • Providers confirm that RSN responds in writing to submitted Corrective Action plans and provides confirmation of completion, in writing or at next site visit, depending on the topic. • Providers state that chart audits do involve employees; supervisors review charts with RSN and provide feedback to clinical staff.
Standard 2 Count (Target 4 Met):	**1**	**2**	**1**	**Target Points: 16 Actual: 9**

Standard
3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)

Requirement	Met	PM	Not Met	Findings Comments
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		**1**		• Minutes for 2 meetings in early 2006 contained brief mention of provider audits and utilization reports; no

PIHP: Southwest RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				supporting reports or documents provided. No specific data provided. • Schedule of provider review reports at QMC indicates plan for reporting on each provider 3 times/year.
B. PIHP analyzes and trends individual provider performance.			**0**	• PIHP provided evidence of chart review summaries provided to agencies for specific site visits. • PIHP did not provide evidence of reports that trend agency performance over time. • Minutes of QMC indicate some discussion of agency-specific review results – reports not provided.
C. PIHP analyzes and trends system-wide performance.			**0**	• No evidence provided of system-wide reports trending and analyzing performance on reviews.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.			**0**	• Mention was made of provider reviews in Quality Management Committee minutes – there was, however, no detail provided nor any reports supporting statements noted in the minutes. • No evidence that clinical quality results were reported in any other venue.
Standard 3 Count (Target 4 Met):	**0**	**1**	**3**	**Target Points: 16 Actual: 1**

PIHP: Southwest RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**1**		• Policy 602 – Consumer Complaint Grievance Appeal Fair Hearing: requires providers to track events/timelines/outcomes – analyze trends and use in QM committee for system change, if needed. • Provided log of NOAs in Excel file with data only – no analysis. • Evidence in QMC minutes of brief discussion of Ombuds report (not provided).
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.		**2**		• QM Plan mentions review of complaints and appeals once as part of list of quality reviews conducted. • Complaint policy requires provider reporting, trending, use for QAI, in committee. • No mention in QM minutes of any reporting of complaints, grievances, and appeals; however, Ombuds report referenced as being circulated. No discussion described. • Providers report that this information is compiled by them and reported monthly

PIHP: Southwest RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				to QMC; they have seen some analysis and QI activities related to addressing requirements related to 2nd opinions. • Ombuds states she attends all QMC meetings and reports on serious concerns, such as length of time to get an appointment; types of complaints; her numbers are entered into Exhibit N report quarterly.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.		**3**		• RSN provided no evidence of training regarding grievance and appeals. • Provider staff reports they get trained as Intake workers when they start; sometimes get information about changes in staff meetings; trainings provided in general for all staff – RSN has trainings several times annually, and grievance and appeal included periodically (last one approximately 5 months ago). • Staff able to describe role in complaint/grievance process. • Ombuds demonstrated thorough understanding of role; obtained information and training from multiple sources, including RSN policies, orientation with previous Ombuds, attendance at provider staff meetings, and quarterly Ombuds meetings

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PIHP: Southwest RSN

Requirement	Met	PM	Not Met	Findings Comments
				conducted by WIMRT.
Standard 4 Count (Target 3 Met):	0	3	0	Target Points: 12 Actual: 6
Grand Totals Count (Target 17 Met): 3				Target Points: 68 Actual: 33

Summary Quality Assurance and Improvement Findings
Southwest PIHP has accomplished much of what is needed to design and implement an effective QAI plan. As described in the Plan, their structure could be very effective in ensuring that information is provided to the appropriate stakeholders, and decisions about system improvements are made and monitored at appropriate levels in the QAI structure. Because the PIHP did not provide reports that are reviewed in their Quality Management Committee, and the minutes lacked detail, it was difficult to ascertain the extent to which that body performed to its fullest potential. Discussions with network providers, however, revealed a close working relationship in which there is a great deal of contact in a variety of forums, with feedback going in both directions. Despite the inconsistency of QMC meetings over the last year, the PIHP did keep up with clinical oversight activities and has made progress on some of the projects defined in their Annual Work Plan.

QAI Strengths

- The PIHP has maintained a vigorous site visit schedule this past year, despite distractions of an RFQ, the departure of the RSN Administrator, and a new contract to implement for September 2006.
- IT and Finance representatives sit on the Quality Management Committee, ensuring a full system process.
- The PIHP provides timely and useful information to providers about site visit results and follows through with Corrective Action requests.
- The PIHP engages participation of providers, consumers, and other stakeholders in all aspects of assessing quality of care.

QAI Challenges

- It will be important for the PIHP to re-engage the QMC and use that forum as an effective working group, empowered to analyze reports, make recommendations, and track results of QI activities.

QAI Recommendations

1. Streamline the QM Plan to reduce redundancy and clarify goals.

2. Create a matrix of indicators that clearly and specifically define what will be looked at, how it will be measured, target results, level of performance requiring action, and reporting frequency and responsibility.

3. Develop data analysis capabilities to support effective use of information gathered and reported. Create reports that trend results over time for individual agencies and for the system as a whole.

4. For Annual Work Plan, select 2-4 activities that reflect high priority improvements; use data from previous year to assist in selection. It is not necessary to address all needs in a given year.

5. The chart monitoring tool requires revision to support compliance with BBA and WAC standards; inter-rater reliability training should be implemented as a key aspect of effective monitoring.

6. Expand meeting minutes to reflect greater detail of discussions and attach copies of reports. Someone who missed a meeting would be unable to understand discussion details from the minutes submitted to APS.

Recommendations

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Clarify definition of denial, 14-day start point for enrollee request for services, and provider receipt of Notice of Action in grievance system policies and procedures and NOA letter.

3. Establish well-defined procedures for collecting and analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

4. Clarify delegated PIHP functions and develop processes related to sub-delegation:
    - Conduct a formal evaluation of subcontractor ability to perform PIHP- delegated functions prior to their delegation;
    - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    - Review their related performance on an annual basis.

5. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

6. Develop and incorporate into policy specific client marketing and educational material requirements. Emphasize procedures related to translation of materials into all prevalent languages and alternative formats, and define particular client materials expected to be made regularly available.

7. Revise and update monitoring tools incorporating review elements related to the BBA and the PIHP's new and revised policies and procedures.

8. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

Performance Measure Recommendations

1. Develop a policy and procedure outlining the requirement for data submission when out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

Performance Improvement Project Recommendations

1. Use existing data from indicators to identify areas of greatest need and/or potential impact around which to develop new PIPs.

2. Keep the plan simple, and focus on developing details of the intervention and data analysis.

Encounter Validation Recommendations

1. Document in a policy the data completeness standards the PIHP will implement.

2. Conduct analyses of PIHP data. Preferably, this would be accomplished on a frozen dataset (a copy of the "live" data held in a database other than that being used by the RSN and providers). Such analysis needs to be conducted for two reasons: (1) there is no chance for errors being introduced to the data through the analytical process, and (2) the data can be revisited for further analysis or research.

3. Modify the existing encounter validation policy to meet contract requirements the PIHP has with the State.

4. The PIHP's encounter validation reports to the State need to be stand-alone documents that explain its entire encounter validation program. The comments with respect to number 5 in the Encounter Validation tool indicate more specifically what should be included.

5. Employ a more system-wide approach to conducting an encounter validation. The current approach assumes that errors found were corrected, and that potential errors may have been avoided. Nonetheless, an increased emphasis on systemic issues may yield critical information about wider problems in the PIHP dataset.

6. Create a cross-reference between the complete data set collected and the process for ensuring its accuracy and completeness. This tool would enable the PIHP to ensure that adequate oversight exists for each required data element.

Quality Assurance and Improvement Recommendations

1. Streamline the QM Plan to reduce redundancy and clarify goals.

2. Create a matrix of indicators that clearly and specifically define what will be looked at, how it will be measured, target results, level of performance requiring action, and reporting frequency and responsibility.

3. Develop data analysis capabilities to support effective use of information gathered and reported. Create reports that trend results over time for individual agencies and for the system as a whole.

4. For Annual Work Plan, select 2-4 activities that reflect high priority improvements; use data from previous year to assist in selection. It is not necessary to address all needs in a given year.

5. The chart monitoring tool requires revision to support compliance with BBA and WAC standards; inter-rater reliability training should be implemented as a key aspect of effective monitoring.

6. Expand meeting minutes to reflect greater detail of discussions and attach copies of reports. Someone who missed a meeting would be unable to understand discussion details from the minutes submitted to APS.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Pierce County
Prepaid Inpatient Health Plan

External Quality Review
2006

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APS HEALTHCARE
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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Pierce County PIHP is responsible for managing mental health care and services for Medicaid consumers in Pierce County, in the state of Washington. The PIHP is located in Tacoma, Washington and, as of June 2006 is governed by a board comprised of three County Council members, three members of the County Executive's office, and three members from the community. The PIHP Administrator reports to the Board. The PIHP contracts with six community mental health centers and specialty providers, which serve approximately 8,500 adult and child consumers on a monthly basis. Total annual Medicaid enrollment in the PIHP is about 133,000. The PIHP does not delegate any managed care functions.

This report covers the period between November 7, 2005 and November 6, 2006, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and

an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	

Activity	Timeline	Documents/Content
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	October 6, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	October 20, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	November 6, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	November 21, 2006	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	November 29, 2006	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	December 20, 2006	
4. Debrief conference call	January 9, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	January 17, 2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities.

Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Pierce County PIHP did submit a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Pierce County PIHP, significant events include:

- The governance of the PIHP changed significantly in 2006. Prior to the change, governance was the responsibility of the County Executive and his Chief of Staff. In June, a new Governing Board was created, comprised of elected officials, the County Executive's office, and members of the community. This change also included a decision to separate functions of the RSN Administrator from those of the larger social services agency, resulting in the recruitment of a new RSN Administrator. This activity required significant time and energy on the part of RSN staff required to orient a new board with no prior knowledge of the mechanics/requirements of the State or County mental health system.

- The hospital used for community-based inpatient services was closed during the review year; that facility subsequently became a licensed RTF that includes an Evaluation and Treatment unit (E&T), a 16-bed detox unit, and a 16-bed triage center also housing the Mobile Outreach Crisis Team.

- In September 2006, the PIHP shifted its utilization management functions from a delegated, private MCO to the PIHP staff, having determined that the MCO was not performing at an acceptable level. This move required organizational changes and policy/procedure development in partnership with its provider network.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- The PIHP's policies contain current procedures as well as procedures that are no longer effective. In addition, the PIHP submitted blank forms and significant documentation outside the review period. Therefore, determining current practices and procedures was challenging.

4. 2006 Review Results

This report provides results and a summary of Pierce County PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Pierce County PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.224 [Q51]	**PIHP audits subcontractors for privacy compliance**			
	No evidence that PIHP ensures through audits of their subcontractors that procedures are in place that protect privacy according to the provision of 45 CFR.	Submit a corrective action plan to the MHD by 4/4/05	CAP submitted- date unknown	CAP was implemented by PIHP. However, the PIHP HIPAA Compliance Confirmation Letters to providers were dated October 23, 2006, a year after providers were required to submit their HIPAA P&Ps to the PIHP. Interviewed provider management reported they had not received any response or feedback (including letters

APS HEALTHCARE
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CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
				referenced above) from the PIHP on their policies and procedures. No evidence of PIHP conducting provider monitoring related to HIPAA security requirements. PIHP has attained a score of 2**-** **Partial Compliance**.
438.242	**Health Information Systems**			
	No Evidence of reports that are used to verify the accuracy of data submitted.	Submit a corrective action plan to MHD by 4/4/05	CAP submitted-date unknown	The PIHP instituted a process to conduct data integrity audits of all providers. Evidence of these checks and the tools used by the PIHP were reviewed by the WAEQRO. This item should be considered completed.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence

reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D, and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Pierce County PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

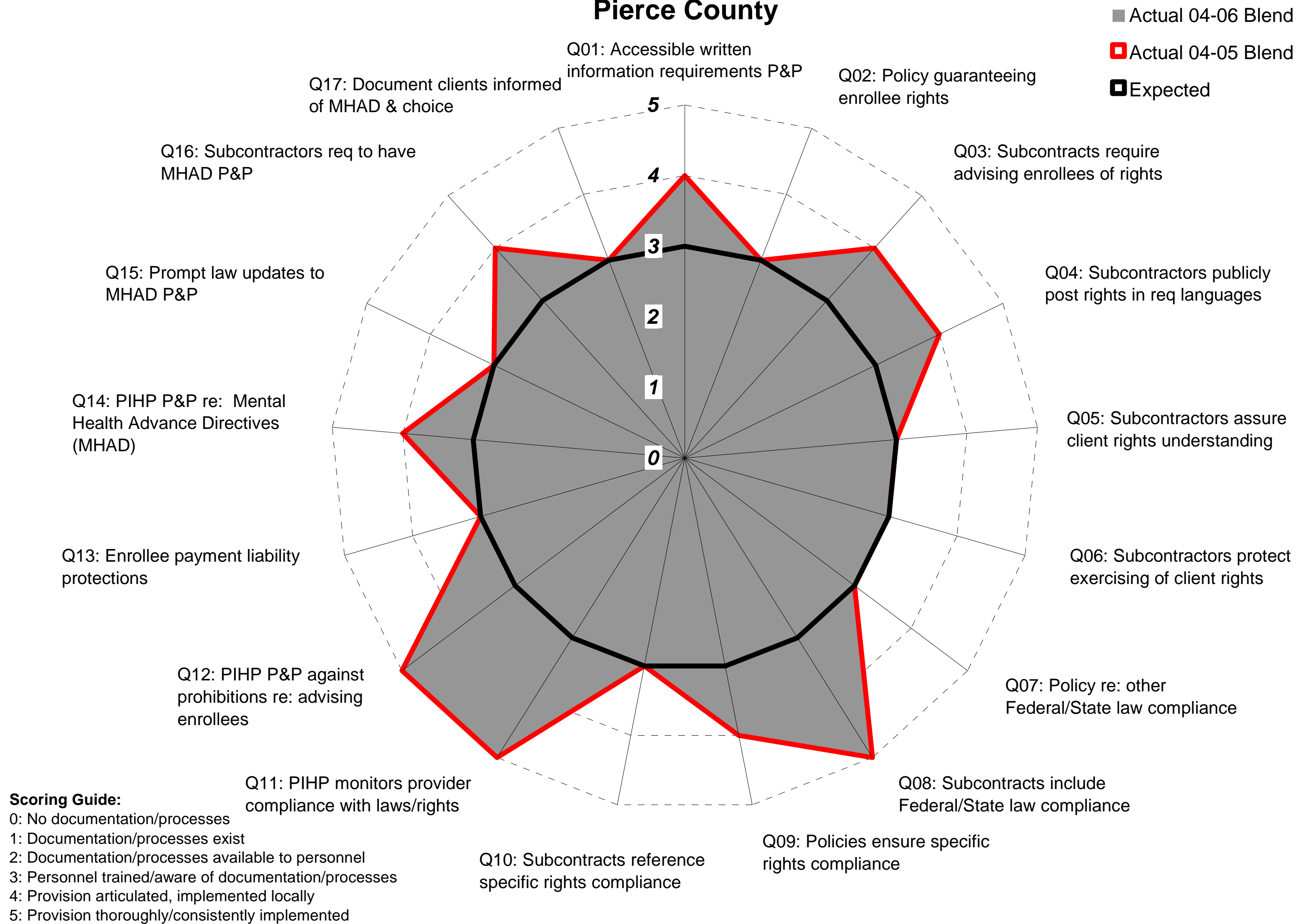
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Pierce County

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
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5: Provision thoroughly/consistently implemented

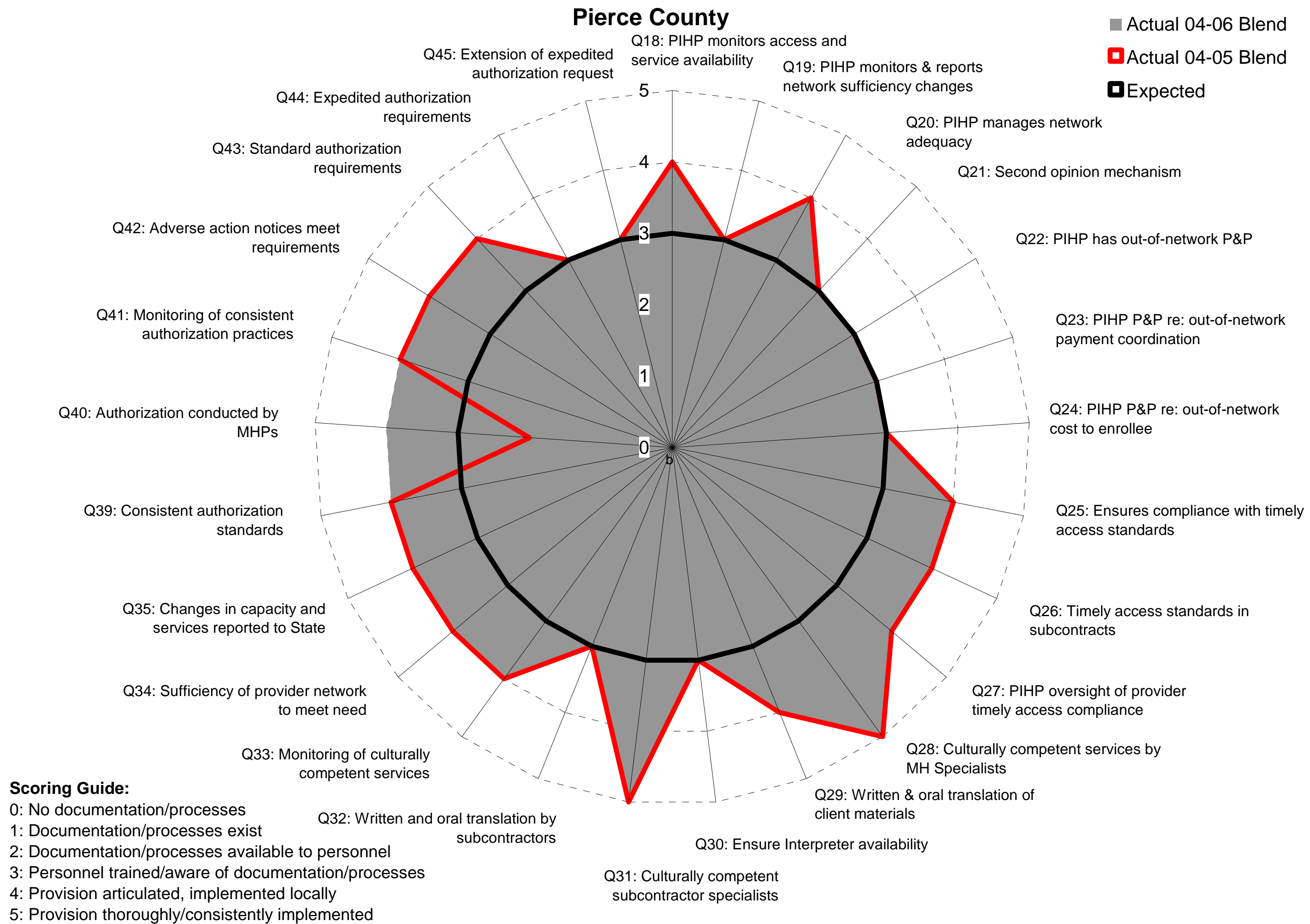
Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	4		4
Q02: Policy guaranteeing enrollee rights	3		3
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	4		4
Q05: Subcontractors assure client rights understanding	3		3
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	3		3
Q08: Subcontracts include Federal/State law compliance	5		5
Q09: Policies ensure specific rights compliance	4		4
Q10: Subcontracts reference specific rights compliance	3		3
Q11: PIHP monitors provider compliance with laws/rights	5		5
Q12: PIHP P&P against prohibitions re: advising enrollees	5		5
Q13: Enrollee payment liability protections	3		3
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	4		4
Q17: Document clients informed of MHAD & choice	3		3

Pierce County PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

Pierce County PIHP achieved Expected compliance for all Subpart C scores in 2005. Therefore, no Subpart C review elements were re-scored in 2006.

Subpart D (Part 1): Access Standards



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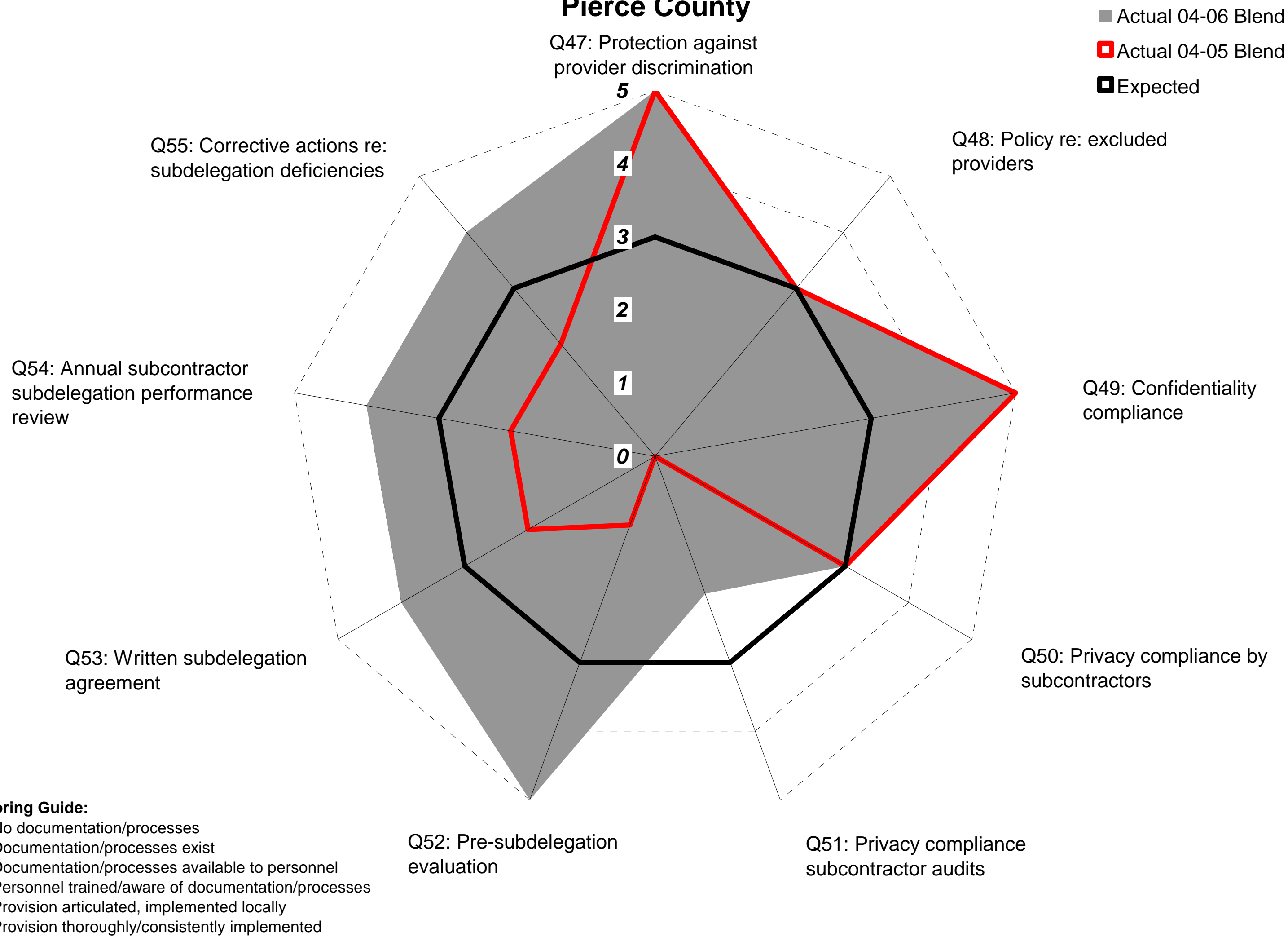
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	4		4
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	4		4
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	3		3
Q24: PIHP P&P re: out-of-network cost to enrollee	3		3
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	4		4
Q27: PIHP oversight of provider timely access compliance	4		4
Q28: Culturally competent services by MH Specialists	5		5
Q29: Written & oral translation of client materials	4		4
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	5		5
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	4		4
Q34: Sufficiency of provider network to meet need	4		4
Q35: Changes in capacity and services reported to State	4		4
Q39: Consistent authorization standards	4		4
Q40: Authorization conducted by MHPs	2	4	4
Q41: Monitoring of consistent authorization practices	4		4
Q42: Adverse action notices meet requirements	4		4
Q43: Standard authorization requirements	4		4
Q44: Expedited authorization requirements	3		3
Q45: Extension of expedited authorization request	3		3



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2004-2006 Subpart Scoring Trend and Detail for
Pierce County

Scoring Guide for Subparts C, D and F:
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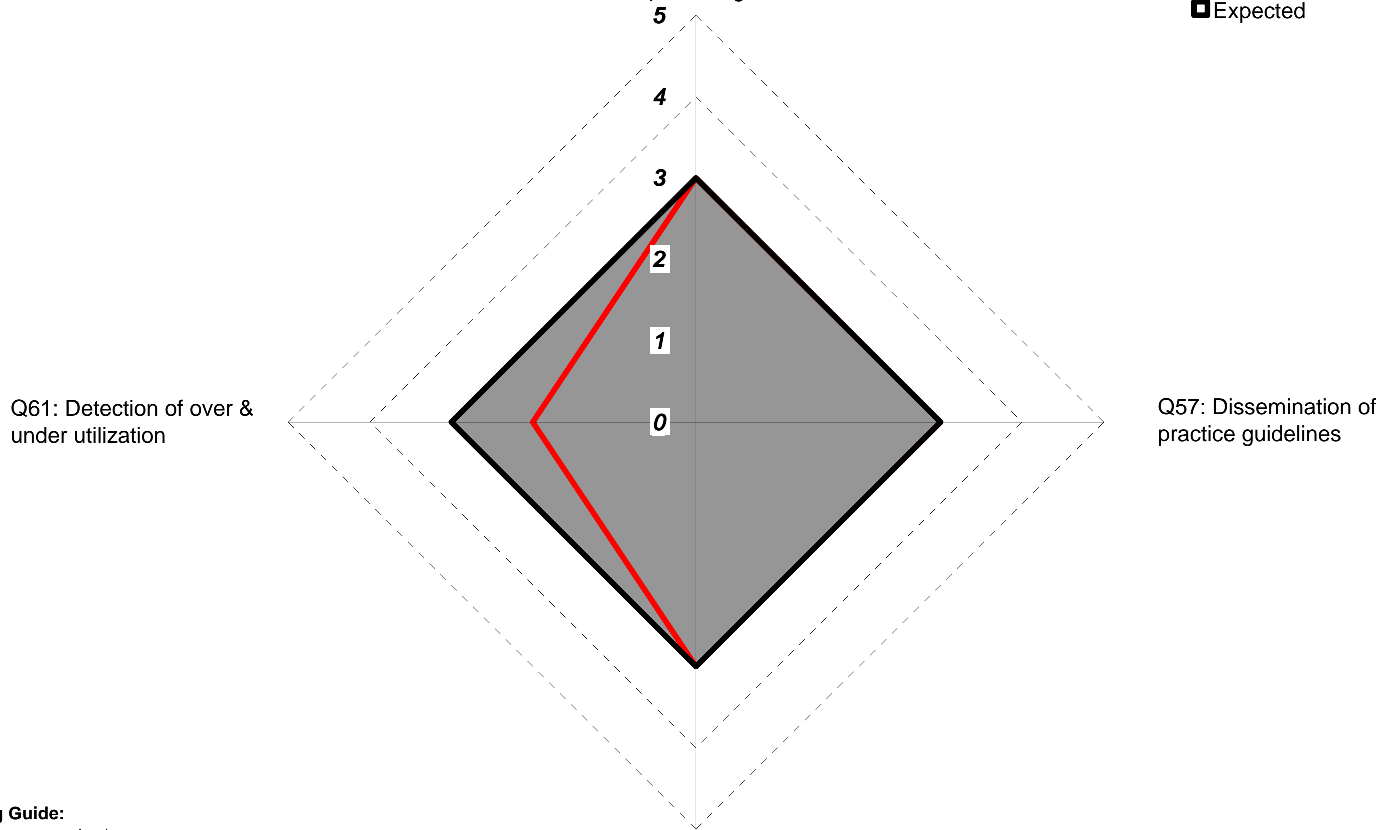
5: Provision thoroughly/consistently implemented

Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	5		5
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	0	2	2
Q52: Pre-subdelegation evaluation	1	5	5
Q53: Written subdelegation agreement	2	4	4
Q54: Annual subcontractor subdelegation performance review	2	4	4
Q55: Corrective actions re: subdelegation deficiencies	2	4	4

Subpart D (Part 3): Measurement and Improvement Standards

Pierce County



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Pierce County

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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	3		3
Q57: Dissemination of practice guidelines	3		3
Q58: Application of practice guidelines	3		3
Q61: Detection of over & under utilization	2	3	3

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.210(b)	**Authorization of Services**	
[Q40]	**Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise** Evidence: • PIHP Statement of Standard and Compliance states: "PCRSN ensures that all decisions to deny service or to authorize services at a lower level of care than initially requested are made by an appropriate health care professional [Care Manager], and that all denials of inpatient care are issued by a licensed physician after consultation with the participating Care Manager and within 72 hours of the proposed denial." • 4.14 Guidelines for Accessing Acute Psychiatric Inpatient Admission references that if Care Manager is considering denial of an inpatient certification, consultation with another mental health professional shall occur. All denials shall be reviewed by a psychiatrist and if enrollee is under 21 should also involve consultation with a child specialist. However, policy and procedure does not define qualifications of individuals 'approving' inpatient authorizations. • PIHP Care Manager Job Description- "Masters degree in psychology, social work or related field, and five or more years of clinical experience in a mental health setting including two years specialized experience. Individual positions require mental health designation as a mental health professional in accordance with WAC 275.57.020 (25) Mental Health Professional; WAC 275.57.320 (1) Child Mental Health Specialist; (2) Geriatric Mental Health Specialist; and (3) Ethnic Minority Mental Health Specialist." • Care Management Employment Applications showing qualifications of current Care Managers. • Children's Outpatient Services Automated Authorization Screens- indicating pended authorizations per Care Manager review, Care Manager assigned and identified by name. • Residential Service Approvals- emails indicating approval of Residential Level of Care by Care Manager. Emails include feedback for improved services and quality of care. • Inpatient Review Rounding Forms- reviews of inpatient authorizations showing concurrence or non-concurrence among Care Managers. • Care Management Meeting Minutes of 8/21/06 and distributed	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	New Authorization Flowchart shows evidence of discussion of PIHP online authorization system and indicates that PIHP Care Managers perform authorization functions. • Provider management accurately described the PIHP's authorization processes and identified the PIHP Care Managers as having primary responsibility for approving and denying care. • Recommend policies and procedures be updated to consistently and accurately reflect the PIHP positions responsible for conducting authorizations and denials of service and their required qualifications. (Substantial Compliance)	4
438.210(e)	**Compensation for Utilization Management Activities**	
[Q46]	**Protections against financial incentives for authorization decisions** Evidence: • PIHP's Statement of Standard and Compliance states: "All PCRSN utilization management activities are conducted by professionals who are salaried employees of the RSN, with the exception of the consulting psychiatrist, who is reimbursed as an independent contractor. None of these individuals have incentives of any sort (financial or otherwise) to deny, limit, or discontinue medically necessary services to any enrollee. All Care Managers are salaried employees and are not eligible for any financial or other incentives based on decisions to deny, limit, or discontinue medically necessary services to any enrollee" (as evidenced by Pierce County Class Description, Program Specialist 4). • Pierce County RSN/PIHP's consulting psychiatrist is compensated on an hourly ($125.00 per hour) basis. Payment is specifically limited to services provided, and there are no incentives, financial or otherwise, to deny, limit, or discontinue medically necessary services to any enrollee (as evidenced by Personal Services Agreement, Dr. Martha Bird). • As of September 2006, the PIHP initiated a new outpatient authorization process that requires Care Managers to review all proposed Denials of Service and all cases in which one or more Access to Care criteria are not met. Pending all such cases for individual review by a Care Manager insures that requests for authorization cannot proceed without meeting all necessary criteria established by the MHD. • High Utilizer report and Identified Adult High Utilizer form- the High Utilizer Group reviews all individuals having had 2 or more inpatient admission or 6 or more visits to Crisis Triage in the	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	past 3 months. This monitoring allows the group to identify individuals of concern who are then monitored for a minimum of 90 days by the PIHP Care Management for adequacy of services to reduce the risk of additional inpatient or crisis services. If, during the 90-day period, the consumer is significantly underserved, the CMHA receives a letter of corrective action. No corrective actions were submitted for review. • As reported by the PIHP in the 2006 WAEQRO Information Request Update, payment to BHO (UM sub-delegate for the period of October 1, 2006 thru September 30, 2006) was based on a flat rate of $.30 per member per month. This payment methodology minimizes the risks of financial incentives related to authorizing or denying an individual enrollee's care and services. (Substantial Compliance)	4
438.224	**Confidentiality**	
[Q51]	**PIHP audits subcontractors for privacy compliance** Evidence: • PIHP Provider Contract '05-'07 states that age, linguistic, and culturally competent community mental health services shall be provided or purchased for those whom such services are medically necessary and clinically appropriate pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or any successors. • The PIHP Provider Contract '05-'07 also requires the CMHA to submit a copy of their written policies and procedures that protect privacy in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) by October 31, 2005. In addition, the PIHP Corrective Action Plan for 2004 EQR states, "The PIHP has Business Associate Agreements in place with each provider. In addition, the PIHP will contractually require subcontractors submit to the PIHP the subcontractor's procedures that protect privacy according to the provision of 45 CFR. The PIHP will then review these procedures to ensure they comply with 45 CFR." • PIHP Compliance Confirmation Letters indicating the PIHP Compliance Officer reviewed and found the policies and procedures to meet requirements. Letters to each network provider (except SeaMar-no letter) were dated October 23, 2006, a year after the policies and procedures were required to be submitted to the PIHP. PIHP staff reported the delay in conducting the review of the policies was due to the CMHAs delinquent submission of their policies to the PIHP. In addition,	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	PIHP staff stated unequivocally the letters were sent to the CMHAs. • All interviewed provider management reported they had submitted their HIPAA policies and procedures to the PIHP; however, stated they had **not** received a Compliance Confirmation Letter or any other type of response or feedback from the PIHP. • Recommend PIHP staff explore the breakdown in communication related to the length of time the providers took to submit their HIPAA policies to the PIHP, and the non-receipt of the Compliance Confirmation Letters as reported by the providers. • No evidence of PIHP conducting provider monitoring related to HIPAA security requirements. (Partial Compliance)	2
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	

[Q52]	**Evaluation of Subcontractor ability to perform delegated functions**
	Evidence:
	• PIHP Statement of Standard and Compliance states, "Pierce County RSN/PIHP evaluated two prospective MCOs through a Request for Proposals (RFP) process to determine which one had the ability to perform the activities to be delegated. A contract that included activities delegated and the right to revoke these duties if performance was inadequate was fully executed."
	• Documents submitted for review included:
	  o Pierce County PIHP Request for Proposals for Utilization Management Services Number 05-01 RSN,
	  o RFP 05-01-RSN Utilization Management Eval-Behavioral Health Options (BHO)-Avg Score (9-12-05),
	  o RFP 05-01-RSN Utilization Management Eval-United Behavioral Health (UBH)-Avg Score (9-12-05).
	• PIHP staff were able to accurately articulate RFP process and outcome as outlined in above documents.
	(Maximum Compliance)
		5

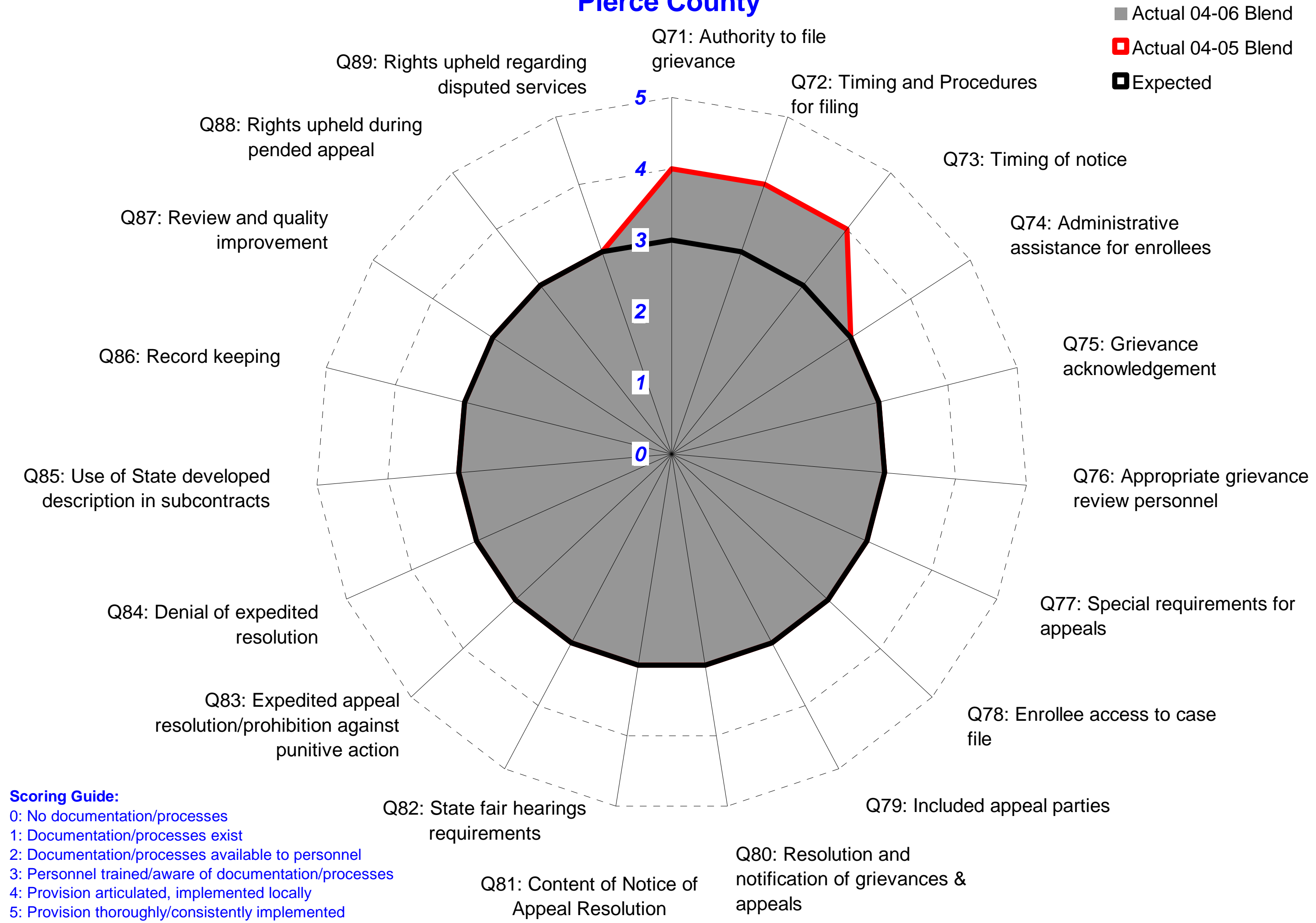
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • PIHP Statement of Standard and Compliance states, "Pierce County RSN/PIHP evaluated two prospective MCOs through a Request for Proposals (RFP) process to determine which one	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	had the ability to perform the activities to be delegated. A contract that included activities delegated and the right to revoke these duties if performance was inadequate was fully executed." • BHO Contract.10-05 to 9-06- Utilization Management Services Contract which generally incorporates the requirements of this provision. • PIHP sent staff to BHO Headquarters in Las Vegas to train BHO UM staff on PIHP's local system of care and refine the authorization implementation process. (Substantial Compliance)	4
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • PIHP Statement of Standard and Compliance states, "Performance was monitored using Rounding Forms and determined inadequate resulting in numerous attempts to have the situation corrected and finally termination of the contract when issues could not be resolved to the satisfaction of the RSN/PIHP." • BHO Contract.10-05 to 9-06- Utilization Management Services Contract that generally incorporates the requirements of this provision. • Inpatient Rounding Peer Reviews: PIHP Utilization Management conducted a comprehensive peer review process on a 25% sample of inpatient authorization requests using a structured scoring tool. Begun during 2005 when evaluating the work of the PIHP's contracted UM-MCO, this process provided immediate feedback to Utilization Managers about the quality of their work in determining medical necessity for those in crisis. • PIHP staff reported that they noticed difficulties with BHO right away and worked with them on a weekly basis (via phone conferences and emails) to do things the way the PIHP wanted. However, this work was to no avail. • PIHP sent staff to BHO Headquarters in Las Vegas to train BHO UM staff on PIHP's local system of care and refine the authorization implementation process. • Multiple Emails specifically address BHO's under-performance and request improvements and corrections. • PIHP reported that although they provided continual feedback and frequently requested quality improvements, they issued no formal corrective actions to BHO. • June 23, 2006 PIHP Termination Letter to BHO- stating, "This notice of non-renewal is made in accordance with the following	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	term of the County's Personal Services Agreement with BHO which states: The initial term of this Agreement ("Initial Term") shall be for **one (1) year,** from **October 1, 2005 to September 30, 2006**. The contract shall be renewed annually for four (4) additional one-year terms, unless either party gives notice of non-renewal not less than 60 days prior to the expiration of any one-year term." (Substantial Compliance)	4
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • BHO Contract.10-05 to 9-06- Utilization Management Services Contract that generally incorporates the requirements of this provision. However, PIHP did not incorporate specific language regarding corrective actions and the related process. • PIHP Statement of Standard and Compliance states, "Throughout the contract period the RSN made continued requests of the MCO regarding the timeliness, accuracy and quality of outpatient data and service to both the RSN and its contracted providers. Weekly phone conferences between RSN staff and MCO operations staff failed to resolve ongoing problems. The inpatient authorization process also continued to fail to meet performance expectations during the contract period. Quality evaluations of inpatient authorizations by the MCO, a process known as rounding, conducted by Care Managers during the contract period revealed consistent substandard authorizations despite repeated attempts by Utilization Management to train MCO staff to acceptable standards of performance…. Performance was monitored using Rounding Forms and determined inadequate resulting in numerous attempts to have the situation corrected and finally termination of the contract when issues could not be resolved to the satisfaction of the RSN/PIHP." • PIHP sent staff to BHO Headquarters in Las Vegas to train BHO UM staff on PIHP's local system of care and refine the authorization implementation process. • Multiple Emails specifically address BHO's under performance and requests improvements and corrections. • PIHP reported that although they provided continual feedback and frequently requested quality improvements, they issued no formal corrective actions to BHO. • June 23, 2006 PIHP Termination Letter to BHO- stating, "This notice of non-renewal is made in accordance with the following term of the County's Personal Services Agreement with BHO which states: The initial term of this Agreement ("Initial Term")	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	shall be for **one (1) year,** from **October 1, 2005 to September 30, 2006**. The contract shall be renewed annually for four (4) additional one-year terms, unless either party gives notice of non-renewal not less than 60 days prior to the expiration of any one-year term." (Substantial Compliance)	4
438.240	**Quality Assessment and Performance Improvement Program**	
[Q61]	**Effective mechanisms to detect under and over utilization** Evidence: • Statement of Standard and Compliance and Continuity of Care and Coordination policy and procedures incorporate mechanisms for monitoring care to detect both under and over utilization of services. Included is a detailed list of monitoring activities per service population and service type. • Six Month Access Report, Jan-July '06: Regular review of the 6-month report by the Utilization Manager, RSN/PIHP Adult Services Manager, Data Operation Coordinator, and Care Managers allows for an analysis of trends regarding penetration and overall service provided by CMHAs. • High Utilizer Report, June-Aug '06: High Utilizer Meetings-review of all individuals having had 2 or more inpatient admissions or 6 or more visits to Crisis Triage in the past 3 months. Consumers felt to have had insufficient services become a focus of concern during the next 90-day period by RSN/PIHP Care Management for adequacy of services. If, during the 90-day period, the consumer appears significantly underserved, the CMHA is required to take corrective action. • Inpatient Rounding Peer Reviews: PIHP Utilization Management conducts a comprehensive peer review process on a 25% sample of inpatient authorization requests using a structured scoring tool. This review began during 2005 when evaluating the work of the PIHP's contracted UM-MCO and has continued now that UM is conducted by the PIHP. This process provides immediate feedback to Care Managers about the quality of their work in determining medical necessity for those in crisis. • Greater Lakes Concurrence Review for May 2006: Included chart reviews with feedback focused on assessments, authorization and level of care, and treatment plans. • Residential Service Request Fax and Feedback: During 2006, the PIHP initiated protocols for the review of all residential level of care authorization/reauthorization requests. Care Management assesses the level of active treatment planned for or provided each consumer in a residential facility and the	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	effectiveness of previous treatment, given the consumer's identified needs. This monitoring process has resulted in formalized discussions with two CMHAs to improve the information supporting residential requests. • Additional documents submitted included: o Proposed Denials Spreadsheet, o Sample Geriatric Consult, o DD Weekly Staffing Consult Form, and o DDD Billing report • PIHP reported that they hold a variety of meetings in which issues of over and under utilization are addressed: o Hospital Diversion Meetings, o Care Management Meetings, o Consulting Psychiatrist Staffings, o Crisis Response Meetings, and o Discharge Transition Plan. PIHP did not submit minutes from these meetings; therefore, reviewer unable to verify that content of meetings includes issues related to over and under utilization. • Provider Management described a few of the mechanisms identified above which the PIHP employs to monitor over and under utilization and are used to improve quality of care on a case by case basis. However, they were not sure how the information and data are used for system-wide improvements. (Moderate Compliance)	3



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

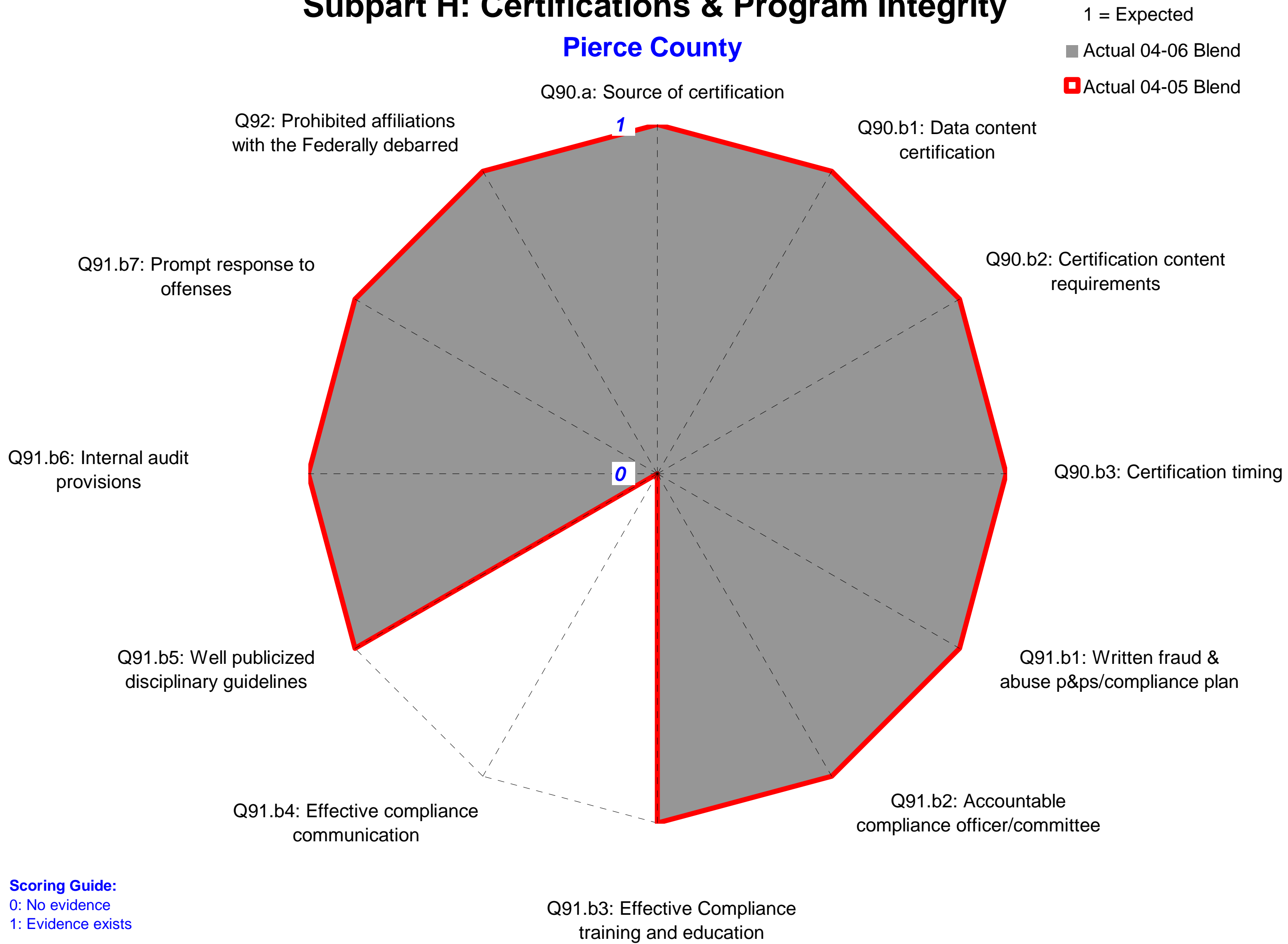
2004-2006 Subpart Scoring Trend and Detail for
Pierce County

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	4		4
Q72: Timing and Procedures for filing	4		4
Q73: Timing of notice	4		4
Q74: Administrative assistance for enrollees	3		3
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	3		3
Q87: Review and quality improvement	3		3
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

Pierce County PIHP achieved Expected compliance for all Subpart F scores in 2005. Therefore, no Subpart F review elements were re-scored in 2006.



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for
Pierce County

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	0	0	0
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	1		1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness and truthfulness of the data. (Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State. (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification. (Compliance)	1
438.608	**Program Integrity Requirements**	

[Q91.b4]	**Effective lines of communication between Compliance Officer and employees**
	Evidence:
	• No policy and procedure submitted for review. In the documentation folder submitted by the PIHP, reviewer located the PIHP's Fraud and Abuse policy and procedures. However, the policy does not contain language that specifically relates to effective lines of communication between the Compliance Officer (CO) and PIHP employees.
	• Compliance Report covering period 10-05 to 9-06 from the CO to the PIHP Administrator reporting no incidents of Fraud and Abuse, and compliance with all program integrity and managed care requirements. This establishes communication between the CO and the PIHP Administrator; however, it does not establish effective lines of communication between the CO and PIHP employees.
	• The following submitted documentation was outside the review period:
	  o Feb 2004 CMS Video Conference Attendees,
	  o Feb 2004 Training Questions and follow-up letter from	

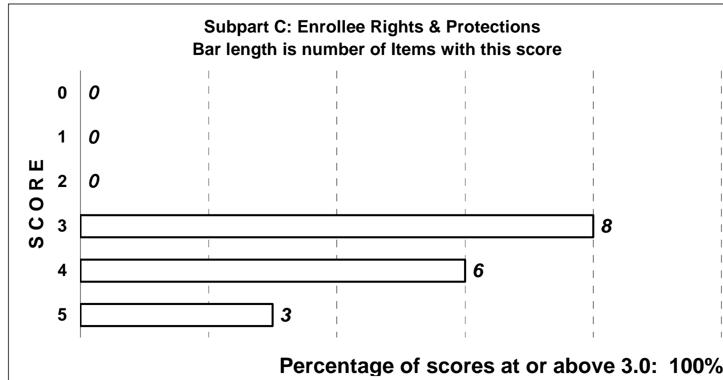
	DHHS/CMS, o Training Evaluation Form for CMS training, and o February 24, 2005 letter to Comprehensive Mental Health Center requiring immediate suspension of their spend-down practices which were not in compliance with State Law. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.	
	(No Compliance)	0

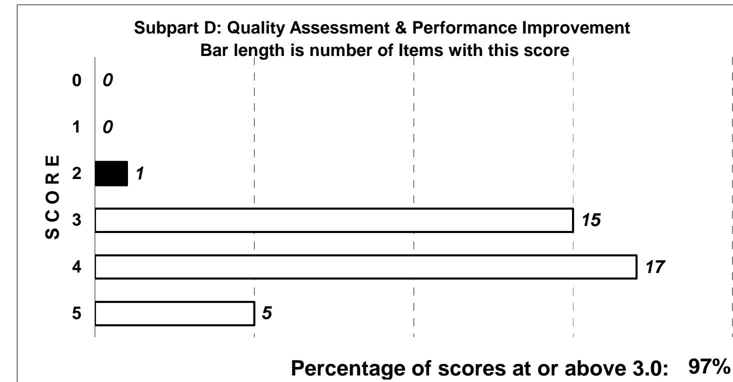
Scoring Frequency Overview

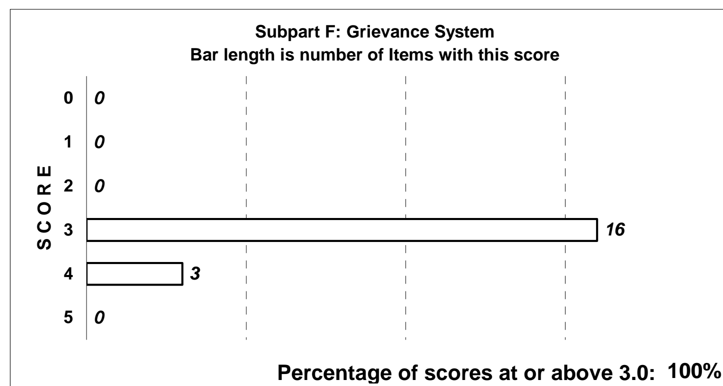
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Pierce County

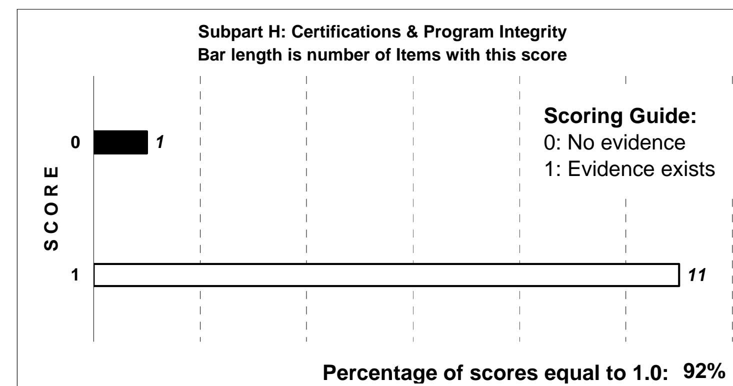
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 100%
Subpart D: 97%
Subpart F: 100%
Subpart H: 92%

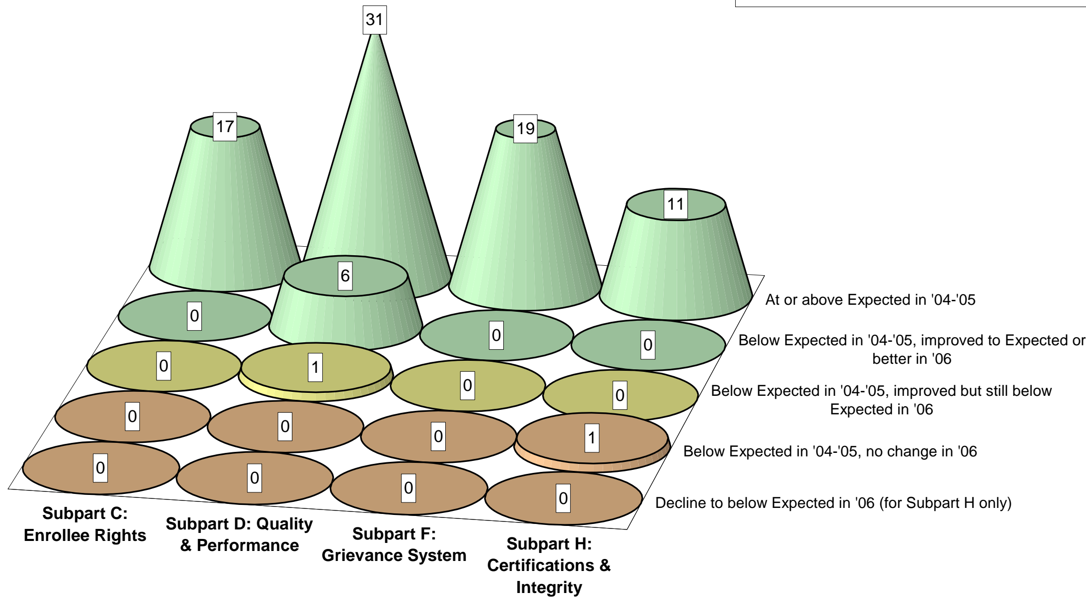
By prioritizing enrollee rights and protections and their grievance system, Pierce County PIHP achieved Expected compliance in Subparts C and F in 2005.

The PIHP continues to make progress with respect to Subpart D and has achieved Expected compliance for all review elements with the exception of one: audits of subcontractors for privacy compliance. In addition, Pierce County PIHP has met all but one of the requirements associated with Program Integrity. Effective lines of communication between their Compliance Officer and employees have not been sufficiently addressed in their policies and procedures. Overall, Pierce County has achieved a high level of Expected compliance within all four Subparts.

Score Trend Summary for:
Pierce County

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Percent	Subpart D: Quality & Performance Item Count	Percent	Subpart F: Grievance System Item Count	Percent	Subpart H: Certifications & Integrity Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	0	0.0%	0	0.0%	1	8.3%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	1	2.6%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	0	0.0%	6	15.8%	0	0.0%	0	0.0%
At or above Expected in '04-'05	17	100.0%	31	81.6%	19	100.0%	11	91.7%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, Pierce County PIHP performance relative to Subpart C (*Enrollee Rights*) showed 17 out of 17 items (100%) already at or above the Expected level of performance. Therefore, Pierce County was not re-scored on any Subpart C review elements in 2006.

In addition, for Subpart F (*Grievance System*), the PIHP entered the 2006 review with 19 out of 19 (100%) already at or above Expected; thus, in 2006, the PIHP was not re-scored on any Subpart F review elements.

Subpart Strengths

- The PIHP sustained a high level of operations despite several challenges posed by an internal re-organization, their successful response to the MHD Request for Qualifications, and a new MHD contract.
- Effective implementation of the Delegation standards for prior evaluation and ongoing assessment and oversight.
- Development and implementation of in-house authorization and utilization management functions and related activities.

Subpart Challenges

- Maintaining on-going, effective, and productive communication with network providers is critical to the success of the area's mental health care system.
- Revised policies and procedures were not re-approved once revisions were finalized.

Subpart Recommendations

1. Create a process to officially approve **revised** policies and procedures. Include dated signatures of PIHP officials or designees, date of revision, and effective date of policy. In addition, remove procedures from policies that are no longer in effect.

2. Continue to develop procedures for collecting and analyzing aggregate data to identify individual provider and system-wide trends related to over and under utilization.

3. Design and incorporate into PIHP's Fraud and Abuse policy, procedures related to effective lines of communication between the Compliance Officer and PIHP employees.

4. Expand privacy compliance audits of subcontractors to incorporate a management information security review. In addition, ensure that reviews and related reports are conducted in a timely manner and made available to provider management.

5. Update policies and procedures to consistently and accurately reflect the PIHP's positions (with qualifications) responsible for conducting authorizations and denials of service.

6. Revise monitoring tools incorporating review elements related to the BBA and the PIHP's new and revised policies and procedures.

7. Develop a formal Corrective Action policy and procedure for use with future Delegation Agreements/Contracts.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions. These items remain unchanged from the 2005 review.

1. Mapping non-standard codes
   Mapping non-standard codes is discussed and coordinated in the data group meeting that the RSN hosts for its providers. The group's agenda drives their meeting schedule; originally slated to meet monthly, they now meet two or three times a year.

2. Unique member ID
   The PIHP assigns a unique member ID and regularly searches for duplicates.

3. Tracking across product lines
   Tracking across product lines takes place primarily at the Agency level. The PIHP's focus is Medicaid and crisis services.

4. Tracking individuals through enrollment, disenrollment, and re-enrollment
   The PIHP's system can track individuals through enrollment, disenrollment and re-enrollment.

5. Calculating member months
   The PIHP defined methods available to calculate member months for individuals served. They are not using member month calculations in any management report performance indicators.

6. Member database
   The PIHP has been maintaining a member database using data made available by MHD for more than five (5) years.

7. Provider Database
   As mandated by the State, the PIHP maintains provider information in its

database.

8. Data easily under-reported
   The PIHP has no policy and procedure to ensure they capture data that is easily under-reported.

PM Summary

PCRSN has strong pre-submission screening processes on its data but did not fare well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. Unfortunately, the PIHP's efforts also fell short in this year's analysis and encounter validation review (described below). The overall score of Partially Met in the 2006 encounter validation review has an impact on the general state of the PIHP's performance measure accuracy. The general state of the PIHP's data is evaluated as "fair", despite the 2005 EV performance. Fortunately, steps are being taken to help improve their data quality to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- PIHP has committed significant resources and effort to addressing necessary improvements in its data management system.

PM Challenges

- Continue work on using local data for calculating PIHP performance measures to compare with State-generated measures.

PM Recommendations

1. Develop a policy and procedure to ensure that data from an out-of-network provider is captured in the PIHP's data system.

2. Continue to develop member month calculations for use in performance management reporting.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two submitted PIPs for Pierce County PIHP: Implementation of a Depression Practice Guideline, which was identified by the PIHP as clinical. Included in the desk review were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and to evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006 (see, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

Pierce County submitted a clinical PIP designed to study the effect of implementing a practice guideline related to treating severe depression. The guideline staff chose is the Institute for Clinical Systems Improvement (ICSI) Clinical Practice Guideline for Major Depression in Adults for Mental Health Care Providers. The RSN had previously adopted a different guideline for the same population, but had not found it useful or effective. Staff searched for a different guideline and useful tool to measure change; they have begun the process of training staff in use of the guideline and testing consumers at the point of diagnosis. The measurement tool selected is the PHQ-9. The PIP report submitted by the RSN was well-written and covered the essential bases of the CMS protocol for conducting a performance improvement project. As discussed below, there are some details yet to be fully developed and described in their PIP report; however, the plan appears to have potential for a valid assessment of the effectiveness of this treatment protocol.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				Clients with Severe Depressive Disorders comprise the study population.
1.2. Is selected following collection and analysis of data (or was selected by the State).			X		PIHP created a PIP from a required activity: implementing practice guidelines.
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	
1.4 Includes all eligible populations that meet the study criteria.	X				All clients with Major Depression diagnoses either given at intake or changed to this during study period.
1.5. Does not exclude members with special health care needs.	X				All clients served by the PIHP are considered to have special healthcare needs.
1.6 Has the potential to affect member health, functional status, or	X				The intervention is the implementation of a practice guideline based on scientific data

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
satisfaction.					demonstrating improvement in clinical outcomes.
Totals for Step 1:	**4**	**0**	**1**	**1**	
Number of shaded critical evaluation elements met for Step 1: 1/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.	**X**				"Will the implementation of the ICSI Major Depression Guidelines result in at least a 25% reduction (between the initial and 3-month follow-up assessment) in the PHQ-9 scores of individuals participating in the study?"
2.2 Is answerable/provable.	**X**				PHQ-9 has been validated and will be used for pre-and post intervention measurement.
Totals for Step 2:	**2**	**0**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 2: 2/2					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.	**X**				Single indicator: score on PHQ-9. Percentage of clients with at least a 25% decrease in score from measurement 1 to measurement 2. Goal: 80% of clients in study achieve targeted improvement.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
3.2. Are based on practice guidelines, with sources identified.	X				Target for improvement not based on science; scoring for PHQ-9 is valid.
3.3 Allow for the study question/hypothesis to be answered or proven.	X				PIHP will be able to measure the change.
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	X				PHQ-9 is valid measure of severity of depression.
3.5 Have available data that can be collected on each indicator.	X				Will be collecting data for each client in study at intake or initial severe depression diagnosis and again at specified intervals.
3.6 Include the basis on which each indicator was adopted, if internally developed.	X				PIHP conducted review of depression scales and made selection based on validity of scales, ease of use, cost, and Guideline recommendation.
Totals for Step 3:	**6**	**0**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 3: N/A					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					
4.1. Is accurately and completely defined.		X			• PIP description does not specify time frame for selection of participants; however, schedule for data collection implies a 3-month period during which all

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					consumers who qualify will be captured for the study. • Plan does not address impact on clients currently in treatment, with qualifying diagnoses, during study period. • Plan does not specify which 3-month initial period it will study first (and, by definition, which clients).
4.2. Includes requirements for the length of a member's enrollment in the MCP.			X		Is not addressed.
4.3 Captures all members to whom the study question applies.		X			Plan for engaging all eligible clients not articulated.
Totals for Step 4:	**0**	**2**	**1**		
Number of shaded critical evaluation elements met for Step 4: 0/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).	X				• Initial survey conducted of clients who meet qualifications; • Study will use the entire eligible population.
5.2. Identify the sample size (or use the entire population).				X	
5.3. Specify the confidence interval to be				X	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
used (or use the entire population).					
5.4 Specify the acceptable margin of error (or use the entire population).				X	
5.5 Ensure a representative sample of the eligible population.				X	
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.				X	
Totals for Step 5:	**1**			**5**	
Number of shaded critical evaluation elements met for Step 5: N/A					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.	X				Will use PHQ-9 responses/scores.
6.2. Identification of specified sources of data.	X				
6.3. A defined and systematic process for collecting baseline and remeasurement data.		X			• Will administer instrument at Intake. • Also want to capture clients whose diagnoses changed to a qualifying one; not clear how that will be implemented.
6.4. A timeline for collection of baseline and remeasurement data.		X			• Baseline data to be collected during 1st 3 months of study; specifics for capturing those with changed diagnoses not

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					provided. • Remeasurement to be conducted 3 months later for each client.
6.5. Qualified staff and personnel to abstract manual data.	X				Qualified clinical staff will administer questionnaire; scores to be entered into Excel database at each agency - specific staff responsibility not stated.
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.		X			Use of PHQ-9 captures data; training on use of tool provided to staff. Process to ensure accurate capture of scores not provided.
6.7 A manual data collection tool that supports inter-rater reliability.		X			PHQ-9 is a reliable tool; however, no description of training was provided nor was mention made of inter-rater reliability precautions.
6.8 Clear and concise written instructions for completing the manual data collection tool.			X		Training materials were not provided for this element of study activity.
6.9 An overview of the study in written instructions.		X			PIHP summary of Guidelines provided. Includes description of validation of fidelity to guideline; however, PIP plan did not discuss training in detail.
6.10 Automated data collection algorithms that show steps in the production of	X				

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
indicators.					
6.11 An estimated degree of automated data completeness.			X		Only mention of data integrity references clients who drop out of study.
Totals for Step 6:	**4**	**5**	**2**	**0**	
Number of shaded critical evaluation elements met for Step 6: 0/1					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.			X		PIHP required to have 2 Practice Guidelines in place; initially had chosen a different Depression guideline and found it not “useful or feasible” for their system. No data provided to support this contention. This PIP reflects implementation of different guideline.
7.2 System changes that are likely to induce permanent change.		X			• PIP plan did not address extent to which the mental health system already provides treatment consistent with the guideline. • Assuming this guideline requires significant change in treatment methods, significant change could result.
7.3 Revised if original interventions are not successful.				X	
7.4 Standardized and monitored if interventions are successful.				X	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Totals for Step 7:		**1**	**1**	**2**	
Number of shaded critical evaluation elements met for Step 7: 0/1					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					
8.1. Is conducted according to the data analysis plan in the study design.					The study has not progressed this far.
8.2. Allows for generalization of the results to the study population if a sample was selected.					
8.3. Identified factors that threaten internal or external validity of findings.					
8.4. Includes an interpretation of findings.					
8.5 Is presented in a way that provides accurate, clear, and easily understood information.					
8.6 Identifies initial measurement and remeasurement of study indicators.					
8.7 Identifies statistical differences between initial measurement and remeasurement.					
8.8 Identifies factors that affect ability to compare initial measurement with					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
remeasurement.					
8.9 Includes the interpretation of the extent to which the study was successful.					
Totals for Step 8:					
Number of shaded critical evaluation elements met for Step 8: N/A					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.					
9.2. There is documented improvement in processes or outcomes of care.					
9.3. The improvement appears to be the result of planned intervention(s).					
9.4. There is statistical evidence that observed improvement is true improvement.					
Totals for Step 9:					
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
sustained improvement, or the decline in improvement is not statistically significant.					
Totals for Step 10:					
Number of shaded critical evaluation elements met for Step 10: N/A					

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS
Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported** * Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported** ***** Not Met = Reported PIHP PIP results or plan/activities not credible**
Summary of Aggregate Validation Findings
* ☒ **Met** * * ☐ **Partially Met** *** ☐ **Not Met**

Summary of PIP validation findings:
This PIP is designed to study the impact of a practice guideline on all new clients who fall within a certain diagnostic group or those whose diagnosis changes during the initial data-gathering period. The PIP is an outgrowth of a required activity and, as such, was not selected based on data gathering and analysis. Most of the other essential elements are described or addressed, although some details are not provided and supporting documentation is missing. Evidence that this PIP had been discussed in their QI (COG) committee or that it had been "officially" selected from among other possibilities was not included with the PIP submission; however, such documentation was seen in evidence related to the QAI Review. With fine-tuning, the PIHP may obtain valuable information about the effectiveness of this particular Depression Guideline.

PIP Strengths

- PIHP has mastered the basic concepts of the CMS protocols for conducting PIPs.
- The Practice Guideline selected for study and the measurement tool used for evaluation of results have sound scientific underpinnings.
- Single Indicator and method for calculation (well described) will enable PIHP to clearly measure implementation results of the guideline.

PIP Challenges

- A staggered pre- and post-intervention measurement period may complicate data collection and analysis.
- Assuring data integrity will be essential in evaluating the outcome of Practice Guideline implementation; PIP submission did not address this issue.

PIP Recommendations

1. Provide details of methodology for training clinicians in use of Guideline and administration of PHQ-9; demonstrate assurance of inter-rater reliability.

2. Provide details of data collection, documentation, and analysis, including tests of statistical significance applied to results.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Met	PCRSN documents the data requirements in an RSN-specific data dictionary. The RSN data dictionary is based on the State's data dictionary (DD). The DD outlines format, submission methods, timeliness, and all data expectations of the RSN for its provider network. Completeness standards are listed in the MIS section of the quality manual.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	Data requirements are appropriately communicated to provider agencies.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Partially Met	Evidence was presented to support that the RSN has made some efforts to document its provider network IT capabilities and vulnerabilities. They presented documentation of disaster recovery plans submitted by their providers. The RSN is evaluating these plans and is working with the agencies to ensure that their networks will be capable of recovery after a disaster. Other evidence not presented includes documentation of systems and processes used by provider staff to enter, maintain, and transmit data accurately and in a timely manner. Also not included is a risk assessment defined by the RSN designed to seek out vulnerabilities that could be

PIHP Encounter Validation Process Review

Item	Rating	Comments
		monitored or addressed.

3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Not Met	The PIHP employs an array of processes to ensure that data is accurate and complete prior to submission. The various processes used are documented and scheduled in a yearly master calendar. The primary emphasis of the data checks employed by the RSN and provider agencies is on the current data set being prepared for submission and the correction of errors in data recently submitted. The PIHP does not conduct a specific data analysis to validate its completeness and accuracy. Efforts to verify such data prior to transmission are excellent, but do not provide the views needed to calculate actual completeness values needed in this analysis.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Not Met	Data analysis specific to an encounter validation is not conducted.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data analysis specific to an encounter validation is not conducted.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Partially Met	The encounter validation/matching efforts meet some of the requirements outlined in the contract between the MHD and PCRSN. It was clear that encounter information was matched against the clinical record; however, not evident were specific steps to ensure that provider names match and that further steps were taken to ensure that the encounter actually took place. The PIHP's sample size meets the standard. The contract between the MHD and the PIHP requires a sample size of 1% of the first six months of encounters, or 250, whichever is less; this PIHP checked a total of 3,529 encounters.
PIHP includes additional data elements in matching exercise.	Partially Met	The PIHP does study a much larger set of data than is required in the contract; however, it lacks a method to ensure that all data elements are included over time.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Not Met	The specific tools used to capture raw data from the reviews were not submitted for review. Result summaries provided lack sufficient descriptive information to allow understanding of the data.

PIHP Encounter Validation Process Review

Item	Rating	Comments
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Met	The report to the State describes the encounter validation process and its results. Individual provider agency reports were also submitted that detail findings of audits conducted by the RSN. Where the RSN does provide report details, information is sufficient. Ideally, however, the report should include all information requested by this tool. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	PIHP staff provided evidence demonstrating that they share results of these review exercises with their providers.

PIHP Encounter Validation Process Review

Item	Rating	Comments
PIHP regularly reports internally for quality improvement activities.	Met	Reports are used extensively with respect to checks on the quality of provider data submissions. These checks are made prior to data entry into the PIHP's system. Specific internal activities designed to improve the quality of data were not evident in documents submitted for review.
6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Partially Met	Evidence of follow-up activities was present, but a specific policy and procedure defining these processes and procedures was not.
If warranted, evidence of follow-up activity was presented.	Met	Evidence of follow-up activities was present.

Summary of Encounter Validation Findings

Score Met _43_%

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ **Met** ☒ **Partially Met** ☐ **Not Met**

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP fall short of requirements set forth in the contract between the MHD and the PIHP. The encounter validation review did not include all items specified in the contract. There were efforts made to validate other data elements. Additional steps to ensure that encounters checked actually took place were not made. An analysis of the PIHP's data for the purpose of an encounter validation was not conducted.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 43% of all items meeting a score of Met, 28% at Not Met, and the remaining 29% at Partially Met.

EV Strengths

- The PIHP implements a comprehensive process which needs only a few adjustments.

EV Challenges

- The PIHP maintains a complete error tracking system.

EV Recommendations

1. Document a complete data standard, specifying expectations on an element by element basis.

2. Develop a data check matrix defining the data and a related check process to ensure that all data is evaluated.

3. Develop reports with descriptive information sufficient to allow understanding by an independent reader.

4. Define more specifically the elements of the encounter validation; e.g., random sampling techniques employed.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. Each standard was then scored separately and the number of Met/Partial/Not Met summed for each. Total percentages are calculated by dividing the number in each category of Met/Partial/Not Met by the total number of items scored. Scores greater than 80% are considered an overall Met score; 65% to 79% is Partially Met, and those below 65% are considered overall as Not Met.

APS HEALTHCARE
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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Pierce County RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		**2**		• Plan is well-written and organized and easy to read, but lacks key details about oversight activities. • Inclusion of finance and IT are important aspects of a comprehensive plan. • Plan does not provide information about committee structure and composition; does include matrix for data reporting, analysis, and follow-up for top level oversight committees.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		**2**		• Plan states there will be an annual review; process not included.

PIHP: Pierce County RSN

Requirement	Met	PM	Not Met	Findings Comments
C. Plan includes annual work plan and process for review of associated activities and progress.		**1**		• Work plan is separate document; spreadsheet related to indicator monitoring. • Does not include focused QI projects related to previous year's monitoring results.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		**2**		• None of the detail regarding provider review is provided in plan; no policy reference to direct the reader. • Plan does address other types of reviews and contains table specifying the types of information collected, where reported, what happens, and who is responsible for reporting. • Narrative language emphasizes use of data for quality improvement.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.		**2**		• Specifies that QRT and Ombuds data will be routinely collected and analyzed. • Allied service provider satisfaction is assessed. • Lacks detailed description of composition of committees that would identify consumer, provider, and family participation.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**3**		• Sample provider QI plan review; name of provider, specific date of review, reviewer name not provided; language in review column sounds like agency

PIHP: Pierce County RSN

Requirement	Met	PM	Not Met	Findings Comments
				may have filled out the tool or part of it. • Copy of report to provider agency following site visit. • Minutes of COG for August 2006 noted initiation of monthly "concurrence reviews" and identification of improvement needs related to chart documentation noted during this review process. • Minutes, training schedule, and training materials reflect implementation of depression practice guideline. • Submitted an extensive list of trainings provided for broad array of groups, by PIHP and agency staff. • Submitted Power Point and Benefits Book used to train network providers on Grievance and Appeals in 2005 and 2006; in addition, provided materials for training Children's Best Practice for Trauma-focused CBT. • May 4, 2006 COG meeting minutes reflect RSN intention to provide list of performance indicators to group for discussion and suggestion. o Reports for all indicators not in place during review year; however, RSN did provide sample Six Month utilization reports and High Utilizers

PIHP: Pierce County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				report. Both reports are spreadsheets with no indication that data is aggregated or trended. • Evidence that utilization review activities conducted according to plan: o Reports populated by service providers. o Site reviews – chart reviews concurrence re: levels of care, compliance with contract requirements. o For Children's system, ongoing discussion at meetings and 6-month outcome reports for intensive levels of care. o Provider confirms attendance at monthly High Utilizer meetings; each situation is assessed and treatment alternatives developed. o QRT reports were not provided; however, RSN staff stated that they report at least annually to COG, SLOG, and the Advisory Board. o Ombuds reported that they attend COG, SLOG, sit on QRT, and Performance Indicator Work Group at the State.

PIHP: Pierce County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard 1 Count (Target 6 Met):	**0**	**6**	**0**	**Target Points: 24 Actual: 12**
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care. (2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis		1		• Report to network provider detailed findings for each element reviewed and included recommendations for improvement. • Completed chart reviews were submitted for APS review. • Only documentation of frequency of chart reviews is name of tool: "Quarterly". • RSN did not provide a policy detailing the chart review process and follow-up activity; all mention of clinical review was high level and very general. • One provider agency stated that the RSN has not conducted a site visit in several years. The RSN reports that a twice yearly schedule has been created with the provider and that the first visit will occur in early 2007. • One provider agency confirms that

PIHP: Pierce County RSN

Requirement	Met	PM	Not Met	Findings Comments
				chart reviews are conducted quarterly for adults and children; adult reviews focus on concurrence with authorization decisions.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		1		• Document submitted as "Quarterly Site Review Tool" is limited in scope and scoring capability. Tool is used for "concurrence with authorization decisions" review only. • Chart review tool for children's services is more comprehensive, covering all aspects of provision of appropriate care. • No documentation submitted that detailed the agency aggregate scoring process for chart reviews. Targets for performance and thresholds for corrective actions are not articulated.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		1		• No evidence of training relative to conducting reviews for RSN staff. • No evidence of inter-rater reliability assessment or testing. • RSN staff report that part of review process is discussion about cases at site review, among each other and with agency clinical staff.

PIHP: Pierce County RSN

Requirement	Met	PM	Not Met	Findings Comments
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		1		• Documentation submitted demonstrating RSN/provider agency communication about development of requested CAP; no final resolution provided. • Series of communications with provider regarding need for CAP; activity was just prior to WAEQRO document submission deadline, so no final resolution documented. • No documentation indicating that RSN has system for tracking requests and agency progress on meeting requirements.
Standard 2 **Count (Target 4 Met):**	**0**	**4**	**0**	**Target Points: 16 Actual: 4**

Standard

3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)

Requirement	Met	PM	Not Met	Findings Comments
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		1		• Monthly DMIO report referenced in COG meeting minutes (9/15/06). • No minutes from meetings during the review period include discussion of

PIHP: Pierce County RSN

Requirement	Met	PM	Not Met	Findings Comments
				results of provider chart reviews. • Providers report that discussion of site visits occurs routinely in children's meetings; however, adult providers' results are shared more informally and are not necessarily tied to reports. • Reports provided at children's system meetings provided for review.
B. PIHP analyzes and trends individual provider performance			**0**	• No evidence submitted demonstrating reporting and trending of individual provider performance on chart reviews. • Provider agency states that they receive written reports from the RSN after the site visit. Samples of those reports indicate that information is related to the most recent review; trends are not identified.
C. PIHP analyzes and trends system-wide performance			**0**	• Six-month report (Jan-June 2006) was provided that contains raw data re: utilization for all populations in inpatient and outpatient care. • No evidence that data was analyzed or trended compared to previous periods or from one agency to another.

PIHP: Pierce County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.			**0**	• No documentation submitted demonstrating routine communication with network or other stakeholders regarding results of provider clinical quality reviews.
Standard 3 **Count (Target 4 Met):**	**0**	**1**	**3**	**Target Points: 16 Actual: 1**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**1**		• Denial tracking log provided; some fields not completed; not clear how spreadsheet can be analyzed. • Spreadsheet does document referrals made when services are denied. • Provider agencies report that they submit Exhibit N data to the RSN twice annually. • Provider agency reports that a detailed Ombuds report is presented at SLOG and that trends are discussed.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I		**1**		• Six-month report (Exhibit N) and narrative analysis provided; however,

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PIHP: Pierce County RSN

Requirement	Met	PM	Not Met	Findings Comments
reviews and system improvement activities.				no minutes for COG reflecting discussion of report. • Analysis of above report did identify need to continue monitoring denials. • No Ombuds reports submitted; no evidence of their discussion in COG minutes; SLOG minutes not provided.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.		2		• List of RSN-sponsored training between 9/1/05 and 11/1/06 identifies Grievance and Appeal training for some providers specifically, and for the COG. • Documentation of content of Grievance and Appeal training provided. • One agency reports that RSN provides training for management staff who are then expected to forward information to remaining staff. • Provider agencies demonstrated working knowledge of grievance/appeal system, with some exception; however, staff have access to policies, if necessary. • Ombuds displayed solid knowledge of grievance/appeal process; have easy access to RSN, and work closely with staff. • Ombuds report that they were trained

PIHP: Pierce County RSN					
Requirement		**Met**	**PM**	**Not Met**	**Findings Comments**
					by WAPAS and WIMIRT; Pierce RSN supportive of their attendance at other training, and they always receive policy and procedure changes from the RSN.
Standard 4	**Count (Target 3 Met)**	**0**	**3**	**0**	**Target Points: 12 Actual: 4**
Grand Totals	**Count (Target 17 Met)**	**0**	**14**	**3**	**Target Points: 68 Actual: 21**

Summary Quality Assurance and Improvement Findings

This RSN has written a document that clearly articulates their values and goals for providing high quality care to their consumers. Their challenge lies in developing the detailed methods for accomplishing those goals and measuring their performance. The Clinical Oversight Group does not function as a true quality assurance and improvement committee, reviewing reports from all areas of the operation and assessing the need for follow-up and providing oversight for those activities. Their data reporting and analysis needs significant development to allow clear understanding of where they need to focus; as they develop this capacity, they will be in a better position to support a consistent QAI process.

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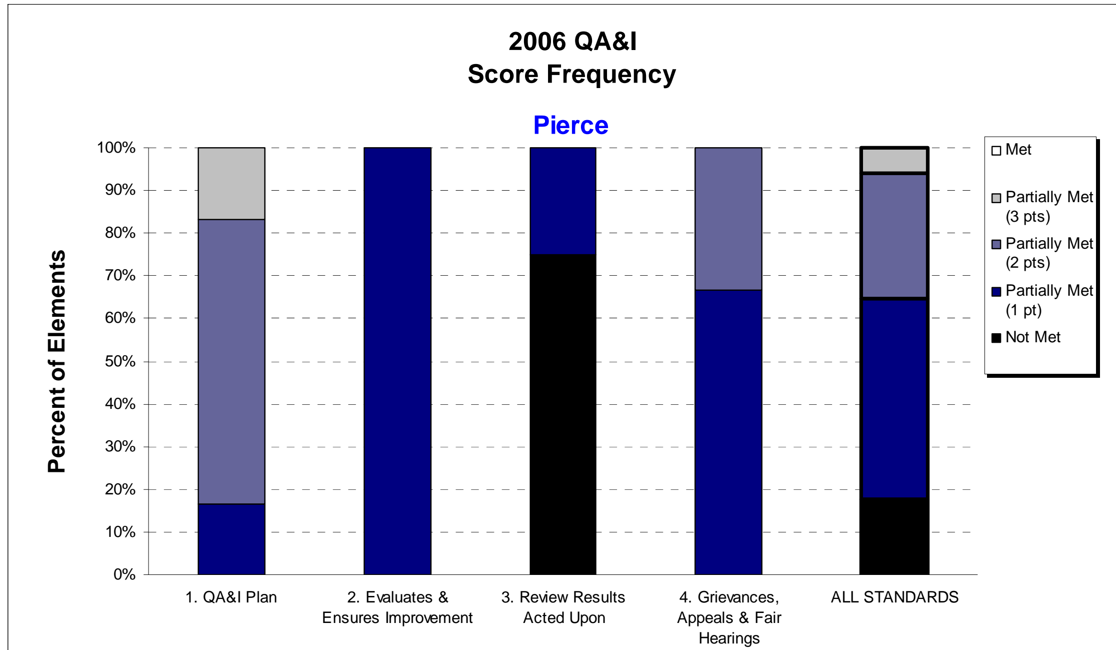

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	0	1	4	1	0
2. Evaluates & Ensures Improvement	4	0	0	0	4	0
3. Review Results Acted Upon	4	0	0	0	1	3
4. Grievances, Appeals & Fair Hearings	3	0	0	1	2	0
ALL STANDARDS	**17**	**0**	**1**	**5**	**8**	**3**

QAI Strengths

- The children's system of care in this region appears to have developed useful tools and structures to identify opportunities for improving clinical care, and has fostered relationships across agencies and the RSN that contribute to productive problem solving.
- The RSN staff appear to possess the skills and abilities required to conduct effective quality assurance and improvement activities. They understand the changes that are needed and resources required. Recent hiring of an IT manager with significant experience in the State will have a positive impact on their QAI system.

QAI Challenges

- The structure currently in place does not support effective QAI activity. The Clinical Oversight Group appears to focus on the issue of the moment when it should be consistently reviewing system-wide performance indicators.

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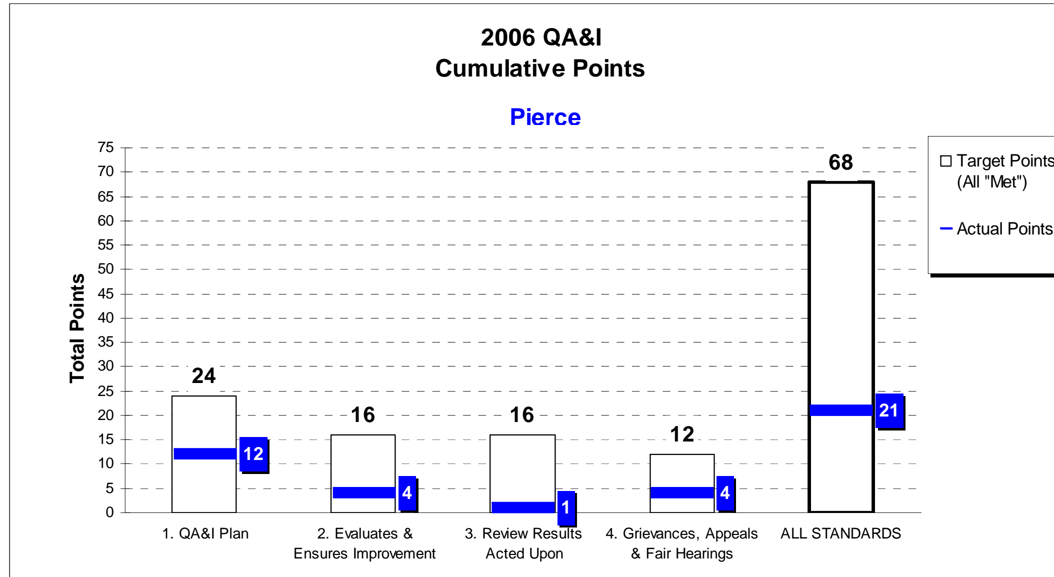

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	12
2. Evaluates & Ensures Improvement	16	4
3. Review Results Acted Upon	16	1
4. Grievances, Appeals & Fair Hearings	12	4
ALL STANDARDS	**68**	**21**

QAI Recommendations

1. Consider redesign of COG, with a new "charter" that ensures routine oversight of system operations based on data and verbal reports from key stakeholders (Ombuds, QRT, etc.).

2. Develop standards of measurement for all performance indicators, as well as thresholds for taking action.

3. For Annual Work Plan, identify 3-4 quality improvement activities, based on analysis of system performance. Incorporate current "work plan" spreadsheet into QAI Plan as set of indicators to be reported periodically.

4. Develop a clinical chart review process and tool that captures adherence to BBA, State Contract, and WAC requirements for provision of care, addressing effectiveness of intake assessment, treatment planning, and service provision. Design scoring such that agency and system-wide trends in service delivery can be observed and addressed if deficiencies are found.

Recommendations

Subpart Recommendations

1. Create a process to officially approve **revised** policies and procedures. Include dated signatures of PIHP officials or designees, date of revision, and effective date of policy. In addition, remove procedures from policies that are no longer in effect.

2. Continue to develop procedures for collecting and analyzing aggregate data to identify individual provider and system-wide trends related to over and under utilization.

3. Design and incorporate into PIHP's Fraud and Abuse policy, procedures related to effective lines of communication between the Compliance Officer and PIHP employees.

4. Expand privacy compliance audits of subcontractors to incorporate a management information security review. In addition, ensure that reviews and related reports are conducted in a timely manner and made available to provider management.

5. Update policies and procedures to consistently and accurately reflect the PIHP's positions (with qualifications) responsible for conducting authorizations and denials of service.

6. Revise monitoring tools incorporating review elements related to the BBA and the PIHP's new and revised policies and procedures.

7. Develop a formal Corrective Action policy and procedure for use with future Delegation Agreements/Contracts.

PM Recommendations

1. Develop a policy and procedure to ensure that data from an out-of-network provider is captured in the PIHP's data system.

2. Continue to develop member month calculations for use in performance management reporting.

PIP Recommendations

1. Provide details of methodology for training clinicians in use of Depression Guideline and administration of PHQ-9; demonstrate assurance of inter-rater reliability.

2. Provide details of data collection, documentation, and analysis, including tests of statistical significance applied to results.

EV Recommendations

1. Document a complete data standard, specifying expectations on an element by element basis.

2. Develop a data check matrix defining the data and a related check process to ensure that all data is evaluated.

3. Develop reports with descriptive information sufficient to allow understanding by an independent reader.

4. Define more specifically the elements of the encounter validation; e.g., random sampling techniques employed.

QAI Recommendations

1. Consider redesign of COG, with a new "charter" that ensures routine oversight of system operations based on data and verbal reports from key stakeholders (Ombuds, QRT, etc.).

2. Develop standards of measurement for all performance indicators, as well as thresholds for taking action.

3. For Annual Work Plan, identify 3-4 quality improvement activities, based on analysis of system performance. Incorporate current "work plan" spreadsheet into QAI Plan as set of indicators to be reported periodically.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Peninsula
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Peninsula PIHP is responsible for managing mental health care and services for Medicaid consumers in Clallam, Jefferson, and Kitsap counties in the state of Washington. The PIHP is located in Port Orchard, Washington and is governed by a board comprised of nine county commissioners, three from each county. Kitsap County is the designated Administrative Entity for the PIHP; the PIHP Administrator reports to the Kitsap County Personnel and Human Services Department. The PIHP contracts with four community mental health centers which serve approximately 5,000 adult and child consumers on a monthly basis. Total annual Medicaid enrollment in the PIHP is about 38,000. The PIHP delegates authorization/utilization management for outpatient and inpatient services to a private organization and delegates IT to Kitsap Mental Health, one of its network providers.

This report covers the period between October 21, 2005 and October 20, 2006 and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);

4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts	June-August, 2006	

Activity	Timeline	Documents/Content
• Review of 2004 Corrective Actions		
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	August 20, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	October 2, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	October 17, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	November 2 and 3, 2006	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	November 3, 2006	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	December 5, 2006	
4. Debrief conference call	December 15, 2006	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	January 4, 2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Peninsula PIHP submitted a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

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2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Peninsula PIHP, significant events include:

- The QA Manager position has been vacant since June 2006, significantly impacting the PIHP's ability to conduct routine QAI activities;

- The PIHP delegated utilization management of inpatient and outpatient care to a private entity, Community Network Behavioral Healthcare (CommCare), beginning November 1, 2006, necessitating a pre-delegation review and design and oversight of detailed contractual requirements.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- The policies and procedures submitted for review did not include a date of approval or official approval signature. However, "PRSN Executive Board" was typed in the "Approved by" place holder. Consequently, the WAEQRO was unable to determine whether all policies and procedures submitted for review had been officially adopted and approved. They were, however, considered in the scoring.

- The PIHP's sample network provider contracts for September 1, 2005 - August 31, 2006 inconsistently contained dated signatures of contracting parties. The WAEQRO was unable to determine if the contract references were from an officially executed contract. The sample contract, however, was considered in scoring the Subparts.

- Evidence submitted for the Subpart review was limited with respect to PIHP and provider network staff training on policies and procedures. Therefore, WAEQRO was challenged in determining whether policies and procedures have been put into practice.

- The PIHP did not submit PIP documents for review; the WAEQRO was therefore unable to complete a formal validation.

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4. 2006 Review Results

This report provides results and a summary of Peninsula PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Peninsula PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.206 (b)(3) [Q21]	**Systematic method of accessing a second opinion throughout service delivery system**			
	Second Opinion policy does not provide for an enrollee to request second opinion from outside provider network. PIHP monitoring for this has not occurred.	Submit a corrective action plan to the MHD by 3/9/05.	Revised CAP requested by MHD on 3/28/05; due 4/22/05. Submitted by PIHP 6/21/05.	Revised 2.13 Second Opinion and 2.12 Consumer Rights and Consent for Treatment policy and procedures contain basic requirements related to enrollee access to a second opinion. Included in PIHP FY 2005 Administrative Review of providers. PIHP has attained a score of 4-**Substantial Compliance.**

438.210(b) [Q41]	**Written policies and procedures addressing accessible information requirements**			
	Develop and implement authorization functions that include controls that guard against conflict of interest and potential fraud and abuse. Implement monitoring for consistent application of access to care standards.	Submit a corrective action plan to the MHD by 3/9/05.	Revised CAP requested by MHD on 3/28/05; due 4/22/05. Submitted by PIHP 5/12/05.	PIHP has designed a standard authorization process for inpatient, outpatient, and residential services to be utilized by the provider network. All Authorization and Notice of Action activities are delegated and subcontracted to CommCare, an ASO/MCO that does not provide direct service to the PIHP's enrollees. PIHP monitors consistent application of Access to Care Standards via chart reviews. PIHP has attained a score of **4-Substantial Compliance**.
438.230(b) [Q52]	**Evaluation of Subcontractor ability to perform delegated functions**			
	Need to evaluate subcontractor's ability to perform PIHP delegated functions for information system services.	Submit a corrective action plan to the MHD by 3/9/05.	Revised CAP requested by MHD on 3/28/05; due 4/22/05. Submitted by PIHP 5/12/05.	PIHP has a revised set of policies that collectively incorporate the PIHP's processes for evaluating prospective subcontractor ability to perform PIHP-delegated functions. The PIHP has completed a comprehensive

				evaluation of subcontractor ability to perform the delegated PIHP Management Information Services, and Authorization and Utilization Management functions. PIHP has attained a score of **5-Maximum Compliance**.
438.242	**Health Information Systems**			
	Need to accept data reports past cutoff date.	Submit a corrective action plan to the MHD by 3/9/05.	Corrective action plan submitted on 5/16/05.	The policy was modified outlining the steps required when submitting data after the submission timeframe. This issue has been fully addressed.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections

- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of “Expected” performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does,

however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);
- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Peninsula PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

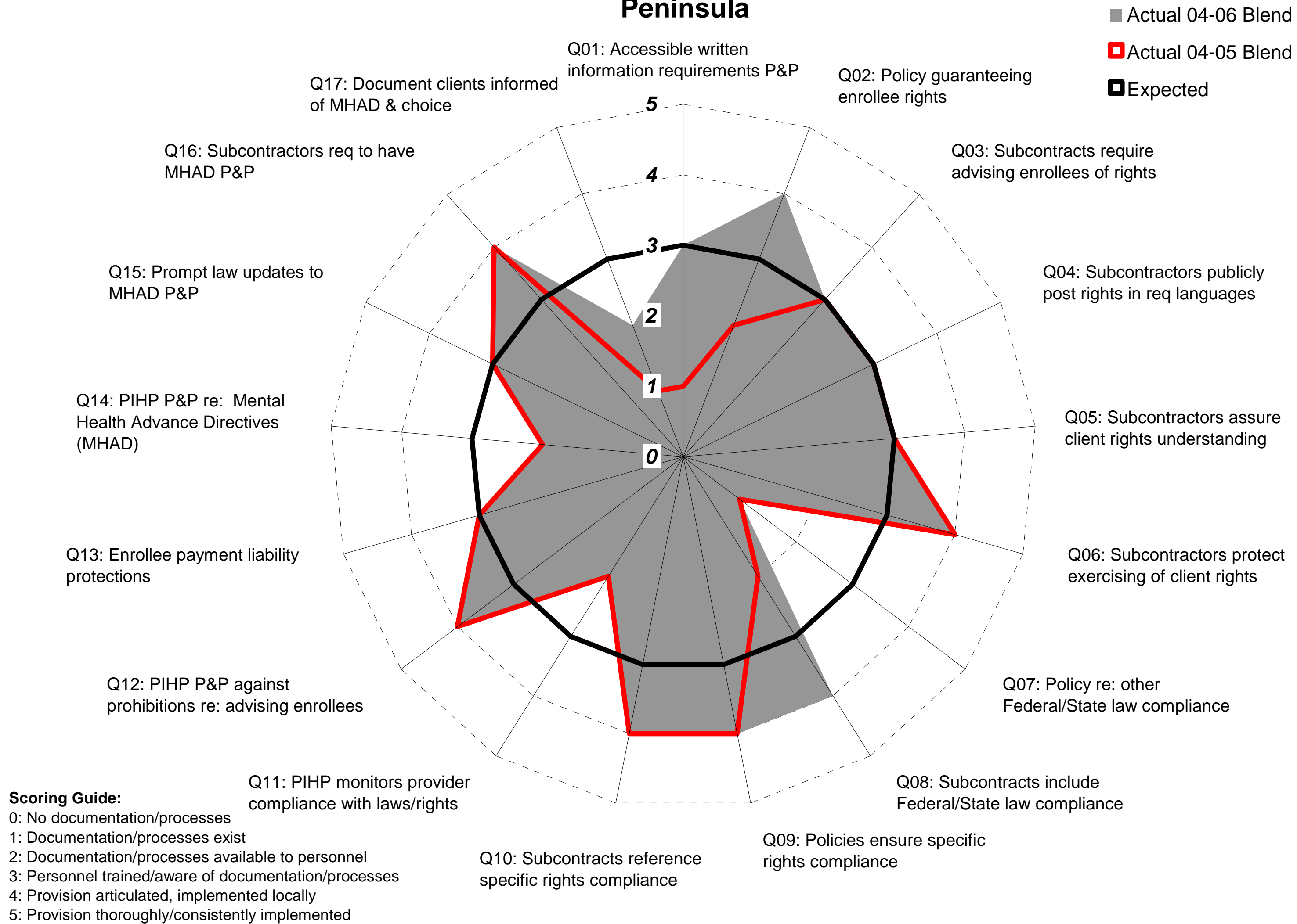
Subpart Radar Charts

The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for “Expected” performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. “Expected” performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Peninsula

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	1	3	3
Q02: Policy guaranteeing enrollee rights	2	4	4
Q03: Subcontracts require advising enrollees of rights	3		3
Q04: Subcontractors publicly post rights in req languages	3		3
Q05: Subcontractors assure client rights understanding	3		3
Q06: Subcontractors protect exercising of client rights	4		4
Q07: Policy re: other Federal/State law compliance	1	1	1
Q08: Subcontracts include Federal/State law compliance	2	4	4
Q09: Policies ensure specific rights compliance	4		4
Q10: Subcontracts reference specific rights compliance	4		4
Q11: PIHP monitors provider compliance with laws/rights	2	2	2
Q12: PIHP P&P against prohibitions re: advising enrollees	4		4
Q13: Enrollee payment liability protections	3		3
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	2	2	2
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	4		4
Q17: Document clients informed of MHAD & choice	1	2	2

Peninsula PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
438.10	**Information Requirements**	
[Q1]	**Written policies and procedures addressing accessible information requirements** Evidence: • In combination, the following documents generally meet the requirements of this provision, including mechanisms for monitoring: o 2.06 General Information Requirements o 2.11 Enrollee Rights o 2.12 Consumer Rights and Consent for Treatment o 2.14 Interpreter Services & Assistance o 2.15 Consumer Rights in Braille o 3.10 Notification of Network Provider Termination o 3.11 Notification of Primary MHC Provider Termination o DSHS Benefits Booklet- 7 languages o DSHS Your Rights Statement- 7 languages o MHD Booklet, CMHA memo for 7 Languages o PRSN Admin. Review Tools, current o JMHS Final Rpt, 4-05 o KMHS Final Rpt, 1-05 o PCMHC Final Rpt, 12-05 • DSHS Public Mental Health System Benefits Booklet for people enrolled in Medicaid, translated in DSHS required languages. • PIHP expects network providers to have above benefit booklet available to consumers in all required languages. • Provider network management reported PIHP conducts an annual Administrative Audit of each provider and includes a facilities check to ensure the "Point to Language" sign and the client rights are posted in all required languages in areas accessible to clients, check availability of benefits booklets, and review related provider policies and procedures. • PIHP reported conducting a "hands-on check" of each provider's TTD system as well as the 24-hour language line. • There remain inconsistencies among provider management staff as to the specific client materials required to be translated in all seven prevalent languages and made available in alternative formats for persons with sensory impairments. Recommend PIHP identify in provider contracts specific client materials to be translated and identify the required languages and formats in	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	which materials are to be made available. (Moderate Compliance)	3
438.100(b)	**Specific Enrollee Rights**	
[Q2]	**Policy guaranteeing the rights of enrollees** Evidence: • Revised 2.12 Consumer Rights and Consent for Treatment policy and procedure states, "The Peninsula Regional Support Network (PRSN) shall ensure consumer rights and consent for treatment are uniformly provided throughout the provider network. The PRSN provides standardized outpatient rights that the core network providers are required to use for signature." • Revised PRSN Client Rights Statement for Outpatient Services is inclusive of all required rights listed in this provision. The PIHP Handbook also has a very comprehensive list of rights for Medicaid enrollees. • New Promoting Recovery and Resiliency policy and procedures expounds on the right to participate in treatment decisions. • Provider direct service staff able to articulate knowledge of consumer rights and process by which they inform consumers of their rights. • Provider management reported that the PIHP monitors via periodic chart review that clients have received and signed rights. In addition, the PIHP looks for posting of rights and reviews them to ensure that they remain current. Provider management also reported that the PIHP monitors complaints and grievances to ensure no violations of client rights or retaliation towards clients who exercise their rights has taken place. • Recommend the PIHP use a consistent list of client rights in their Handbook and in policies and procedures where client rights are referenced. (Substantial Compliance)	4
438.100(d)	**Compliance with Other Federal and State laws**	
[Q7]	**Compliance with other Federal and State laws is reflected in policies** Evidence: • Revised 1.05 General Duties and Responsibilities policy and procedures state, "It is the policy of the Peninsula Regional Support Network (PRSN) to comply with the rules and regulations governing RSNs in CFR, RCW, and WAC and to comply with the general duties and responsibilities therein	

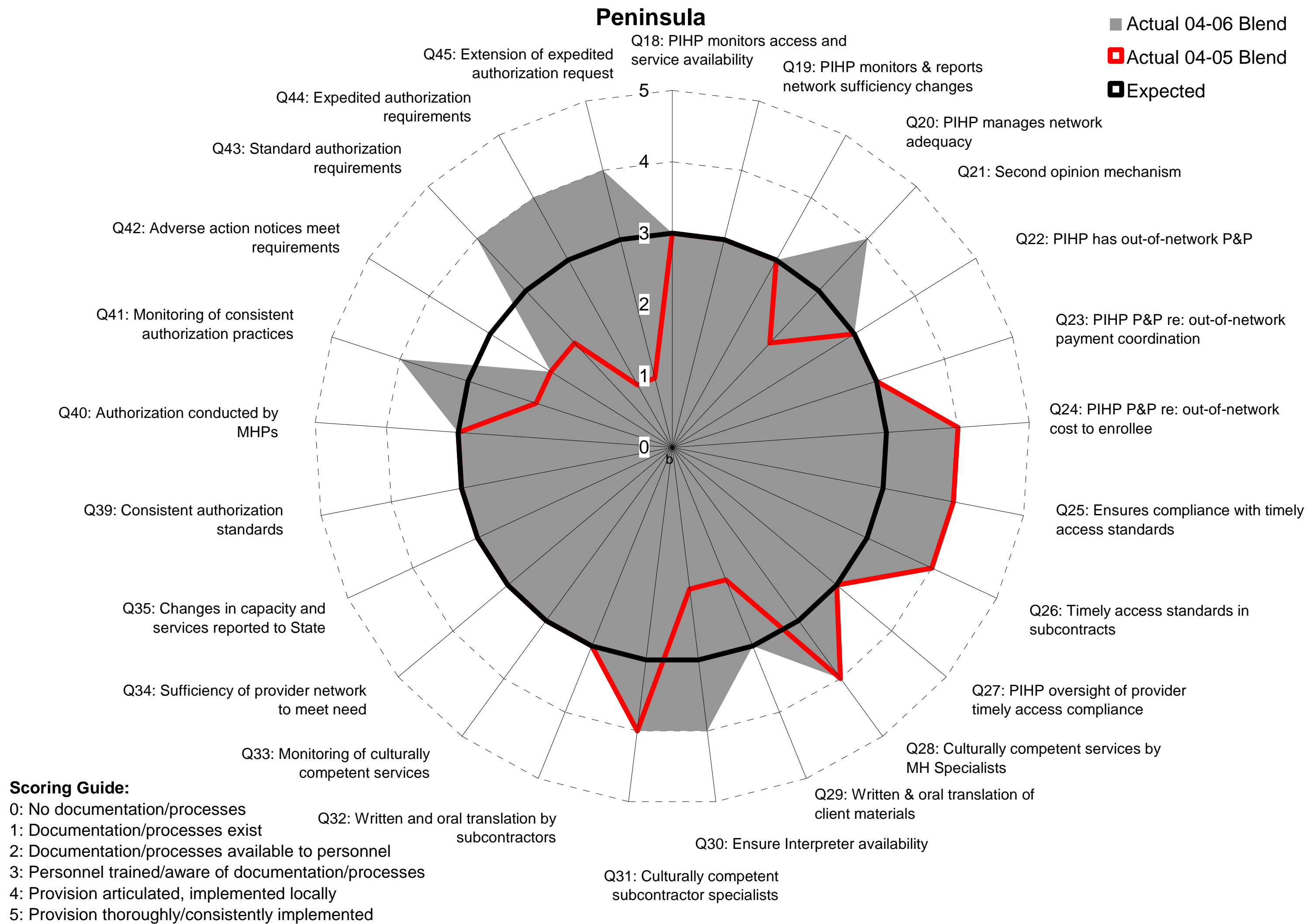
CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	specified." • Revised 2.11 Enrollee Rights, 2.12 Consumer Rights and Consent for Treatment, 2.13 Second Opinion, policies and procedures address three rights identified in the provision. • No explicit reference to the nondiscrimination laws cited in this provision were found in the PIHP's policies and procedures. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
[Q8]	**Subcontracts include Federal/State law compliance** Evidence: • 2006 and 2007 KMHS, sample contracts include requirements to comply with other Federal and State laws and specifically identify the nondiscrimination laws set forth in this provision. • Provider management reported that the PIHP monitors compliance with relevant nondiscrimination laws during the annual administrative audit. The PIHP reviews provider policies and procedures, as well as personnel records. In addition, the PIHP interviews HR staff, monitors results of current ADA facility audits, and watches for complaint and grievances related to client discrimination. (Substantial Compliance)	4

[Q11]	**PIHP monitors subcontractor compliance with Federal and State laws and client rights**
	Evidence:
	• Revised 9.02 Monitoring of Contractors policy and procedures contains procedures for monitoring subcontractors to ensure compliance with Federal and State laws and client rights.
	• The list of monitoring mechanisms includes but is not limited to:
	    o Telesage Outcomes,
	    o MHSIP surveys,
	    o Administrative Reviews,
	    o Random sample of Clinical and Quality Chart Reviews, R&E and MIS reports, MIS,
	    o Exhibit N Reports-showing patterns of complaints and grievances,
	    o Consumer and Ancillary provider surveys.
	• PIHP provider administrative reviews show evidence of monitoring compliance with nondiscrimination laws and access to second opinions. Results of Admin reviews submitted to Quality Improvement Committee (QUIC) on annual basis.
	• Evidence of PIHP monitoring for consumer involvement in treatment planning is in clinical chart reviews. This is also	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	identified as a quality indicator monitored quarterly, with results submitted to QUIC. • Provider network results of 2002 and 2004 consumer perception of participation in treatment (MHSIP survey results). • Provider management reported that the PIHP monitors compliance with relevant nondiscrimination laws during the annual administrative audit. The PIHP reviews provider policies and procedures, as well as personnel records. In addition, the PIHP interviews HR staff, monitors results of current ADA facility audits, and watches for complaint and grievances related to client discrimination. • Score remains the same as 2005 EQR due to no evidence found related to PIHP monitoring of consumer access to clinical records. (Partial Compliance)	2
438.10(g) 438.6(l)	**Advance Directives**	
[Q14]	**PIHP has Mental Health Advance Directive policies and procedures** Evidence: • Revised 2.02 Advance Directives policy and procedures includes all requirements of this provision with the exception of "giving advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law." • Score remains the same as 2005 EQR due to above-mentioned requirement missing from policy and procedure. (Partial Compliance)	2
[Q17]	**Client informed in writing of Mental Health Advance Directives, and choice is documented** Evidence: • Revised 2.02 Advance Directives policy and procedures, an attachment to the PIHP provider contracts, states, "The Peninsula Regional Support Network (PRSN) network providers shall provide information to all consumers regarding their right to create an advance directive. Advance Directives shall include and demonstrate an individual's voice in developing the plan(s)." In addition, the policy defines the procedures by which the providers shall provide Advance Directive information to enrollees. The policy also requires that network providers	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	document in the clinical record whether the consumer chose to execute and Advance Directive. • Multiple brochures containing Advance Directive information. • Sample of provider Advance Directive policies and procedures. • Provider Disclosure/Acknowledgement Receipts. • Provider treatment plan and intake assessment which indicate that Advance Directive information was provided to client. Each provider has its own unique method of documentation. • The provider network documentation forms do not contain the requirement to document consumer choice related to whether they want an Advance Directive. • Provider direct service staff reported they are required to document that Advance Directive information was given to the client and if the client already has an Advance Directive. In addition, staff stated that the client's crisis plan should mimic what is in the Advance Directive. Direct service staff did not confirm they are required to document consumer choice as to whether they want to execute an Advance Directive. • Recommend that PIHP standardize the method for documenting the provision of Advance Directive information and enrollee choice for the provider network. (Partial Compliance)	2

Subpart D (Part 1): Access Standards

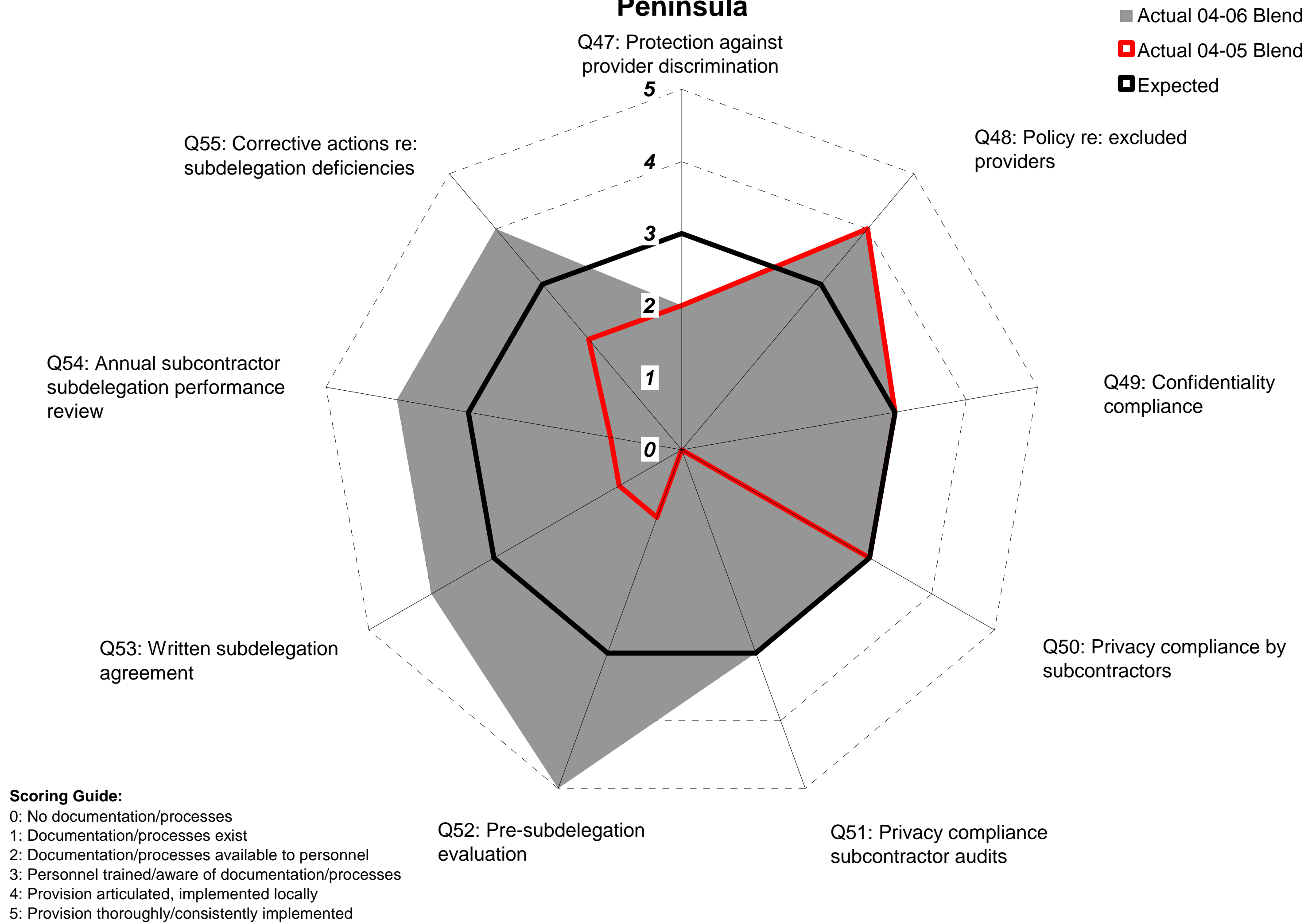


Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Peninsula

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	2	4	4
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	3		3
Q24: PIHP P&P re: out-of-network cost to enrollee	4		4
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	4		4
Q27: PIHP oversight of provider timely access compliance	3		3
Q28: Culturally competent services by MH Specialists	4		4
Q29: Written & oral translation of client materials	2	3	3
Q30: Ensure Interpreter availability	2	4	4
Q31: Culturally competent subcontractor specialists	4		4
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	3		3
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	3		3
Q40: Authorization conducted by MHPs	3		3
Q41: Monitoring of consistent authorization practices	2	4	4
Q42: Adverse action notices meet requirements	2	2	2
Q43: Standard authorization requirements	2	4	4
Q44: Expedited authorization requirements	1	4	4
Q45: Extension of expedited authorization request	1	4	4



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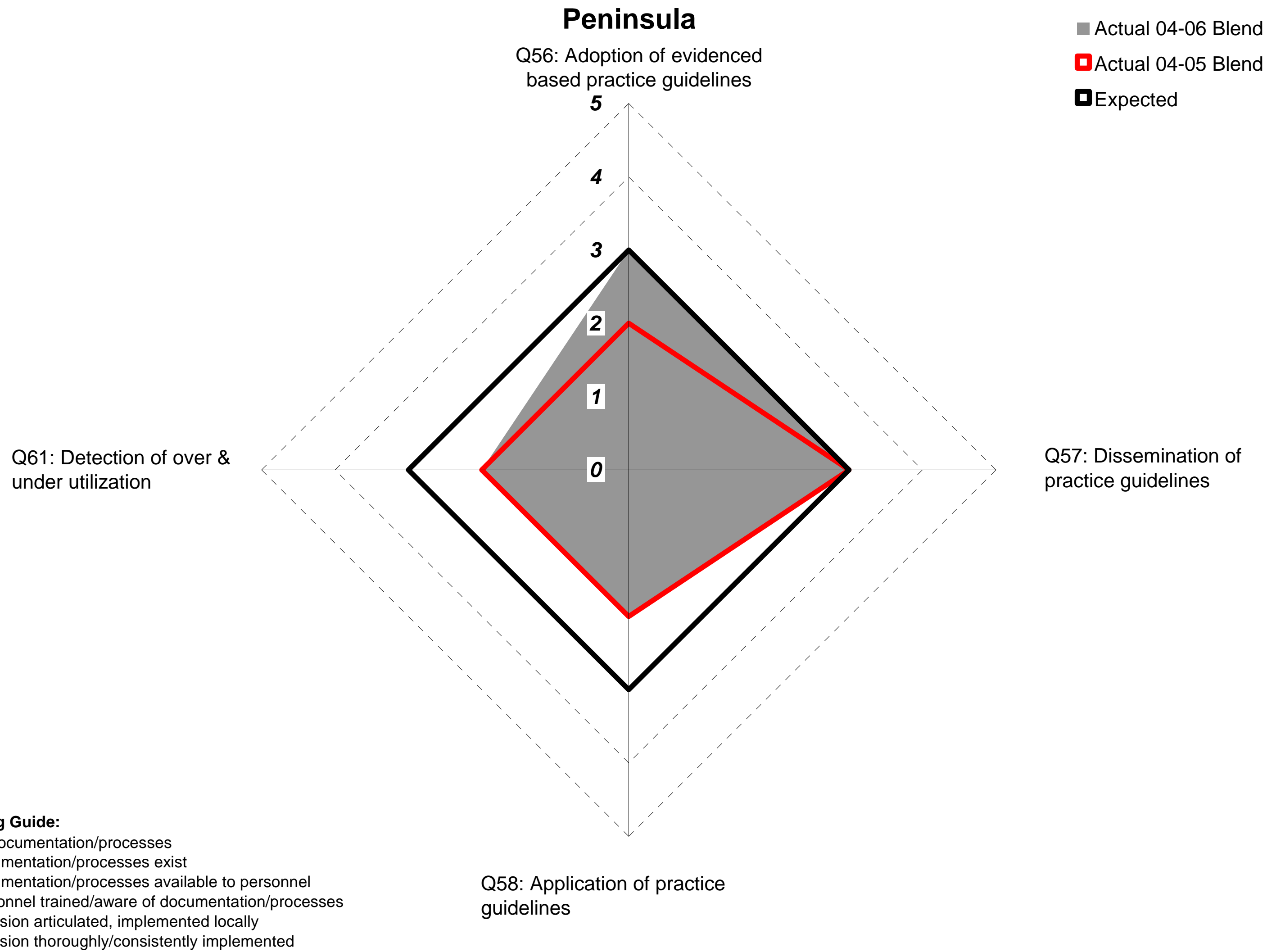
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	2	2	2
Q48: Policy re: excluded providers	4		4
Q49: Confidentiality compliance	3		3
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	0	3	3
Q52: Pre-subdelegation evaluation	1	5	5
Q53: Written subdelegation agreement	1	4	4
Q54: Annual subcontractor subdelegation performance review	1	4	4
Q55: Corrective actions re: subdelegation deficiencies	2	4	4

Subpart D (Part 3): Measurement and Improvement Standards



Scoring Guide:
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2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
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2004-2006 Subpart Scoring Trend and Detail for Peninsula

Scoring Guide for Subparts C, D and F:
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4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	2	3	3
Q57: Dissemination of practice guidelines	3		3
Q58: Application of practice guidelines	2	2	2
Q61: Detection of over & under utilization	2	2	2

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (b)(3)	**Delivery Network-Second Opinion**	
[Q21]	**Systematic method of accessing a second opinion throughout service delivery system** Evidence: • Revised 2.13 Second Opinion and 2.12 Consumer Rights and Consent for Treatment policy and procedures contain basic requirements related to enrollee access to a second opinion. • Recommend that the PIHP stipulate specific procedures in the policy; e.g., required components of a second opinion assessment, who has access to the assessment, how the assessment incorporated into treatment decisions, and consumer's participation in related decisions. • Letters of Ineligibility to consumers from CommCare—provide reason as to why enrollee does not meet criteria for services and describe their option for a second opinion if requested in 30 days. • Notice of Action (NOA) letters which do not inform enrollee of the option for a second opinion. • PIHP FY 2005 Administrative Review of providers included the following interview question: "If a client or family member requested a second opinion, what are the next steps?" All FY 2005 review reports show provider compliance. • No evidence of training PIHP or network provider staff submitted for review. • Provider direct service staff are knowledgeable about consumer rights to a second opinion, and able to articulate how they would access a second opinion for a consumer, if needed. • Provider management not sure how PIHP monitors consumer access to second opinions other than by reviewing their policies and procedures and grievances. (Substantial Compliance)	4
438.206 (c)(2)	**Furnishing of Services Continued-Culturally Competent**	
[Q29]	**Written and oral translation of client materials** Evidence: • Revised 2.06 General Information Requirements, 2.14 Interpreter Services and Assistance, 2.15 Consumer Rights in	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	Braille, new 3.03 Culturally Competent Service Structure, new 2.05 Comprehensive Information Plan, together generally meet the basic requirements for written and oral translation of client materials. • 7.14 Utilization Management Plan (no date) states, "Individuals with sensory impairments, or who speak a language other than English, are provided equal access to this information through: o Provision of material in Braille. o Use of a DSHS TDD language line. o Access to certified sign and language interpreters. o PRSN contracted hearing impaired consultant. o Client rights are posted in common areas of the network agencies in the seven DSHS identified languages." • DSHS Public Mental Health System Benefits Booklet for people enrolled in Medicaid, translated in DSHS required languages. • PIHP FY 2005 Administrative Review of providers included facility check for client rights posted in all 8 required languages, posted "Point to Your Language" signs and the following interview question: "Do you know how to access Interpreters/ Hearing Impaired services?" All FY 2005 review reports show provider compliance. • Direct service staff able to articulate languages that must be available in oral translation and how to access interpreters including American Sign Language interpreters. • There remain inconsistencies among provider management staff as to the specific client materials required to be translated in all seven prevalent languages and made available in alternative formats for persons with sensory impairments. Recommend PIHP identify in provider contracts specific client materials to be translated and identify the required languages and formats in which materials are to be made available. (Moderate Compliance)	3
[Q30]	**Ensure Interpreter availability** Evidence: • Revised 2.06 General Information Requirements, 2.14 Interpreter Services and Assistance, 2.15 Consumer Rights in Braille, new 3.03 Culturally Competent Service Structure, new 2.05 Comprehensive Information Plan, together generally incorporate requirements to ensure interpreter availability. • 7.14 Utilization Management Plan (no date) states, "Individuals with sensory impairments, or who speak a language other than English, are provided equal access to this information through: o Provision of material in Braille. o Use of a DSHS TDD language line. o Access to certified sign and language interpreters.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	o PRSN contracted hearing impaired consultant. o Client rights are posted in common areas of the network agencies in the seven DSHS identified languages." • October '05 Clinical Director Meeting notes describe revised guidelines and timeframes for external minority and special population consultations (includes interpreter services). The Specialists and Interpreters have two days to respond to requests from providers and seven days to complete the consultation. Recommend incorporating the new Specialist and Interpreter guidelines and timeframe requirements into PIHP policies and procedures. • PIHP FY 2005 Administrative Review of providers included facility check for client rights posted in all 8 required languages, posted "Point to Your Language" signs and the following interview question: "Do you know how to access Interpreters/ Hearing Impaired services?" All FY 2005 review reports show provider compliance. • Direct service staff able to articulate languages that must be available in oral translation and how to access interpreters including American Sign Language interpreters. (Substantial Compliance)	4
438.210(b)	**Authorization of Services**	
[Q41]	**PIHP audits subcontractors for consistent authorization practices and evidence of policy** Evidence: • Revised 3.09 Subcontractual Delegation and Assessment, 7.01 Authorization for Outpatient Services Based on Medical Necessity, 7.01a Medicaid OP Access Flowchart, 7.01b Medicaid Continuing OP Flowchart, 7.11 Intake Assessment Evaluation Services Standards, 7.14 Utilization Management Plan, collectively provide a detailed and comprehensive view of the authorization and utilization management (UM) processes and procedures. • PIHP has designed a standard authorization process for inpatient, outpatient, and residential services to be utilized by the provider network. All Authorization and NOA activities are delegated by the PIHP to CommCare. • Authorization Notification Letters; Outpatient, Inpatient and Residential Authorization Forms, and Denial Notification Letters, provided a picture of how the standard authorization practices are consistently implemented. • Provider management and direct service staff reported ongoing training for authorization practices occurs in team meetings. All interviewed staff were knowledgeable and able to articulate the	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	standard authorization practices and the roles of all entities involved. • PIHP monitors authorization practices through weekly quarterly UM reports from CommCare. Critical issues that arise are taken to the Utilization Management Committee and QUIC as evidenced in submitted meeting minutes. • PIHP did not submit documentation that specifically relates to monitoring CommCare for consistent authorization practices other than clinical chart reviews. Recommend inter-rater reliability review as well as ongoing concurrent and retroactive review of charts with a focus on intakes, authorizations, Level of Care (LOC), NOAs, and the like. (Substantial Compliance)	4
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: Revised 6.04 Service Denial & Notice of Action Appeal Standard, revised 6.02 Service Denial Auth Decisions and Notifications, revised 6.05 Service Denial and Notice of Action Appeal Expedited, 6.05a Service Denial and Notice of Action Flowchart policies and procedures collectively incorporate the Notice of Action requirements with the exception of: 438.404(4) If the PIHP extends the timeframe in accordance with 438.210(d)(1) it must – (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. • Upon review of several copies of NOAs, reviewer unable to determine if the required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs were submitted for review. • All NOAs are Cc'd to the CMHA serving the enrollee. • PIHP Exhibit N Report memos for November 2005 and May 2006 which include a brief analysis of the data, acknowledging further review will be done by QUIC. • Critical issues that arise concerning NOAs are brought to the UM Committee and QUIC as evidenced by submitted meeting minutes. • No evidence of training PIHP or network provider staff submitted for review.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Provider direct service staff have variable knowledge and understanding of Notice of Actions and their purpose. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • Revised 7.01Authorization for Outpatient Services Based on Medical Necessity policy and procedures state, "Standard authorization decisions are made as expeditiously as the individual's mental health condition requires and within state established timelines but not to exceed 14 calendar days following receipt of the request for services." Revised 7.03 LOC, condensed Version includes requirements related to requests for extensions of standard authorizations and extensions implemented by the PIHP. • Additional documents submitted for this review element included 6.02 Service Denial Authorization Decision and Notification, 6.04 Service Denial & Notice of Action Appeal Standard, 7.01a Medicaid Outpatient Access Flowchart, 7.04 Intake Assessment Eval Services Standards, and do not address requirements related to extensions of standard authorizations. • Provider management and direct service staff reported ongoing training for authorization practices occurs in team meetings. All interviewed staff were knowledgeable and able to articulate the standard authorization practices and the roles of all entities involved. (Substantial Compliance)	4
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Documents listed in [Q43]. • Revised 7.01Authorization for Outpatient Services Based on Medical Necessity policy and procedures contain procedures for expedited authorization decisions and extensions. • Provider management and direct service staff reported ongoing training for authorization practices occurs in team meetings. • Direct service staff familiar and able to articulate basic purpose of an Expedited Authorization. (Substantial Compliance)	4
[Q45]	**Extension of expedited authorization request**	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	Evidence: • Documents listed in [Q43]. • Revised 7.03 LOC, condensed Version includes requirements related to an extension of expedited authorization requests. • Provider management and direct service staff reported ongoing training for authorization practices occurs in team meetings. • Direct service staff familiar and able to articulate basic purpose of an extension of an Expedited Authorization. (Substantial Compliance)	4
438.210(e)	**Compensation for Utilization Management Activities**	
[Q46]	**Protections against financial incentives for authorization decisions** Evidence: • Revised 7.02 Authorization of Services-Independence from Financial Incentives policy and procedures includes protections against financial incentives for authorization decisions. The PIHP network provider payment structure is separate from the authorization for service decisions, and provides no financial incentives to the network or managed care entity. • The PIHP contracts with CommCare for utilization management services, including all authorization determinations, management of the PIHP Notice of Action policy, inpatient authorizations and appeals, and medical director responsibilities, particularly in regard to inpatient care. CommCare is paid on a per-member per-month (pmpm) basis, based on the number of eligible individuals the PIHP receives payment for from the Mental Health Division the previous month. This payment methodology minimizes the risks of financial incentives related to authorizing or denying an individual enrollee's care and services. • 2006 and 2007 PIHP CommCare contracts showing evidence of payment on a pmpm basis for Medicaid enrollees. • Calendar Year 2006 Utilization Management Report (Moderate Compliance)	3
438.214(c)	**Nondiscrimination**	
[Q47]	**Protection against provider discrimination** Evidence: • Revised 3.05 Service Provider Selection partially meets the requirements of this provision by including, "the PIHP will not discriminate against any network provider that is acting within the scope of their license or certification solely based upon the basis of that status." Policy does incorporate protection against	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	provider discrimination for providers that serve high-risk populations or specialize in conditions that require costly treatment. • Additional documents reviewed included: 1.01 Introduction, 1.05 General Duties and Responsibilities, 3.01 Availability of Services, 11.09 Frequent Crisis Services Users, 11.10 High Risk Individuals and no information on protection against provider discrimination that serve high risk populations or provide costly treatment was found. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.224	**Confidentiality**	
[Q51]	**PIHP audits subcontractors for privacy compliance** Evidence: • PIHP has a comprehensive set of new Health Information Portability and Accountability Act (HIPAA) policies and procedures regarding compliance with 45 CFR parts 160 and 164, Subparts A and E. • PIHP New Staff Orientation Checklist (blank form) includes HIPPA Confidentiality and Privacy Training items. • PIHP Compliance Plan incorporates confidentiality practices. • PIHP FY 2005 Provider Administrative Reviews include review of provider HIPAA policies and procedures, staff signed confidentiality statements maintained on file acknowledging understanding and agreement to abide by HIPAA requirements, staff HIPPA training records and that new staff have received training within 30 days of start date. FY 2005 review reports included PIHP assigned Corrective Actions and provider responses. • Corrective Action example: Updated Provider Confidentiality Statement to incorporate HIPAA requirements. New form submitted to show evidence of provider compliance and follow through. • No evidence of PIHP conducting provider monitoring related to HIPAA security requirements. (Moderate Compliance)	3
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence:	

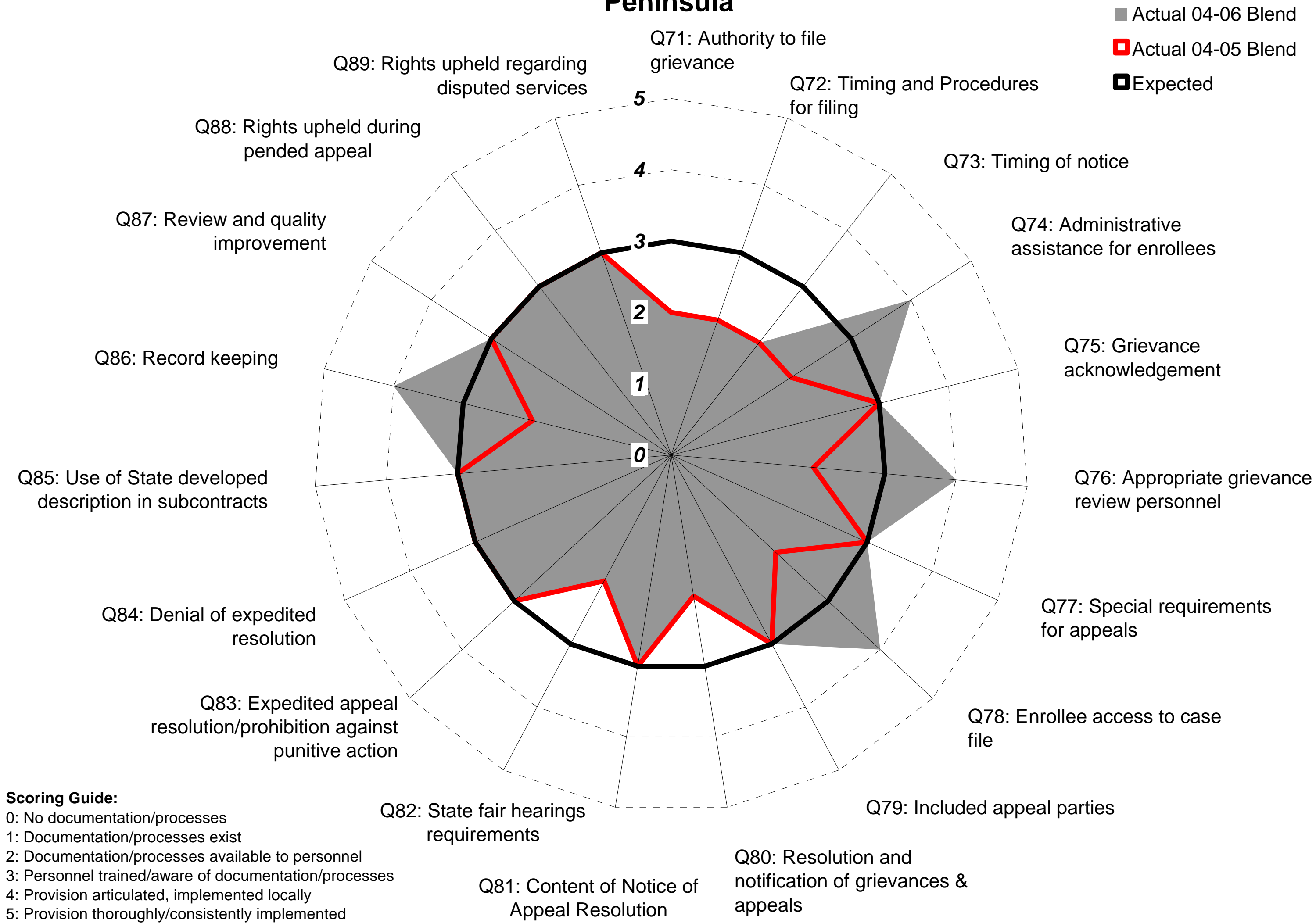
CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Revised 3.09 Subcontractual Delegation and Assessment, 3.09a Subcontractor Assessment Tool-ASO, 3.09b Subcontractor Assessment Tool IS, 9.02 Monitoring Contractors, 9.03 Provider Administrative Review, 9.08 Provider Subcontractor Non-Compliance, and 9.09 Corrective Actions Plans policies and procedures collectively incorporate the PIHP's processes for evaluating prospective subcontractor ability to perform PIHP-delegated functions. • Documents specific to delegation of PIHP Authorization and Utilization Management functions include: o PIHP September 21, 2005 ASO RFP, o RFP Responders Evaluation Summary, o Signature Page, o Debarment Certification, o PIHP Subdelegation Plan for Authorization and UM to CommCare (Dec 1, 2005) and Deliverable Memo, o PIHP-CommCare 2005 and 2006 Contracts with description of duties and responsibilities, o URAC Certification Letter for CommCare, and o Utilization Management Report-CY 2006. • Documents specific to delegation of PIHP Information Services include: o Kitsap Mental Health Service (KMHS) Information Technology (IT) Job Description, o KMHS IT Staff Organization Chart, o KMHS IT Staff Qualifications Table, o MIS Subdelegation Assessment Tool (completed 10-17-06), o MIS Subdelegation Requirements, o 2004 PIHP EQRO Final ISCA and Subpart H Reports, o PIHP-KMHS '05-'06 Contract with description of IT duties and responsibilities. • As evidenced in above listed documentation, the PIHP has completed a comprehensive evaluation of subcontractor ability to perform the delegated PIHP MIS and Authorization and UM functions. (Maximum Compliance)	5
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • Revised 3.09 Subcontractual Delegation and Assessment, and PIHP Subdelegation Plan for Authorization and UM to CommCare (Dec 1, 2005) contain requirements for written MIS and Authorization and UM delegation agreements. • PIHP-KMHS '05-'06 Contract, and PIHP-CommCare 2005 and	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	2006 Contracts, along with the 3.09 Subcontractual Delegation and Assessment, and PIHP Subdelegation Plan for Authorization and UM to CommCare (Dec 1, 2005) specify delegated MIS and Authorization and UM functions, activities and responsibilities. • PIHP-KMHS '05-'06 Contract, and PIHP-CommCare 2005 and 2006 Contracts along with 9.08 Provider Subcontractor Non-Compliance, and 9.09 Corrective Actions Plans provide for revoking delegation or imposing corrective actions or other sanctions if the subcontractor's performance is inadequate. • Series of Utilization Management Committee (UMC) minutes were provided which demonstrate on-going communication, coordination and quality improvements made by CommCare and KMHS IS as feedback from the PIHP and UMC. • No significant quality improvements, corrective actions, or other sanctions have been issued by the PIHP with their MIS and Authorization and UM delegated subcontractors. PIHP staff reported they are very satisfied with the performance of these subcontractors. • Recommend PIHP review above-identified documents to ensure that delegated functions, activities, and responsibilities for MIS and Authorization and UM consistently crosswalk from one document to another. (Substantial Compliance)	4
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • Revised 3.09 Subcontractual Delegation and Assessment, 3.09a Subcontractor Assessment Tool-ASO, 3.09bSubcontractor Assessment Tool IS, 9.02 Monitoring Contractors, 9.03 Provider Administrative Review, 9.08 Provider Subcontractor Non-Compliance, and 9.09 Corrective Actions Plans policies and procedures, along with the PIHP Subdelegation Plan for Authorization, PIHP-KMHS '05-'06 Contract, and PIHP-CommCare 2005 and 2006 Contracts collectively specify monitoring activities related to subcontractor performance of delegated functions. • Series of Utilization Management Committee (UMC), Clinical Director and QUIC meeting minutes provided demonstrate on-going communication, coordination, and quality improvements made by CommCare and KMHS IS as feedback from the PIHP and listed work groups. • Initial Authorization and UM Assessment Tool (completed 11-1-05), and MIS Subdelegation Assessment Tool (completed 10-17-06). PIHP has yet to complete an annual review of	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	CommCare. • No significant quality improvements, corrective actions, or other sanctions have been issued by the PIHP with their MIS and Authorization and UM delegated subcontractors. PIHP staff reported they are very satisfied with the performance of these subcontractors. (Substantial Compliance)	4
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • Revised 3.09 Subcontractual Delegation and Assessment, PIHP Subdelegation Plan for Authorization, PIHP-KMHS '05-'06 Contract, and PIHP-CommCare 2005 and 2006 Contracts along with 9.08 Provider Subcontractor Non-Compliance, and 9.09 Corrective Actions Plans provide for revoking delegation or imposing corrective actions or other sanctions if the subcontractor's performance is inadequate. • See additional documents listed in [Q52]. • Series of Utilization Management Committee (UMC), Clinical Director and QUIC meeting minutes provided demonstrate on-going communication, coordination and quality improvements made by CommCare and KMHS IS as feedback from the PIHP and listed work groups. • Initial Authorization and UM Assessment Tool (completed 11-1-05), and MIS Subdelegation Assessment Tool (completed 10-17-06). PIHP has yet to complete an annual review of CommCare. • No significant quality improvements, corrective actions or other sanctions have been issued by the PIHP with their MIS and Authorization and UM delegated subcontractors. PIHP staff reported they are very satisfied with the performance of these subcontractors. (Substantial Compliance)	4
438.236	**Practice Guidelines**	
[Q56]	**Adoption of practice guidelines meets established requirements** Evidence: • Revised 11.16 Practice Guidelines policy and procedures include the basic requirements of this provision. • After the PIHP determined the 3 most prevalent and covered psychiatric diagnosis in their region, staff researched a variety of practice guidelines, and enlisted the assistance and recommendations from the Provider Network Clinical Directors.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	The PIHP selected and adopted two APA-approved practice guidelines; Bipolar Disorder and Schizophrenia. • September '05 and January '06 Clinical Director's Meeting minutes show evidence of establishing a workgroup to develop practice guidelines and beginning discussion on how to monitor their implementation. • No evidence submitted indicating official adoption of the practice guidelines by QUIC or the Governing Board. • Provider management confirmed participation of their Clinical Directors in researching and selection of the practice guidelines. • No evidence of training PIHP or network provider staff submitted for review. In addition, provider management and direct service staff reported that no practice guideline training has been provided by the PIHP. At one provider, supervisors have reviewed the guidelines with their direct service staff. • Provider management from both CMHAs interviewed, and direct service staff from one provider, were able to identify the adopted practice guidelines. They also reported the practice guidelines are primarily for use by psychiatrists and medical staff. (Moderate Compliance)	3
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • Revised 11.16 Practice Guidelines policy and procedures stipulate the adopted practice guidelines shall be incorporated into their processes of care, including their standardized Levels of care, intake assessments and treatment planning, and utilization management. • No evidence demonstrating PIHP's monitoring the implementation or fidelity of the practice guidelines. • As reported by PIHP staff and provider management, they have yet to create tools, measures, and methods by which the PIHP can monitor fidelity to such practices and provide oversight to ensure their full utilization in clinical services. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.240	**Quality Assessment and Performance Improvement Program**	
[Q61]	**Effective mechanisms to detect under and over utilization** Evidence: • Revised 7.13 Over and Under Utilization Management policy	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	and procedure, 7.13a Over and Under Utilization Table (incomplete), 7.14 Utilization Management Plan, 7.15 Network Resource Management Plan, and FY 2006 Project Definitions collectively describe in detail, methods the PIHP utilizes to monitor and detect under and over utilization. • No documentation submitted showing evidence that mechanisms, as described in the above policies and plans, have been employed by the PIHP to monitor over and under utilization during the review period. • PIHP staff and provider management reported that mechanisms to monitor and detect under and over utilization have not been implemented during the review period due to the PIHP's focus and efforts on the RFQ and RFP processes. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Peninsula

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	2	2	2
Q72: Timing and Procedures for filing	2	2	2
Q73: Timing of notice	2	2	2
Q74: Administrative assistance for enrollees	2	4	4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	2	4	4
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	2	4	4
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	2	2	2
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	2	2	2
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	2	4	4
Q87: Review and quality improvement	3		3
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.402	**Grievance System and Filing Requirements**	

[Q71]	**Authority to file a grievance, appeal, or State fair hearing**
	Evidence:
	• Revised 6.01 Complaint Grievance Appeal and Fair Hearing Process, 6.01a Complaint Grievance Fair Hearing Process Flowchart, revised 6.04 Service Denial & Notice of Action Appeal Standard, revised 6.02 Service Denial Auth Decisions and Notifications, revised 6.05 Service Denial and Notice of Action Appeal Expedited, 6.05a Service Denial and Notice of Action Flowchart policies and procedures collectively demonstrate the PIHP has a grievance, appeal and fair hearing process and contain all filing requirements with the exception of "A Community Mental Health Agency, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal; or that A CMHA may file a grievance or request a State fair hearing on behalf of an enrollee and act as the enrollee's authorized representative."
	• No evidence of training PIHP or network provider staff submitted for review.
	• Provider direct service staff stated that client, Ombuds, family member, and court-appointed guardian could file grievances and appeals. Inconsistent response as to whether CMHA could file.
	• Monitoring activities and reports:
	    o Exhibit P-Exhibit N Instructions,
	    o PIHP Exhibit N Reports,
	    o PIHP Exhibit N Report memos for November 2005 and May 2006, which include a brief analysis of the data, acknowledging further review will be done by QUIC.
	• No additional data or reports showing trending and analysis over time.
	• Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.
	(Partial Compliance)
		2

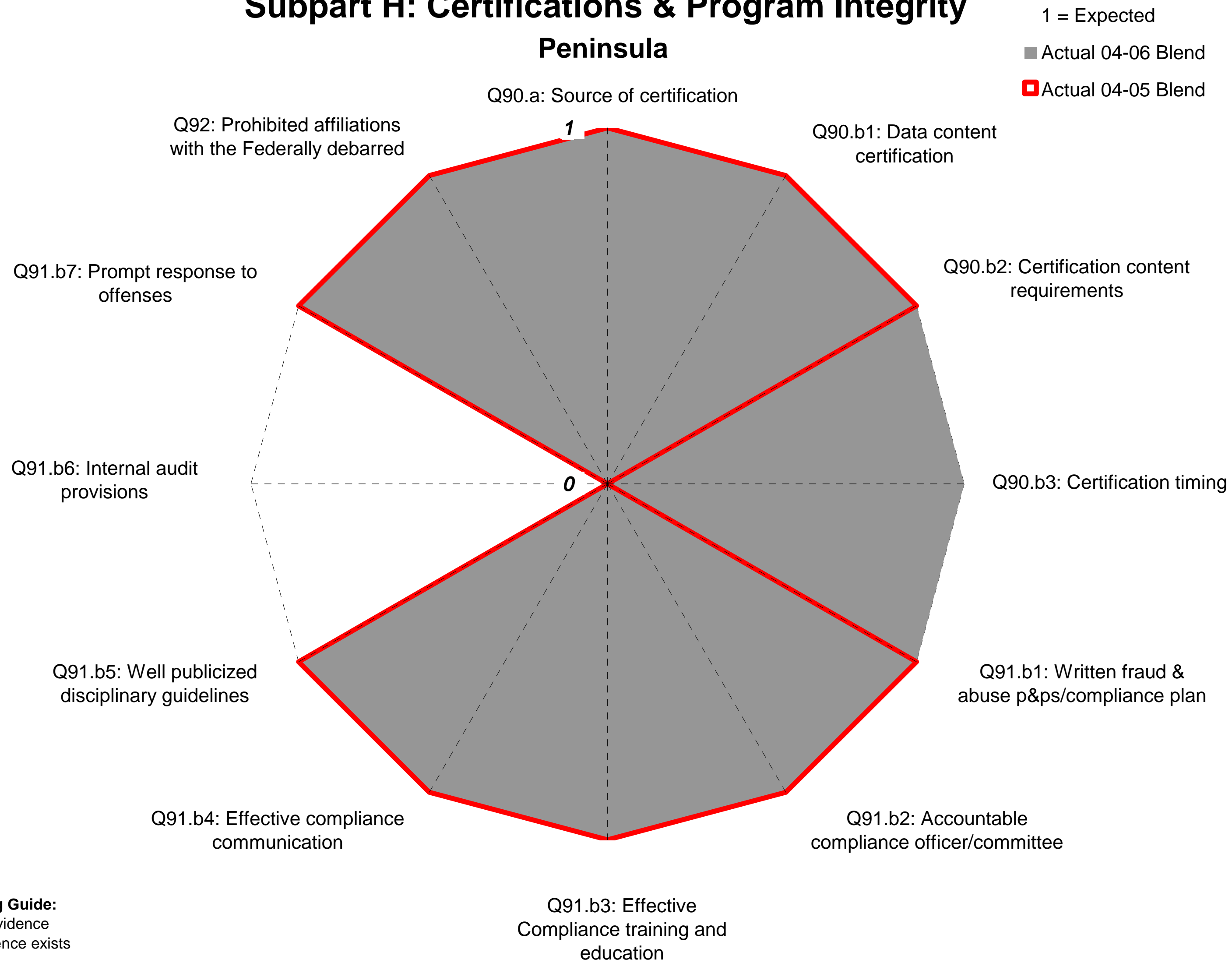
[Q72]	**Timing and Procedures for filing a grievance, appeal, or State fair hearing** Evidence: • Documents listed in [Q71] include partial requirements of this provision: o Included is the requirement that an enrollee may file a grievance either in writing or orally with written to follow.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	The policies inaccurately state that a written grievance must follow within 10 days; it is actually 7 days. o The policies include that an enrollee or representative may file an appeal, either in writing or orally, with written follow-up in 7 days (accurate) unless requests expedited resolution. However, they do not specifically mention that a CMHA may file an appeal. o Policies state that an appeal must be filed within 20 days of receipt of NOA; they do not include that an appeal must be filed within 10 days if enrollee wants service to continue. • No evidence of training PIHP or network provider staff submitted for review. • Provider direct service staff reported that grievances and appeals could only be filed in writing. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.404	**Notice of Adverse Action**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: Revised 6.04 Service Denial & Notice of Action Appeal Standard, revised 6.02 Service Denial Auth Decisions and Notifications, revised 6.05 Service Denial and Notice of Action Appeal Expedited, 6.05a Service Denial and Notice of Action Flowchart policies and procedures collectively contain all timing of Notice requirements with the exception of: 438.404**(**4)If the PIHP extends the timeframe in accordance with 438.210(d)(1) it must – (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. • Upon review of several copies of NOAs, reviewer unable to determine if the required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs were submitted for review. • All NOAs are Cc'd to the CMHA serving the enrollee. • PIHP Exhibit N Report memos for November 2005 and May 2006 which include a brief analysis of the data, acknowledging further review will be done by QUIC.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	• Critical issues that arise concerning NOAs are brought to the UM Committee and QUIC as evidenced by submitted meeting minutes. • No evidence of training PIHP or network provider staff submitted for review. • Provider direct service staff have variable knowledge and understanding of Notice of Actions and their purpose. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.406	**Handling of Grievances and Appeals**	
[Q74]	**PIHP ensures enrollees are provided assistance in completing forms and taking procedural steps** Evidence: • <u>6.01 Complaint Grievance Appeal and Fair Hearing Process</u> and <u>6.04 Service Denial & Notice of Action Appeal Standard</u> policies and procedures incorporate language that ensures enrollees are provided reasonable assistance in completing forms and taking other procedural steps related to grievances and appeals. • No evidence of training PIHP or network provider staff submitted for review. • Provider direct service staff were able to articulate basic requirement by identifying that assistance may be provided by the Ombuds, interpreters, and case managers. (Substantial Compliance)	4
[Q76]	**Review personnel have clinical expertise and no involvement in previous review or decision making** Evidence: • Revised <u>6.04 Service Denial & Notice of Action Appeal Standard</u>, revised <u>6.02 Service Denial Auth Decisions and Notifications</u>, revised <u>6.05 Service Denial and Notice of Action Appeal Expedited</u>, policies and procedures incorporate the requirement that review personnel must have relevant clinical expertise and no involvement in previous review or decision making. • No evidence of training PIHP or network provider staff submitted for review. • Provider management able to articulate basic requirements of this provision. (Substantial Compliance)	4
[Q78]	**Enrollee and representative opportunity to examine case file,**	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	medical records, other documents related to appeal process Evidence: • Revised 6.04 Service Denial & Notice of Action Appeal Standard policies and procedures include language to ensure enrollee and their representative. • No evidence of training PIHP or network provider staff submitted for review. • Provider direct service staff able to articulate basic requirements of this provision by identifying that client has access to their clinical record and any information associated with the actions they are appealing. (Substantial Compliance)	4
438.408	**Resolution and Notification of Grievances and Appeals**	
[Q80]	**Resolution and notification for grievance and appeals** Evidence: • Revised 6.01 Complaint Grievance Appeal and Fair Hearing Process, 6.01a Complaint Grievance Fair Hearing Process Flowchart, revised 6.04 Service Denial & Notice of Action Appeal Standard, revised 6.02 Service Denial Auth Decisions and Notifications, revised 6.05 Service Denial and Notice of Action Appeal Expedited, 6.05a Service Denial and Notice of Action Flowchart policies and procedures collectively incorporate the format of notice requirements. • These policies do not include requirements related to requests for extensions of resolution and notification by the enrollee, their designated representative, or the PIHP or their designee. • No evidence of training PIHP or network provider staff submitted for review. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q82]	**State fair hearings requirements** Evidence: • Revised 6.01 Complaint Grievance Appeal and Fair Hearing Process, 6.01a Complaint Grievance Fair Hearing Process Flowchart, revised 6.04 Service Denial & Notice of Action Appeal Standard, revised 6.02 Service Denial Auth Decisions and Notifications, revised 6.05 Service Denial and Notice of Action Appeal Expedited, 6.05a Service Denial and Notice of Action Flowchart policies and procedures incorporate the majority of requirements for State fair hearings. • These policies do not stipulate the potential parties to a State fair hearing.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	• No evidence of training PIHP or network provider staff submitted for review. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.416	**Record Keeping and Reporting Requirements**	
[Q86]	**Mechanism to maintain records of grievances and appeals** Evidence: • Revised 6.08 Grievance Oversight and Recordkeeping policy and procedures incorporates mechanisms used by the PIHP to maintain records of grievance and appeals. • Additional documentation included 6.01 Complaint Grievance Appeal and Fair Hearing Process, 6.01a Complaint Grievance Fair Hearing Process Flowchart, revised 6.04 Service Denial & Notice of Action Appeal Standard, revised 6.02 Service Denial Auth Decisions and Notifications, revised 6.05 Service Denial and Notice of Action Appeal Expedited, 6.05a Service Denial and Notice of Action Flowchart policies and procedures which do not include mechanisms used by the PIHP to maintain records of grievances and appeals. • PIHP staff are able to describe the mechanisms they employ to maintain records of grievances and appeals. (Substantial Compliance)	4



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for Peninsula

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	0	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	0	0	0
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

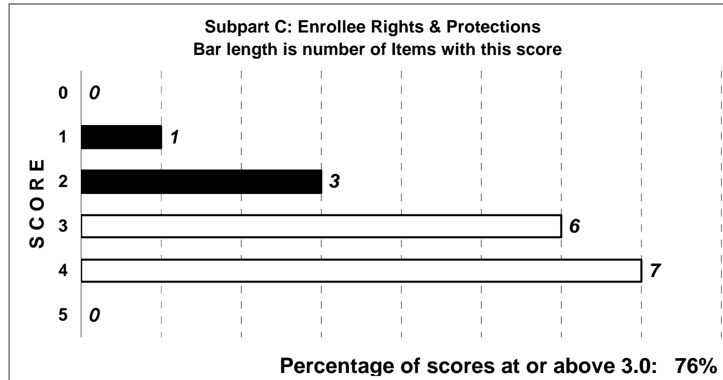
CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness and truthfulness of the data (Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b6]	**Provisions for internal monitoring** Evidence: • PRSN Compliance Plan which has no approval date or signature, no policy number, no effective or revision dates. • Plan does not specify the PIHP's internal monitoring practices related to fiscal management, resource, and utilization management, conduct, conflict of interests, etc., to prevent and detect potential fraud and abuse. • Compliance Activity Checklist which includes monitoring compliance activities at both the PIHP and providers. Areas include, but are not limited to: Disbarment, Confidentiality training and signed statements, HIPPA training and security, Provider R&E reports, Provider annual financial audits, and Provider quality chart reviews. The Activity Checklist does not include PIHP financial and data monitoring processes. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (No Compliance)	0

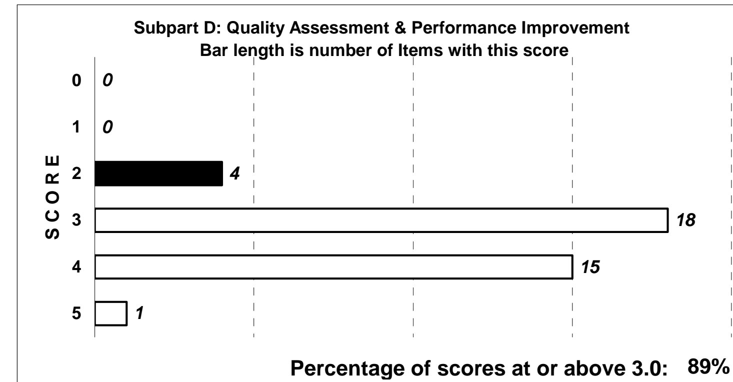
Scoring Frequency Overview

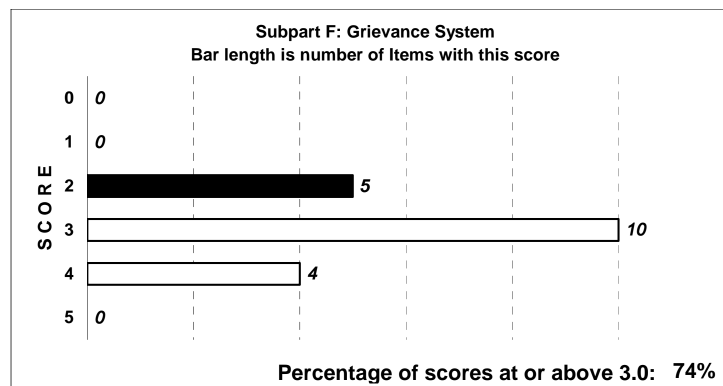
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Peninsula

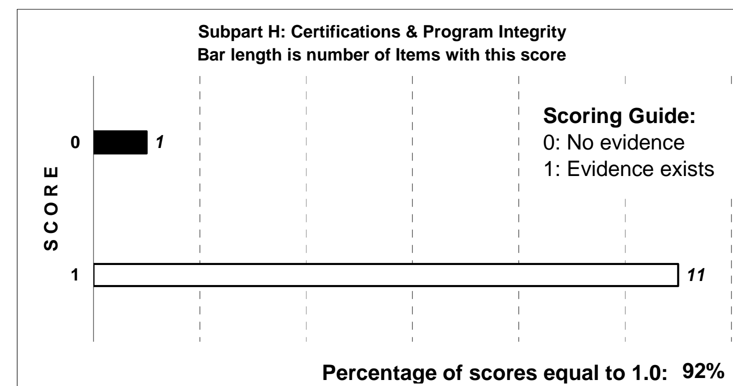
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 76%
Subpart D: 89%
Subpart F: 74%
Subpart H: 92%

The Peninsula PIHP staff have met nearly all of the minimum standards of Subpart H by ensuring that all data certifications meet source, content, and timing requirements, and that all but one of the required elements for program integrity are in place.

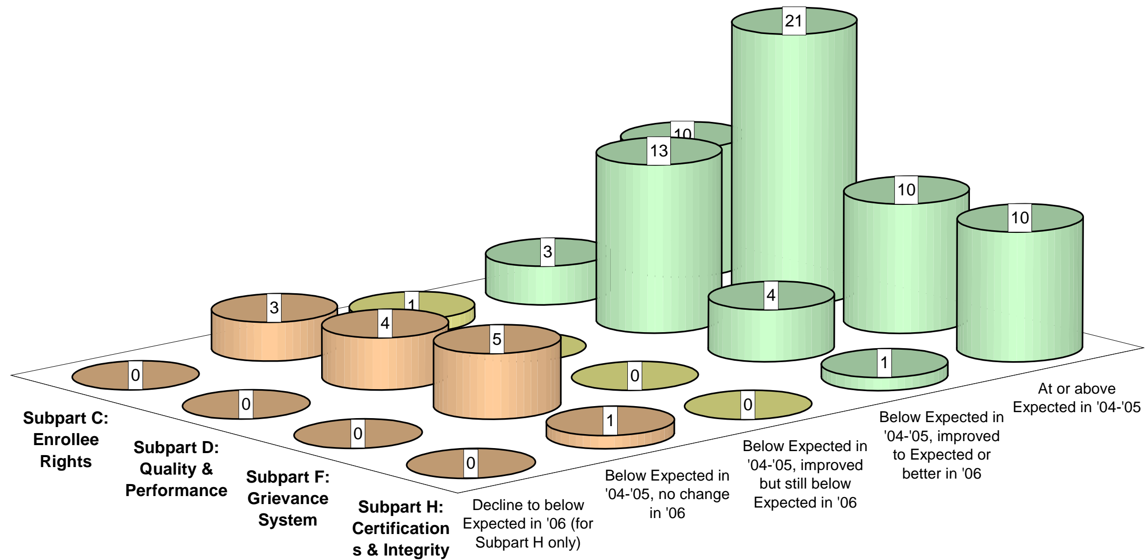
This year, Peninsula PIHP made the greatest improvement in Subpart D-Quality Assessment and Performance Improvement. More specifically, PIHP staff prioritized improvements in standards of access, and their managed care structure and operations.

Peninsula PIHP continues to make progress with respect to Subpart C-Enrollee Rights and Protections and Subpart F-Grievance System. However, relevant policies and procedures remain underdeveloped and are missing key requirements. In addition, the Peninsula PIHP needs to increase knowledge and application of Subparts C and F requirements at the level of network providers and their staff.

Score Trend Summary for: Peninsula

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Subpart C: Enrollee Rights Percent	Subpart D: Quality & Performance Item Count	Subpart D: Quality & Performance Percent	Subpart F: Grievance System Item Count	Subpart F: Grievance System Percent	Subpart H: Certifications & Integrity Item Count	Subpart H: Certifications & Integrity Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	3	17.6%	4	10.5%	5	26.3%	1	8.3%
Below Expected in '04-'05, improved but still below Expected in '06	1	5.9%	0	0.0%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	3	17.6%	13	34.2%	4	21.1%	1	8.3%
At or above Expected in '04-'05	10	58.8%	21	55.3%	10	52.6%	10	83.3%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, Peninsula PIHP performance relative to Subpart C (*Enrollee Rights*) showed 10 out of 17 items (58.8%) already at or above the Expected level of performance. After the 2006 review, 13 items (76.4%) are at the Expected level, reflecting improvement in 3 out of 7 elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), Peninsula PIHP entered the 2006 review with 10 of 19 items (52.6%) already at or above Expected. After the 2006 review, 14 items (73.7%) meet the Expected level of performance, indicating that 4 out of 9 elements improved to Expected or better from 2005 to 2006.

The degree of improvement Peninsula PIHP made in Subpart D-Quality Assessment and Performance Improvement indicates where their efforts for quality improvement were focused in 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- Evidence of new and revised policies and procedures pertaining to the Subpart requirements demonstrates the PIHP's efforts to document, standardize, and operationally define processes to effectively manage care throughout the region.
- PIHP effectively provides oversight to new, improved, and efficient Utilization Management processes that include delegation of the Authorization and NOA functions to CommCare, an ASO/MCO that does not provide direct service to the PIHP's enrollees.
- The PIHP Administrator Executive recognizes the need for additional qualified personnel to sufficiently meet the increased demands of implementing requirements of the Subparts and a quality, managed mental health care system.

Subpart Challenges

- Majority of Subpart recommendations from the 2005 WAEQRO review remain relevant in 2006.
- Despite multiple revisions of the Grievance System policies and procedures, incorporation of all required language remains a challenge.
- Staffing resources appear insufficient to meet ongoing PIHP and provider network training needs to ensure understanding, skill development, and implementation of new and revised PIHP policies, procedures, and mechanisms.

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Create a procedure to officially adopt and approve new and revised policies and procedures. Include dated <u>signatures</u> of PIHP officials or designees.

3. Develop and implement a process to ensure that each policy contains all required provisions referenced in the Code of Federal Regulation (CFR); give particular attention to grievance system policies and procedures.

4. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to Notice of Actions (NOAs).

5. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

6. Establish well-defined procedures for collecting and analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

7. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

8. Prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

9. To provide a reliable record of activities, create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the WAEQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review and, as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO which, if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   Kitsap Mental Health (Peninsula's IT contractor) uses a form to coordinate provider requests for the use of non-standard codes within their system. The IT contractor maintains a crosswalk from non-standard codes to State standard codes for the system. Non-standard codes are not accepted by their system if they are not defined within this crosswalk.

2. Unique member ID
   The Member ID is unique only within the PIHP. The IT contractor runs data queries to search for duplicate member IDs. If duplicates are found, they are flagged to determine whether they are indeed duplicates. Confirmed duplicates are merged into the original member ID.

3. Tracking across product lines
   The PIHP employs a program that can track individuals across product lines through the use of encounter billing codes.

4. Tracking individuals through enrollment, disenrollment, and re-enrollment
   The PIHP IT system tracks individuals through enrollment, disenrollment, and re-enrollment.

5. Calculating member months
   The PIHP does not track member months.

6. Member database
   The PIHP IT contractor maintains a member database using data made available by the Mental Health Division.

7. Provider Database

The PIHP does not maintain provider data.

8. Data easily under-reported
   The PIHP does not have a process or procedure to capture data that is easily under-reported.

PM Summary

Peninsula PIHP has strong pre-submission screening processes on its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. The PIHP's efforts meet the encounter validation requirements specified in their contract with MHD. The overall score of Partially Met in the 2006 encounter validation review (below) undermines confidence in the general state of the PIHP's performance measure accuracy. The general state of the PIHP's data is evaluated as "fair", therefore, despite being aided by the 2005 performance. Unfortunately, no steps are being taken to help bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- This PIHP has very strong pre-submission processes to identify errors before data is entered into their system. These processes are largely responsible for the fairly positive results in last year's encounter validation.

PM Challenges

- All areas discussed in the encounter validation review later in this report are relevant here.
- The PIHP has done little to reconcile data already in their system, data which could provide much useful information in a variety of QA/QI arenas.
- Of the topical items listed above, the PIHP has made little, if any, progress since the last review cycle.

PM Recommendations

1. Develop a policy and procedure to ensure that handling of non-standard codes is consistent and can be reliably repeated.

2. The WAEQRO recommends that the PIHP begin calculating member months. The level of granularity offered by calculating the member month facilitates comparisons between PIHPs and between the State and other entities. Per Member Per Month (PMPM) measures are commonly used within the Managed Healthcare industry to calculate utilization and penetration rates, and as a basis for outcomes analysis.

3. Develop a policy and procedure outlining the requirements for data submission when out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

4. Develop and manage network adequacy using a provider database. Develop reports and establish routine management practices that make use of information contained in the reports.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two submitted PIPs for Peninsula PIHP: "Consumer Participation in Treatment Planning", which was identified by the PIHP as clinical. Included in the document request were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006. (See, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

Peninsula PIHP did not submit an updated description of this PIP, which was selected by the State MHD and not reviewed in 2005. The staff completed a self-validation and provided a report demonstrating agency and PIHP-wide performance on three indicators: signature, quotes, and problems. Provided in a Word document table, this report covers July 2004, through June 2006, and details quarterly performance. The PIHP did not trend the results graphically; discussion of system performance on these indicators is reflected in the minutes from one QUIC meeting (April 2006) during the review year. The PIHP reported that the QUIC did not meet after June, 2006 as the QA Coordinator left and has yet to be replaced.

Discussion with PIHP staff during the site visit was productive and demonstrated that the PIHP understands PIP protocol to a much greater degree since the training. Possibilities for designing new PIPs were discussed and future technical assistance offered.

Because the PIHP did not submit a description of their PIPs and their self-validation lacked sufficient information, formal validation could not be conducted and is not included in this report.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Documents submitted for review were insufficient to conduct this review activity.

Activity 2: Evaluate Overall Validity and Reliability of Study Results

Documents submitted for review were insufficient to conduct this review activity.

PIP Strengths

- Documents submitted for review were insufficient to conduct this review activity.

PIP Challenges

PIP Recommendations

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentation was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff and, in some cases, a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	Peninsula RSN uses the data dictionary published by the State Mental Health Division. PRSN Policies and contracts with its provider network further define the requirements. There was no evidence submitted to support the definition of any completeness standards for the data.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The PIHP does communicate its policies and procedures to its provider network.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	The PRSN PIHP conducts an assessment of its IT contractor as part of a subdelegation review, but does not review the systems, processes, and capabilities of other providers in the network.

3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that	Partially Met	PRSN and KMHS IS staff each review an MHD-created "RSN Weekly Data

PIHP Encounter Validation Process Review

Item	Rating	Comments
include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.		Report" which is available on the MHD Intranet. Any anomaly over 3% is reviewed in detail. All activities illustrated are conducted on the current data submission being processed. There was no evaluation of the entire dataset (measuring against a completeness standard, evaluating the appropriateness of entries, running frequency distributions, etc.).
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Not Met	
Data is evaluated in a frozen state and archived for future possible use.	Not Met	

4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Met	The PIHP meets the minimum standard defined. The PIHP counts the number of records reviewed, not the number of encounters; however, staff reviewed more than a thousand records over a year's period, thus ensuring that the minimum of 250 encounters was surpassed by a wide margin. Although their process was documented, some of the concepts employed were only referenced at a high level. This lack of specific detail makes it difficult to understand how their processes were employed and will ultimately lead to issues with repeatability.

PIHP Encounter Validation Process Review

Item	Rating	Comments
PIHP includes additional data elements in matching exercise.	Not Met	The only additional item check was the duration of service.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Not Met	
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	Although the PIHP did report the results of its encounter validation efforts to the state, the details in those reports were not adequately described. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).

PIHP Encounter Validation Process Review

Item	Rating	Comments
PIHP regularly reports to the provider agencies the findings of the studies.	Met	Reports to provider agencies detailing results of the encounter validation processes were submitted and reviewed. Details explaining the information provided were not present. Information in the reports can be interpreted in different ways; without more detail, they are difficult to understand.
PIHP regularly reports internally for quality improvement activities.	Met	Reports for the Quality Improvement Committee (QUIC) detailing results of the encounter validation processes were submitted and reviewed. Detail explaining the information provided was not present. Information in the reports can be interpreted in different ways and, without more detail, is difficult to understand. These reports were presented in meetings where questions could be addressed to provide clarity; however, in most other contexts, not enough information is provided to be useful.
6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Not Met	The PIHP has a policy that specifies conditions requiring a corrective action, but no information was submitted that addresses documentation and oversight of follow-up activities or corrective actions required of provider agencies.

PIHP Encounter Validation Process Review

Item	Rating	Comments
If warranted, evidence of follow-up activity was presented.	N/A	

Summary of Encounter Validation Findings

Score Met _30_ %

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ **Met** ☒ **Partially Met** ☐ **Not Met**

Summary of encounter validation findings:

The PIHP's encounter validation activities met the requirements set forth in the contract between the MHD and the PIHP. The encounter validation review included the items specified in the contract. While the sampling method was not adequately explained

to allow for evaluation, the sample size did meet the requirements. There were no efforts made to validate other data elements, and additional steps to ensure that encounters checked actually occurred were not taken. An analysis of the PIHP's data for the purpose of an encounter validation was not conducted.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. Had the entire tool been used in computing the score, the PIHP would have scored overall at Not Met, with 30% of all items meeting a score of Met, 46% at Not Met, and the remaining 24% at Partially Met.

EV Strengths

- Encounter record checks far exceed the stated sample size requirement, allowing for greater improvement potential.
- The quality of the PIHP's IT policies and procedures has greatly improved, although continued work in this area is still required.

EV Challenges

- Reliance on a Network Provider for IT functionality poses challenges in defining and implementing a managed care oversight system.

EV Recommendations

1. Define completeness standards for all data elements collected.

2. Conduct an ISCA-like review of the provider network's capability to produce accurate and complete data. This review should evaluate systems, processes, and personnel for their capabilities, paying special attention to issues that may risk timely, accurate, and complete submission of data to the PIHP.

3. Conduct an analysis of the data held within (its) database, evaluating it for accuracy and completeness.

4. Include additional data elements in the encounter validation review. The PIHP is responsible for all data requested by the State Data Dictionary. A system that periodically rotates additional data elements into the review process will ensure that all data is eventually checked.

5. Reports to the state and the PIHP's provider agencies need more detail to ensure sufficient understanding.

6. Develop a sufficiently-detailed policy and procedure outlining the required documentation and follow-up activities related to the EV process.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Peninsula RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		3		• Plan is well-written for the most part. • Structure and accountability well-defined. • Includes detailed table of indicators/definitions/reporting schedule. • Methods and frequency of oversight specified. • Structure for system-change decisions may not be the most effective (Advisory Board as final decision-point). • PIP process is not included in Plan. • IT and Finance functions are not regularly represented on QUIC and in Plan.

PIHP: Peninsula RSN

Requirement	Met	PM	Not Met	Findings Comments
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.	**4**			• Annual review stated in plan; details of process not fully articulated.
C. Plan includes annual work plan and process for review of associated activities and progress.		**2**		• Work plan incorporated into document; however, includes all review and oversight activities to be accomplished rather than selection of focused activities based on previous data analysis.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.	**4**			• Multiple provider review activities, including administrative and clinical quality. • Description of use of information for quality improvement system-wide and for individual providers as indicated. • Attached tools reflect detailed scope of reviews.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	**4**			• Involvement of network providers, consumers, ancillary community services evident on committees and in satisfaction surveys conducted. • Plan lacked detail of types of staff on committees and avenues for direct service staff participation; however, PIHP defined this during site visit.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**3**		• Evidence of review of 2005 performance on multiple parameters at Jan 06 QUIC meeting. • QRT reports presented to QUIC.

PIHP: Peninsula RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• Ombuds report is standing agenda item for QUIC. • QUIC minutes reflect discussion of provider performance on chart audits and trends seen. • Actual trended quality reports not available; however, trended utilization reports provided at site visit • Provider states involved in developing practice guidelines – clinical directors of all agencies collaborated. • Provider states that over/under utilization tracked and reported; every 6 months agencies required to conduct in-depth study of their results. • Direct service staff state that they get immediate feedback on chart reviews, positive and negative. • Providers report that some routine QAI activity has been neglected due to RFQ and RFP, including site visits/chart reviews. • QUIC meetings have not been held since QA Manager left RSN.
Standard 1 Count (Target 6 Met):	**3**	**3**	**0**	**Target Points: 24 Actual: 20**

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PIHP: Peninsula RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis		**2**		• Completed chart reviews submitted for each provider. • Annual administrative reviews appear to have been conducted once during review year for each provider. • Providers report that monthly chart reviews have not been conducted since QA Manager left RSN. • Reviews conducted by RSN QA Manager.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review		**3**		• Tool is comprehensive; criteria for ratings not provided. • Use of tool appears somewhat inconsistent/incomplete; cannot tell why some elements marked N/A; comments boxes rarely used. • Scoring appears to be simple yes/no or rating as adequate or inadequate and tally of scores for all elements for each chart. • Clinical quality and administrative

PIHP: Peninsula RSN

Requirement	Met	PM	Not Met	Findings Comments
				review tools are detailed and overlap to a considerable extent.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**2**		• PIHP reports they conduct internal training on use of tool and have conducted inter-rater reliability training on the State's contract tool, which they use for administrative reviews. • No evidence of training or other related activities submitted.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**2**		Evidence • CAP request sent 11/3 to provider; response w/in 30 days requested; response sent 2 months later, though activity had begun to address problems prior to letter from provider to RSN; no evidence of response from RSN to letter from provider. • RSN states all CAPs sent to QA Manager and then to RSN Administrator for review and approval. • Providers state they are notified in writing about acceptance of the CAP. • RSN states that CAs are tracked at next review to ensure problematic charts corrected; agency-wide CAs are monitored by the QUIC. • Information provided regarding formal notification of completion of CA was contradictory; reviewer unable to

PIHP: Peninsula RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				assess the consistency with which this occurs.
Standard 2 Count (Target 4 Met):	**0**	**4**	**0**	**Target Points: 16 Actual: 9**
Standard **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.	**4**			• From QUIC minutes Jan, 2006: Second quarter FY06 chart review data was reviewed by the QUIC, indicating that system as a whole meets standard. • This is standing agenda item for QUIC. • CA for one provider discussed at QUIC as part of monthly standing report of chart review summaries. • Providers confirm that QUIC reviews quality monitoring results and corrective action plans and progress.
B. PIHP analyzes and trends individual provider performance	**4**			• Per Policy on Clinical Chart Reviews: Information collected from the chart reviews is entered into a database that yields reports specific to each provider

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PIHP: Peninsula RSN

Requirement	Met	PM	Not Met	Findings Comments
				and the region as a whole. Providers will receive raw data and feedback after each chart review. • Providers confirm that they receive timely information regarding performance, individually and in QUIC; trends reported and discussed and possible follow-up action considered. • QUIC minutes reflect above.
C. PIHP analyzes and trends system-wide performance		3		• Per Clinical Chart Review Policy: Summary reports will be forwarded to providers and the QUIC on a quarterly basis. • Chart review summary for FY 05-06 submitted: table showing % charts in compliance overall for each provider; difficult to see trends in table as presented. • Providers confirm QUIC reviews all reports and analyses trends, discusses system-wide issues; comparative reports reviewed and individual provider and system-wide remedies discussed. • Last meeting of QUIC was spring –April or May.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.	4			• Results shared at QUIC and UM Committee on scheduled basis; providers indicate that governing board

PIHP: Peninsula RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				reviews reports. • Clinical staff receive direct feedback at the time of the review and are encouraged to participate in QAI activities. • Representatives from Quality Review Team sit on QUIC and Advisory Board.
Standard 3 Count (Target 4 Met):	**3**	**1**	**0**	**Target Points: 16 Actual: 15**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		2		• RSN policy stipulates that the RSN will collect all complaint, grievance, and fair hearing information from providers, Ombuds, and QRT, and complete Exhibit N report for submission to State and discussion at QUIC. • Sample Exhibit N reports submitted for review. • Providers confirm they submit complaint and grievance data to RSN quarterly.

PIHP: Peninsula RSN

Requirement	Met	PM	Not Met	Findings Comments
				• No evidence submitted regarding tracking compliance with process requirements for complaints/grievances/fair hearings; reports submitted are counts of incidents by type.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.	4			Evidence submitted: • Ombuds report at QUIC resulted in recommendation re: further educating consumers and providers about NOAs under certain circumstances; no follow-up plan created. • Exhibit N discussed at QUIC, including recommendation that Ombuds continue to track complaints and grievances separately to have independent but comparable report. • Providers confirm review of reports on regular basis at QUIC as well as discussion regarding possible trends requiring attention. • Ombuds reports directly to RSN staff monthly re: findings from outreach and support activities.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.		3		• PIHP reports monitoring provider staff through interviews during administrative reviews (10%). • Provider staff demonstrated range of

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PIHP: Peninsula RSN

Requirement	Met	PM	Not Met	Findings Comments
				knowledge about complaint/grievance/appeals/fair hearings and their roles. • Providers differed in reports about extent to which PIHP provides training. • Provider managers take responsibility for ensuring staff trained and knowledgeable. • Ombuds trains with WIMIRT, receives new P&Ps from RSN; demonstrates strong understanding of role in supporting consumers and staying current with system changes.
Standard 4 **Count (Target 3 Met)**	**1**	**2**	**0**	**Target Points: 12 Actual: 9**
Grand Totals **Count (Target 17)**	**7**	**10**	**0**	**Target Points: 68 Actual: 53**

Summary Quality Assurance and Improvement Findings

Peninsula PIHP engages in a relatively effective QAI process, particularly related to the functioning of the QUIC, when it meets. Reports are discussed regularly and analyzed for possible follow-up, and the discussion is documented in some detail. Continuing refinement of reports related to quality of care and tightening up some processes for Corrective Action Plans and system-wide training regarding complaints/grievances/appeals/fair hearings would be useful.

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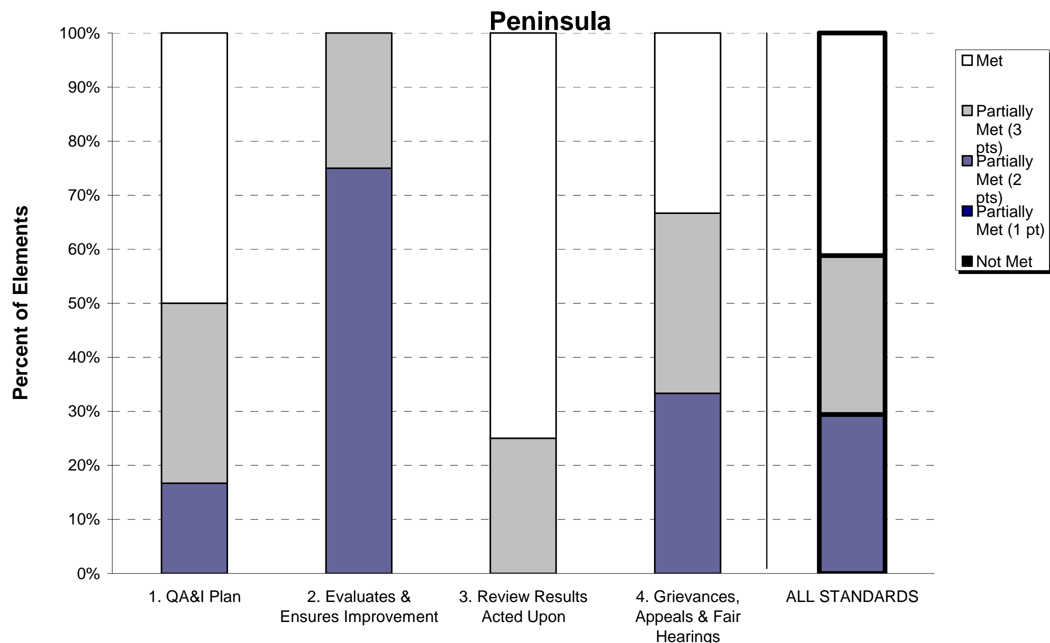

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	3	2	1	0	0
2. Evaluates & Ensures Improvement	4	0	1	3	0	0
3. Review Results Acted Upon	4	3	1	0	0	0
4. Grievances, Appeals & Fair Hearings	3	1	1	1	0	0
ALL STANDARDS	**17**	**7**	**5**	**5**	**0**	**0**

QAI Strengths

- Indicator Matrix is clearly structured and indicators are defined in a way that makes clear how they are measured.
- QUIC functions effectively in reviewing system performance according to plan schedule, as well as analyzing results and recommending changes.
- Chart review tools are very detailed and address all aspects of client care.

QAI Challenges

- The Quality Improvement Committee has not met since April and PIHP has not conducted clinical compliance reviews since that time. Staffing for this function is critical – the PIHP has lost a great deal of time in moving their system forward.
- Chart review tools lack a weighing and scoring system that would highlight areas of concern in a statistically valid manner; administrative and clinical quality tools are redundant.
- The rural nature of this PIHP's geography poses challenges regarding consistency of oversight and training.

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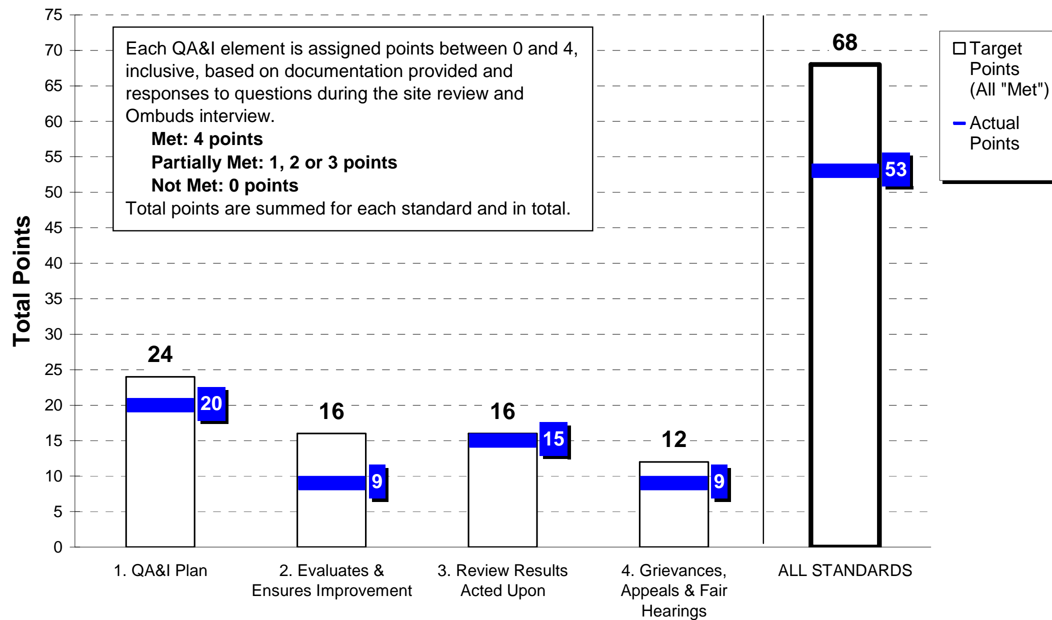

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	20
2. Evaluates & Ensures Improvement	16	9
3. Review Results Acted Upon	16	15
4. Grievances, Appeals & Fair Hearings	12	9
ALL STANDARDS	**68**	**53**

QAI Recommendations

1. QA Plan should have effective date(s) and signatures to ensure accurate tracking of versions and changes.

2. Select 1 target for indicators: either a target or minimum level of performance, then a threshold for “action”, e.g., 3 months performing ____% below standard results in _______.

3. Consider a change in structure for system-wide quality improvement decisions to ensure “scientific” analysis of problem and oversight of process and results.

4. Include IT and Finance representatives on QUIC to ensure that input and planning encompasses all aspects of RSN functioning.

5. Based on data analysis, select 3-4 action items each year for Annual Work Plan; include PIPs and changes that don’t warrant PIP-level activity.

Recommendations

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Create a procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees.

3. Develop and implement a process to ensure that each policy contains all required provisions referenced in the Code of Federal Regulation (CFR); give particular attention to grievance system policies and procedures.

4. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to Notice of Actions (NOAs).

5. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

6. Establish well-defined procedures for collecting and analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

7. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

8. Prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

9. To provide a reliable record of activities, create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance.

PM Recommendations

1. Develop a policy and procedure to ensure that handling of non-standard codes is consistent and can be reliably repeated.

2. The WAEQRO recommends that the PIHP begin calculating member months. The level of granularity offered by calculating the member month facilitates comparisons between PIHPs and between the State and other entities. Per Member Per Month (PMPM) measures are

commonly used within the Managed Healthcare industry to calculate utilization and penetration rates, and as a basis for outcomes analysis.

3. Develop a policy and procedure outlining the requirements for data submission when out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

4. Develop and manage network adequacy using a provider database. Develop reports and establish routine management practices that make use of information contained in the reports.

PIP Recommendations

There were no recommendations in this section.

EV Recommendations

1. Define completeness standards for all data elements collected.

2. Conduct an ISCA-like review of the provider network's capability to produce accurate and complete data. This review should evaluate systems, processes, and personnel for their capabilities, paying special attention to issues that may risk timely, accurate, and complete submission of data to the PIHP.

3. Conduct an analysis of the data held within is database evaluating it for accuracy and completeness.

4. Include additional data elements in the encounter validation review. The PIHP is responsible for all data requested by the State Data Dictionary. A system that periodically rotates additional data elements into the review process will ensure that all data is eventually checked.

5. Reports to the state and the PIHP's provider agencies need more detail to ensure sufficient understanding.

6. Develop a sufficiently-detailed policy and procedure outlining the required documentation and follow-up activities related to the EV process.

QAI Recommendations

1. QA Plan should have effective date(s) and signatures to ensure accurate tracking of versions and changes.

2. Select 1 target for indicators, either a target or minimum level of performance, then a threshold for "action"; e.g., client voice in treatment planning: standard is 85% compliance; performance of 75% or less for 3 months running would result in increase in number of charts reviewed for succeeding 3 months.

3. Consider a change in structure for system-wide quality improvement decisions to ensure

"scientific" analysis of problem and oversight of process and results.

4. Include IT and Finance representatives on QUIC to ensure that input and planning encompasses all aspects of RSN functioning.

5. Based on data analysis, select 3-4 action items each year for Annual Work Plan; include PIPs and changes that do not warrant PIP-level activity.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

North Sound
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

North Sound Mental Health Administration PIHP (NSMHA or North Sound) is responsible for managing mental health care and services for Medicaid consumers in Snohomish, Whatcom, Island, San Juan, and Skagit counties, as well as eight (8) local Tribal sovereign nations. The PIHP is located in Mt. Vernon, Washington and is governed by a board comprised of elected officials from each of the member counties, the President and Vice President of the Regional Advisory Board, and representatives from each of the 8 Tribal sovereign nations. The PIHP Administrator reports to the Board of Directors. The PIHP contracts with an LLC, Associated Provider Network (APN) to develop, fund, manage, and oversee care throughout the region; services to the Spanish-speaking population and crisis services are provided through additional specialty contracts. North Sound serves approximately 1300 adult and child consumers on a monthly basis. Total annual Medicaid enrollment in the PIHP is about 159,000. The PIHP delegates access, inpatient authorization, and utilization management (UM) to a non-profit organization and partially delegates information technology (IT) functions to a private firm.

This report covers the period between January 5, 2006, and January 4, 2007, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);

3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement	June-August, 2006	

Activity	Timeline	Documents/Content
• PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions		
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	December 4, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	December 18, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	December 27, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	January 18 & 19, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	January 25, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	February 15, 2007	
4. Debrief conference call	February 27, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	March 12,	

Activity	Timeline	Documents/Content
	2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. NSMHA did submit a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the NSMHA PIHP, the following event is significant:

- The PIHP was approved to hire 7 new FTEs since the 2005 review and has filled 5 of those positions. This infusion of resources will enhance NSMHA's ability to effectively manage and improve mental health services in their region.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- The policies and procedures submitted for review contained blank place holders for dates they were effective, revised, and reviewed. In addition, some policies were dated and approved by the PIHP Board of Directors with a motion number, while others were dated and approved by the PIHP Executive Director with no motion number. Consequently, the WAEQRO was unable to determine if all the policies and procedures submitted for review had been officially adopted. They were, however, considered in scoring the subparts.

- The PIHP's sample network provider contracts did not contain dated signatures of contracting parties. The WAEQRO was unable to determine if the contract references were from officially executed contracts. The sample contracts, however, were considered in scoring the Subparts.

- One provider did not have sufficient notice with respect to making direct service staff available for the site visit; therefore, only management participated in the interview.

2006 Review Results

This report provides results and a summary of NSMHA PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of NSMHA PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.242	Health Information Systems			
	Verifying the accuracy and timeliness of data. Missing policy and procedure that defines expectations for accuracy and timeliness for new system.	Submit a corrective action plan to the MHD by 3/2/054	Corrective action plan was submitted to MHD on 3/5/05	At the time of the 2004 review, the PIHP had just implemented a new IT system and was defining the processes for using this new system. The PIHP developed policies and procedures defining expectations for data timeliness and accuracy. They currently employ processes to continually verify data accuracy and timeliness. This item should be considered closed.

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CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.606	**Source, Content and Timing of Certifications**			
	Certifications. Timing of certifications could not be verified with related batch submittals.	Submit a corrective action plan to the MHD by 3/2/05	Corrective action plan was submitted to MHD on 3/5/05	At the time of the 2004 review, the PIHP had just implemented a new IT system and was in the process of submitting data after a long period of inactivity. The PIHP has since transmitted their backlog of data. Since that initial review, they developed a data certification process and have successfully met this requirement. This item should be considered closed.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the NSMHA PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

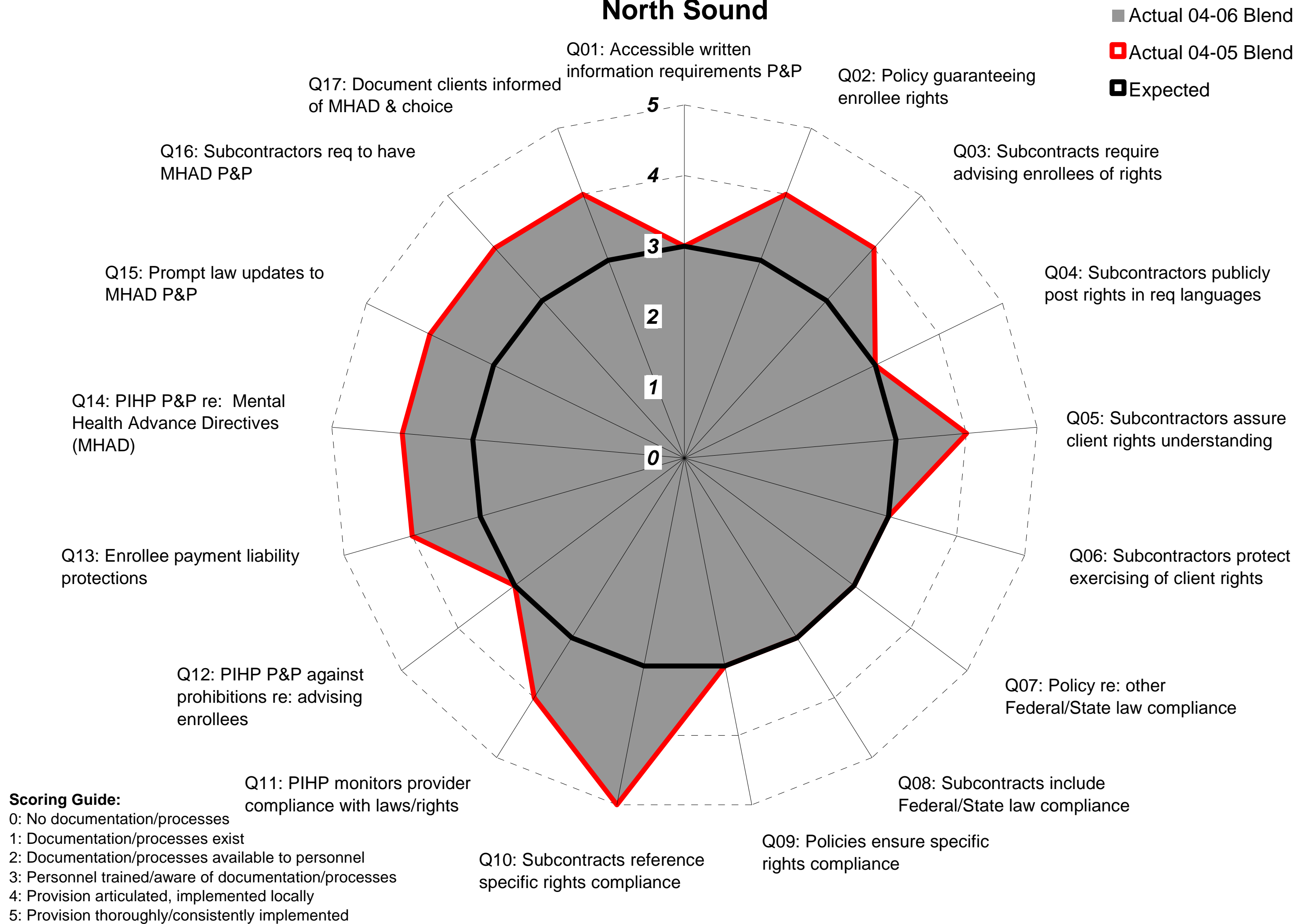
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for North Sound

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

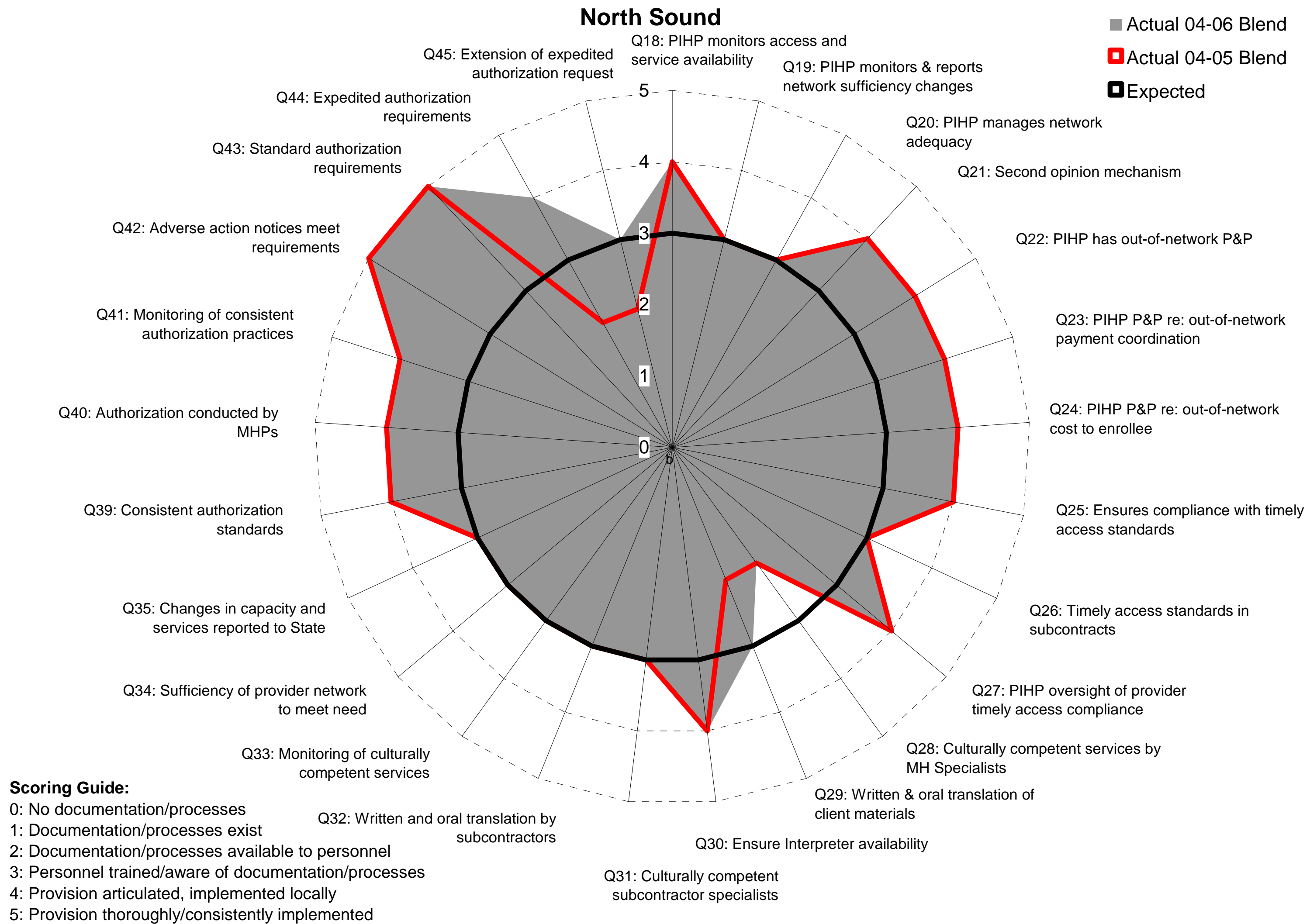
Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	3		3
Q02: Policy guaranteeing enrollee rights	4		4
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	3		3
Q05: Subcontractors assure client rights understanding	4		4
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	3		3
Q08: Subcontracts include Federal/State law compliance	3		3
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	5		5
Q11: PIHP monitors provider compliance with laws/rights	4		4
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	4		4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	4		4
Q16: Subcontractors req to have MHAD P&P	4		4
Q17: Document clients informed of MHAD & choice	4		4

NSMHA PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

North Sound Mental Health Administration achieved Expected compliance for all Subpart C scores in 2005. Therefore, no Subpart C review elements were re-scored in 2006.

Subpart D (Part 1): Access Standards



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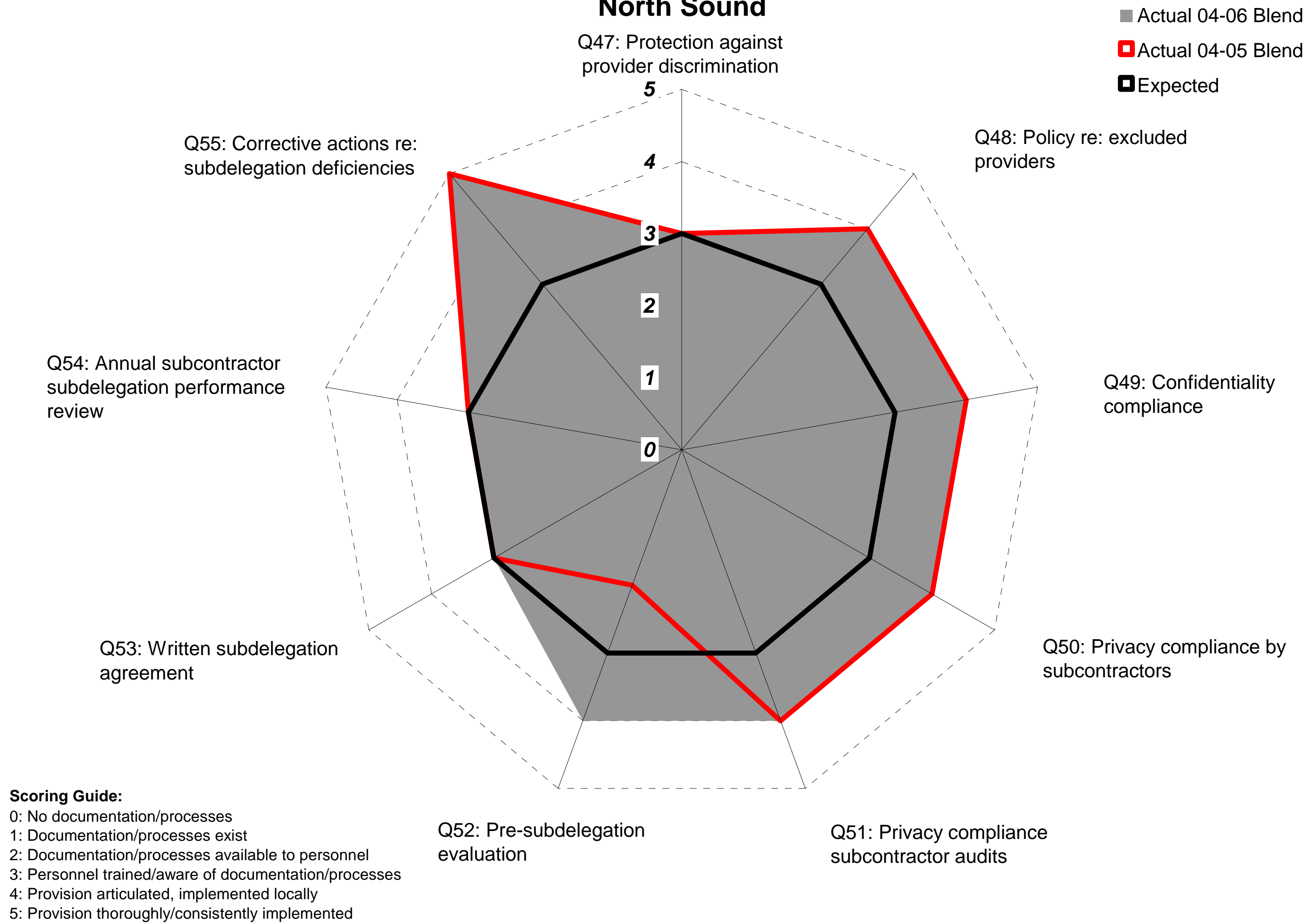
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	4		4
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	4		4
Q22: PIHP has out-of-network P&P	4		4
Q23: PIHP P&P re: out-of-network payment coordination	4		4
Q24: PIHP P&P re: out-of-network cost to enrollee	4		4
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	4		4
Q28: Culturally competent services by MH Specialists	2	2	2
Q29: Written & oral translation of client materials	2	3	3
Q30: Ensure Interpreter availability	4		4
Q31: Culturally competent subcontractor specialists	3		3
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	3		3
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	4		4
Q40: Authorization conducted by MHPs	4		4
Q41: Monitoring of consistent authorization practices	4		4
Q42: Adverse action notices meet requirements	5		5
Q43: Standard authorization requirements	5		5
Q44: Expedited authorization requirements	2	4	4
Q45: Extension of expedited authorization request	2	3	3



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2004-2006 Subpart Scoring Trend and Detail for North Sound

Scoring Guide for Subparts C, D and F:
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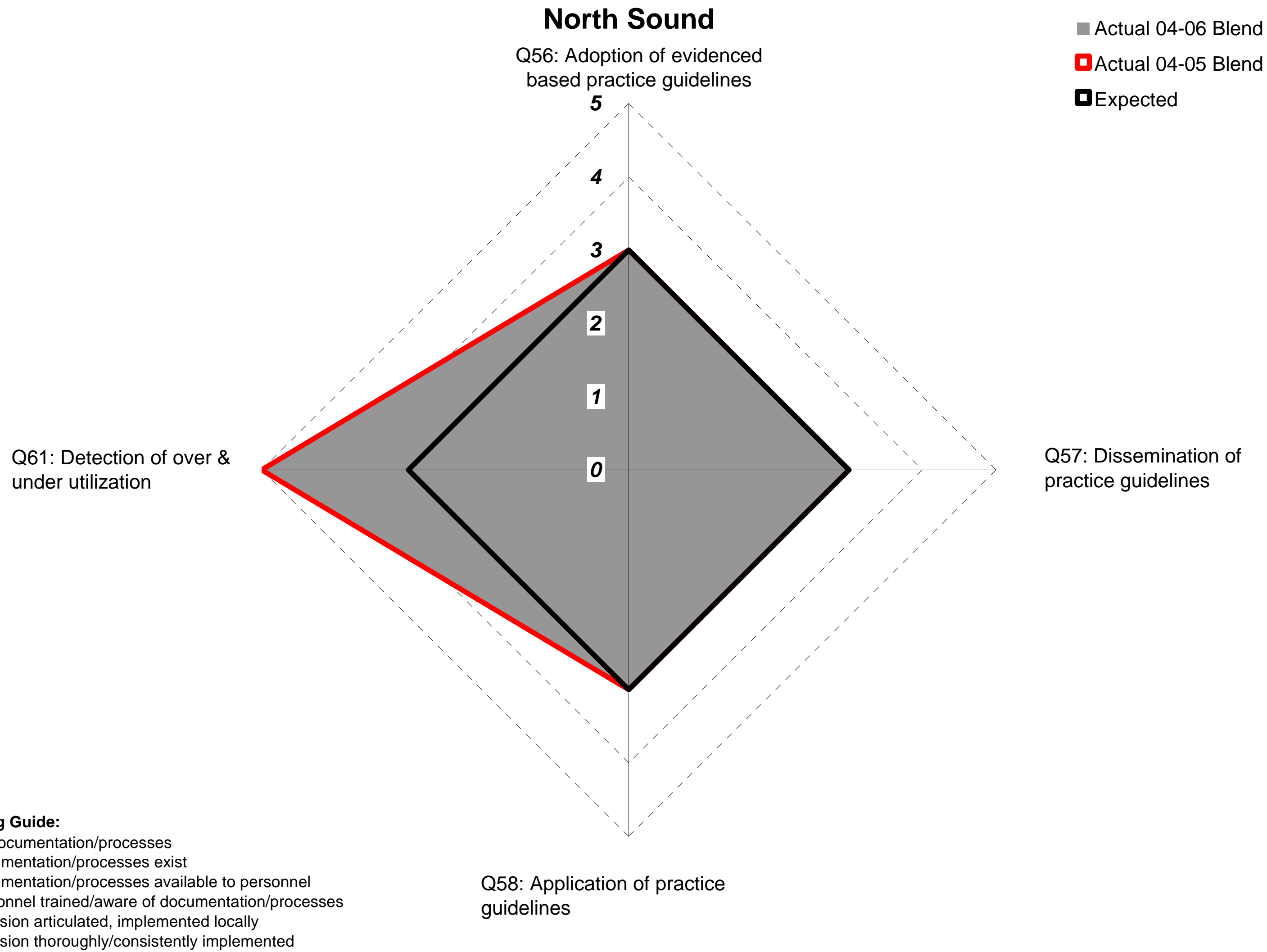
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	4		4
Q49: Confidentiality compliance	4		4
Q50: Privacy compliance by subcontractors	4		4
Q51: Privacy compliance subcontractor audits	4		4
Q52: Pre-subdelegation evaluation	2	4	4
Q53: Written subdelegation agreement	3		3
Q54: Annual subcontractor subdelegation performance review	3		3
Q55: Corrective actions re: subdelegation deficiencies	5		5

Subpart D (Part 3): Measurement and Improvement Standards



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2004-2006 Subpart Scoring Trend and Detail for North Sound

Scoring Guide for Subparts C, D and F:
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2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	3		3
Q57: Dissemination of practice guidelines	3		3
Q58: Application of practice guidelines	3		3
Q61: Detection of over & under utilization	5		5

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (c)(2)	**Furnishing of Services Continued**	
[Q28]	**PIHP ensures culturally competent service delivery utilizing Mental Health Specialists** Evidence: • PIHP submitted excerpt from sample '06-'07 NSMHA-APN Medicaid Contract that states, "Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer. Provide alternative service delivery models to make services more available to underserved persons as defined in WAC 388-865-0150." No standards, expectations, or specific requirements related to Mental Health Specialists are stipulated in contract. • No relevant policy and procedure was submitted for this provision. • 2006 PIHP Administrative Audit Results Summary on documented Mental Health Specialist services provided by Bridgeways, Compass Health, and SeaMar. • NSMHA 2006 Capacity Management Report showing a decrease in staffing levels and proportionate decrease in Mental Health Specialists between 11/2004 and 10/2006. • PIHP staff reported that although they monitor the provision of Mental Health Specialist services based on WAC, they do not have a policy that stipulates their standards and expectations for Mental Health Specialist Services. Recommend PIHP develop such a policy. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q29]	**Written and oral translation of client materials** Evidence: • Revised Interpreter and Translation Services Policy #1515.00 and Cultural and Linguistic Competency Policy #1521 jointly incorporate the requirements for written and oral translation of client materials. • Accommodation / Access To Services Policy #4508.00, indicates the PIHP and its providers make available telecommunication devices and services, and certified interpreters for deaf, sight, or hearing impaired clients, and limited English proficient clients; and other specialized disability	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	services to clients as necessary in order to access and utilize mental health services. The policy states, "any Limited English Speaking (LES)/Limited English Proficient (LEP) person has the right to interpreter and translation services at every aspect of service delivery, at no cost, without significant delay, and in the language in which they prefer to communicate." • DSHS Public Mental Health System Benefits Booklet translated in all DSHS required languages. • PIHP Privacy Notice translated in 5 of the required DSHS languages. • January 2006 PIHP Interpreter Availability Study includes a list of the PIHP's contracted providers and the organizations with whom they have agreements to provide certified interpreter services. • Copies of PIHP Spanish-translated communications related to a particular consumer's appeal. • PIHP Cultural Competence Training Module with post test. Reviewer unable to determine if this training occurs on an ongoing basis, or when the last training occurred. • Provider management reported client rights, grievance procedures, HIPAA privacy practices, and DSHS benefits booklet must be available to clients in required DSHS languages. In addition, management reported that they have no client materials in Braille or audio devices; when needed, however, their staff are required to read required client materials directly to clients when needed. One Provider also stated they had some client materials in large print. • Direct service staff were able to articulate languages that must be available in written translation and how to access interpreters including American Sign Language interpreters. Staff indicated that family members and friends are sometimes used as interpreters. • PIHP staff reported that the Ombuds and QRT inspect each network provider facility to ensure that rights are posted in client sight in all required DSHS languages. The last facilities review was conducted in 2005 and yielded mixed results. No client rights facilities review was conducted during the review period. • PIHP staff also reported that they have no formal monitoring mechanism to monitor provider use of certified interpreters. • The PIHP Interpreter and Translation Services Policy #1515.00 requires that major written client information be provided in the client's own language. "Major written client information" includes: o Washington State Medicaid Benefit Booklet (for	

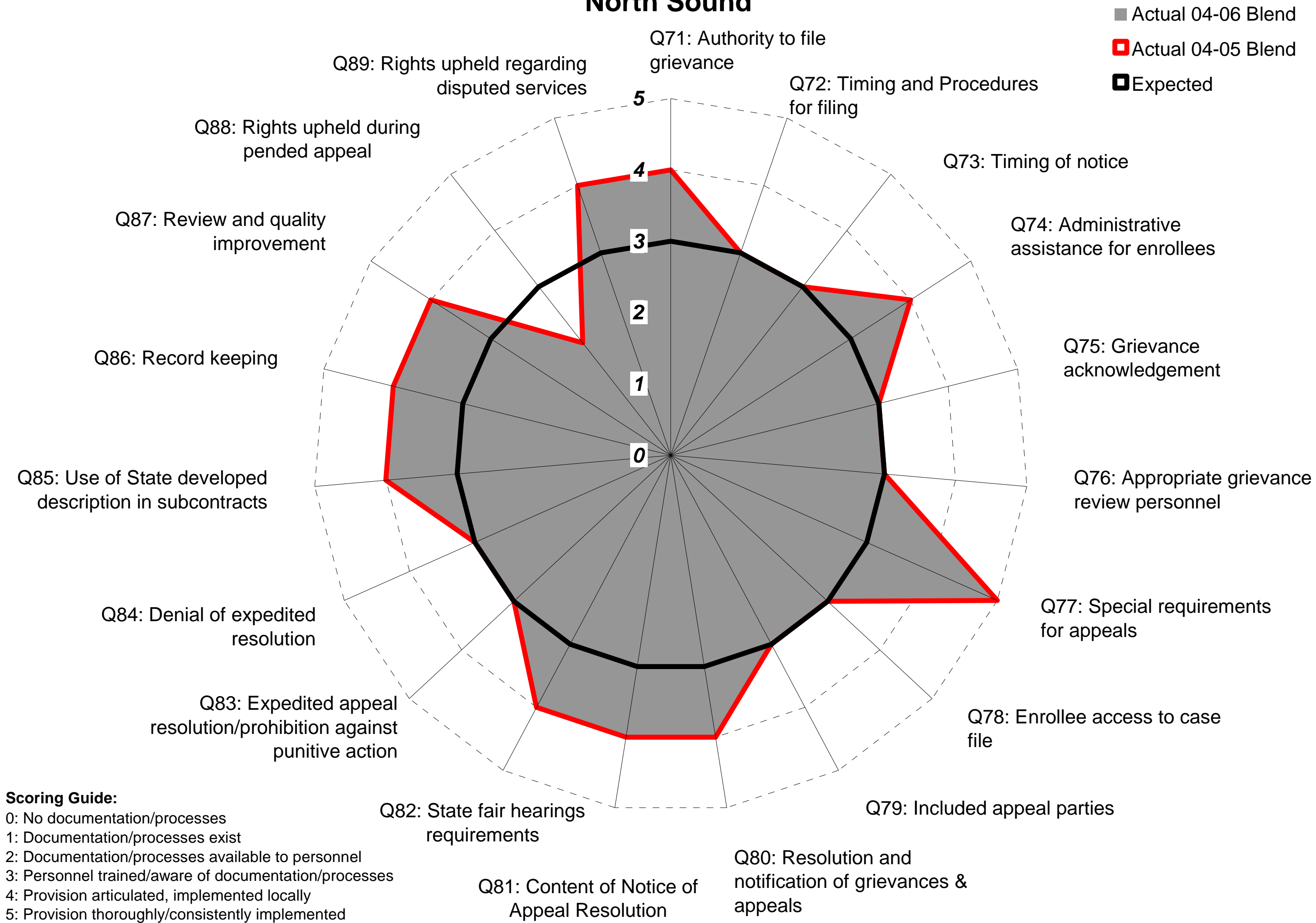
CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	Medicaid enrollees) o North Sound Mental Health Administration Prepaid Inpatient Mental Health Plan Brochure o Notice of Privacy Practices o Notice of Action (for Medicaid enrollees) The PIHP staff and provider management were not able to show evidence that all of these documents (with the exception of the Washington State Medicaid Benefit Booklet) are translated and available to clients in the required DSHS languages. • Recommend that the PIHP and provider network update their client materials to be in compliance with PIHP policy #1515.00. In addition, clarify specific standards related to client materials for all major sensory impairments. Also, recommend that the PIHP institute formal annual monitoring of written and oral translation of client materials, including facility checks and use of certified translators.	
	(Moderate Compliance)	3
438.210(d)	**Timeframe for decisions**	
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Revised Assessments for Ongoing Services Policy #1504.00, revised Authorization for Ongoing Outpatient Services Policy #1505.00, and Continued Stay and Re-authorization Policy #1539.00 contain required procedures for expedited authorization decisions. • Authorization Process Workgroup Meeting minutes from 6/01/06 through 11/1/06 provide evidence of related discussions, and the development of an expedited authorization design to be incorporated into the PIHP authorization process. • Quality Management Committee (QMC) Meeting minutes from 7/20/06 and 10/19/06 indicate that the PIHP updated the QMC on progress of the Authorization Process Workgroup, and the implementation of the authorization process redesign. • Additional documentation submitted for review: o January-June 2006 Denial Report o July-December 2006 Denial Report o 2006 Authorization Process Report, including Expedited Authorizations and Authorization Extensions (September-December) o Authorization Process Flow Chart-November 2006 • PIHP staff reported that expedited authorization policies and procedures have been implemented, including extensions.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	The providers have been informed of this process through the Authorization Process Workgroup and Quality Management Committee (QMC). Expedited authorizations are tracked electronically by a designated field in the data base. • Network provider management reported assigned staff participated in the Authorization Process Workgroup Meeting. Provider Management was able to articulate the expedited authorization process. • Direct Service staff were able to describe that expedited authorization means "quicker turnaround", but did not know the required number of days by which the authorization must occur. • Recommend additional training for direct service staff. (Substantial Compliance)	4
[Q45]	**Extension of expedited authorization request** Evidence: • Revised Authorization for Ongoing Outpatient Services Policy #1505.00, and Continued Stay and Re-authorization Policy #1539.00 contain required procedures for extension of expedited authorization decisions. • Authorization Process Workgroup Meeting minutes from 6/01/06 through 11/1/06 provide evidence of related discussions, and the development of an expedited authorization design to be incorporated into the PIHP authorization process. • Quality Management Committee (QMC) Meeting minutes from 7/20/06 and 10/19/06 indicate that the PIHP updated the QMC on progress of the Authorization Process Workgroup, and the implementation of the authorization process redesign. • Additional documentation submitted for review: o January-June 2006 Denial Report o July-December 2006 Denial Report o 2006 Authorization Process Report, including Expedited Authorizations and Authorization Extensions (September-December) o Authorization Process Flow Chart-November 2006 • PIHP staff reported that expedited authorization policies and procedures have been implemented, including extensions. The providers have been informed of this process through the Authorization Process Workgroup and Quality Management Committee (QMC). Expedited authorizations are tracked electronically by a designated field in the data base. • Network provider management reported that assigned staff participated in the Authorization Process Workgroup Meeting. Provider Management was able to articulate the expedited	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	authorization process, although at one provider, management believed that an expedited authorization extension could only be requested by the client. • Direct Service staff were able to describe that expedited authorization means "quicker turnaround", but did not know the required number of days by which the authorization must occur or if an extension was allowed. • Recommend additional training for provider management and direct service staff. (Moderate Compliance)	3
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • Subcontractural Relationships and Delegation Policy #5002.00, Sample Delegation Plan Form Policy #1548.01, and Delegation of NSMHA Functions and Responsibilities Policy #1548.00 collectively contain the requirements and procedures for evaluation of subcontractor ability to perform delegated functions. • NSMHA Pre-Contract Evaluation for Delegation of Inpatient Certification and Utilization Management and Readiness Review-Volunteers of America (VOA), dated January 4, 2007(?). • NSMHA Pre-Contract Evaluation for Delegation of Access and Readiness Review-Volunteers of America, dated January 4, 2007(?). • NSMHA-VOA-Medicaid-06 contract which specifies delegated services, activities, and responsibilities for Access Line, Inpatient Certification, and Utilization Management. • Access Transition Meeting notes, dated 4/4/06, provide evidence of preparations and planning for the May 1, 2006 transition of the Access Line from Compass Health to VOA. • November 2006, VOA Access Report, shows evidence of tracking data on number and types of calls. • Raintree 2001 RFP-evaluation tool, scores, and reference check process related to partial delegation of management information services. • PIHP staff explained that dates on the Pre-Contract Evaluation for Delegation documents listed above automatically change to the date the document was last updated. PIHP staff were unable to provide the original evaluation documents as requested by the WAEQRO.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	(Substantial Compliance)	4

APS HEALTHCARE
Healthy Together



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

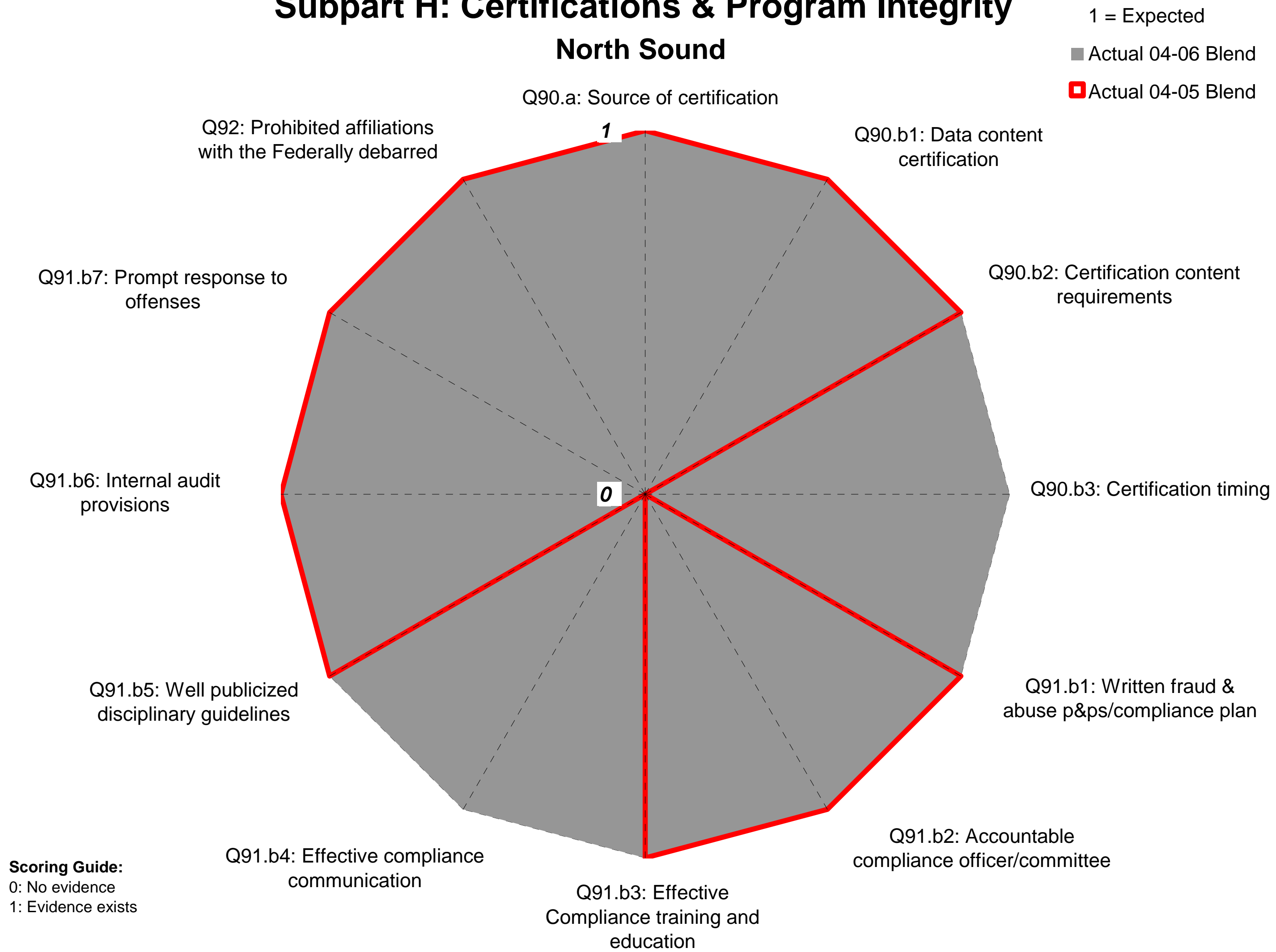
2004-2006 Subpart Scoring Trend and Detail for North Sound

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	4		4
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	3		3
Q74: Administrative assistance for enrollees	4		4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	5		5
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	4		4
Q81: Content of Notice of Appeal Resolution	4		4
Q82: State fair hearings requirements	4		4
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	4		4
Q86: Record keeping	4		4
Q87: Review and quality improvement	4		4
Q88: Rights upheld during pended appeal	2	2	2
Q89: Rights upheld regarding disputed services	4		4

Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.420	**Continuation of Benefits while the PIHP Appeal and the State Fair Hearing are Pending**	
[Q88]	**Continuation of benefits while the appeal and State fair hearing are pending** Evidence: • Appeal Policy #1003.00 contains procedures related to continuation of benefits while an appeal is pending, including the accurate filing timeframe which has been erroneous in past reviews. • Fair Hearing Policy #1004.00 **does not contain** procedures for the continuation of benefits while a State fair hearing is pending. • No evidence of training related to this review element was submitted. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2


Subpart H: Certifications & Program Integrity
North Sound
1 = Expected
Actual 04-06 Blend
Actual 04-05 Blend
Q90.a: Source of certification
Q90.b1: Data content certification
Q90.b2: Certification content requirements
Q90.b3: Certification timing
Q91.b1: Written fraud & abuse p&ps/compliance plan
Q91.b2: Accountable compliance officer/committee
Q91.b3: Effective Compliance training and education
Q91.b4: Effective compliance communication
Q91.b5: Well publicized disciplinary guidelines
Q91.b6: Internal audit provisions
Q91.b7: Prompt response to offenses
Q92: Prohibited affiliations with the Federally debarred
1
0
Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for North Sound

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	0	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	0	1	1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	1		1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification To the accuracy, completeness and truthfulness of the data	
	(Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b4]	**Effective lines of communication between Compliance Officer and employees** Evidence: • Revised Business Ethics and Regulatory Compliance Program Policy #2001.00, NSMHA Personnel Policies and Procedures Manual, and NSMHA Guidelines for Business and Ethical Conduct (Requires all employees to sign an acknowledgement confirming they have received the code, understand that it represents PIHP policies and agree to abide by it), collectively meet the requirements of this provision. • MHD Compliance Plan Audit with PIHP Administrator response and clarification to items scored unknown, or below met. • Copy of PIHP Website Fraud and Abuse Page showing regional, State and Federal hotlines, contacts, and resources. No local hotline or contact information for the PIHP Compliance Officer included. Recommend that this information be added to the PIHP fraud and abuse web page. • Provider Management reported that they were familiar with the PIHP policies related to program integrity and had participated in fraud and abuse training during the review period. However,	

	provider management was unaware of available fraud and abuse hotlines.	
	(Compliance)	1

Scoring Frequency Overview

APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for North Sound

These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
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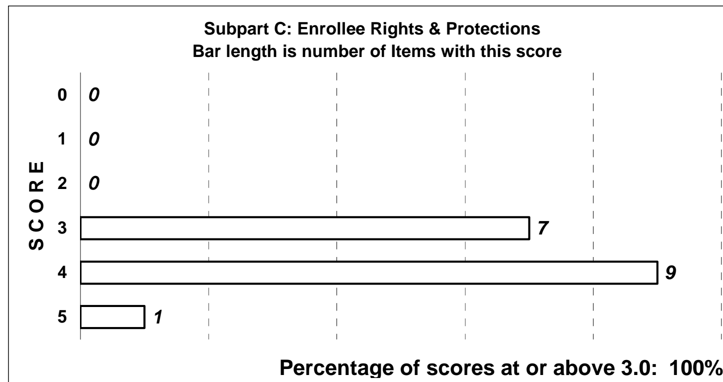
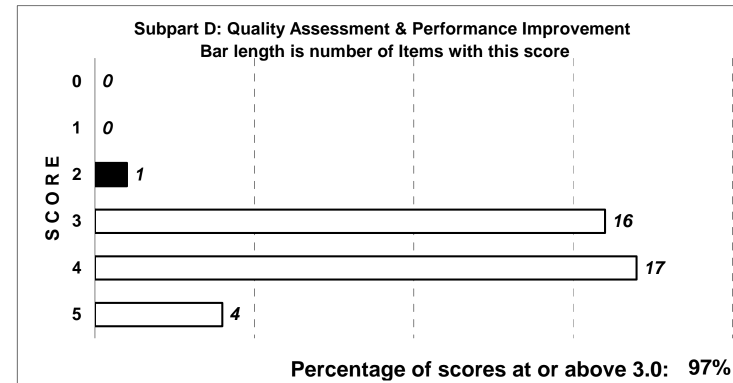
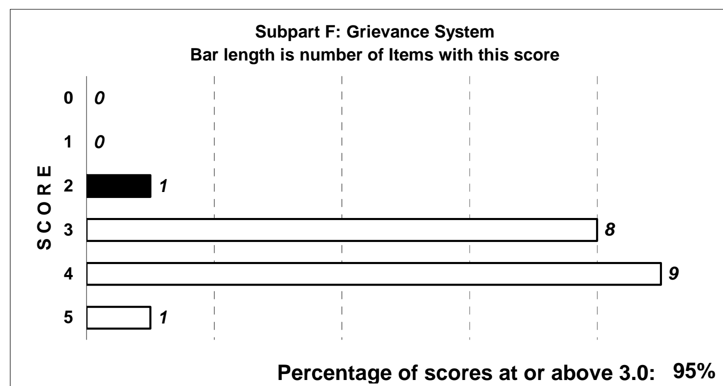
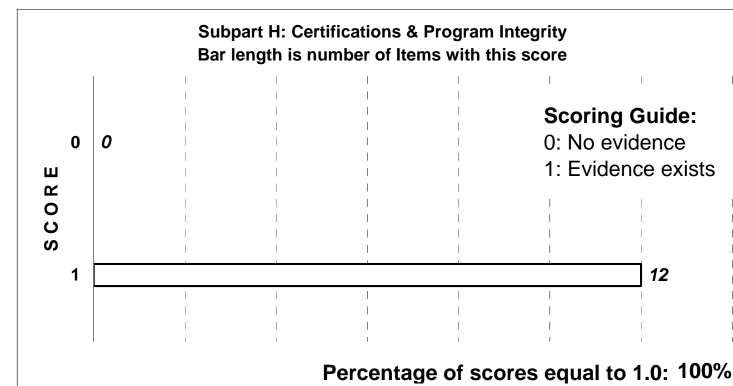
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

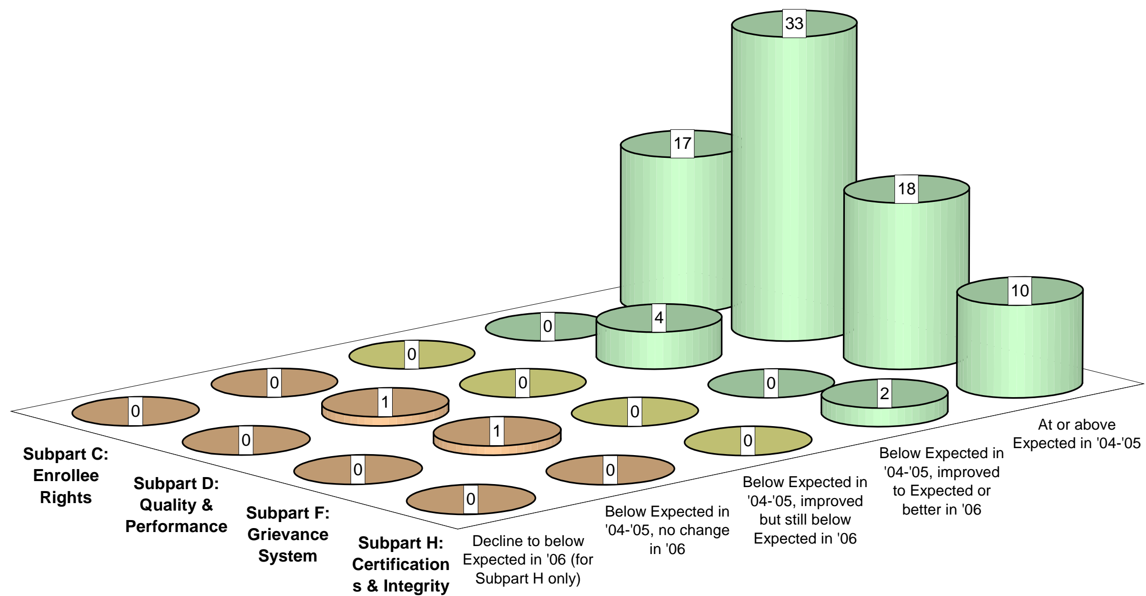
The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 100%
Subpart D: 97%
Subpart F: 95%
Subpart H: 100%

By prioritizing enrollee rights and protections, North Sound Mental Health Administration achieved Expected compliance for Subpart C in 2005. In addition, in 2006 the PIHP has met all requirements associated with Program Integrity.

The PIHP continues to make progress with respect to Subpart D, and has achieved Expected compliance for all review elements with one exception: PIHP ensures culturally competent service delivery utilizing Mental Health Specialists. North Sound Mental Health Administration has also achieved Expected compliance for all but one review element in Subpart F-Grievance Systems. Overall, North Sound Mental Health Administration has achieved a high level of Expected compliance within all four Subparts.



Score Trend Category	Subpart C: Enrollee Rights Item Count	Percent	Subpart D: Quality & Performance Item Count	Percent	Subpart F: Grievance System Item Count	Percent	Subpart H: Certifications & Integrity Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	1	2.6%	1	5.3%	0	0.0%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	0	0.0%	4	10.5%	0	0.0%	2	16.7%
At or above Expected in '04-'05	17	100.0%	33	86.8%	18	94.7%	10	83.3%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, North Sound Mental Health Administration performance relative to Subpart C (*Enrollee Rights*) showed 17 of 17 items (100%) already at or above the Expected level of performance. Therefore, the North Sound Mental Health Administration was not re-scored on any Subpart C review elements in 2006.

For Subpart F (*Grievance System*), North Sound Mental Health Administration entered the 2006 review with 18 of 19 items (94.7%) already at or above Expected. After the 2006 review, North Sound Mental Health Administration had no score changes in Subpart F; therefore, 18 items (94.7%) remain at the Expected level of performance.

Although North Sound Mental Health Administration did not show improvement in Subpart F, improvement in other required Subparts reflects focused efforts on continuous quality improvement during 2006.

Subpart Strengths

- The PIHP has a well-designed outpatient authorization process that incorporates expedited authorizations; an easy-to-follow flow chart effectively displays the process.
- The PIHP Guidelines for Business and Ethical Conduct effectively explains issues related to program integrity and fraud and abuse. Considered a best practice, employees are required to sign an acknowledgement confirming their receipt and understanding of the document, as well as agreement to abide by its standards.

Subpart Challenges

- PIHP documentation of training related to Subpart review elements was limited.
- PIHP was unable to provide dated originals of the Pre-Contract Evaluations for Delegation and Readiness Review of Volunteers of America that relate to delegation of Access, and Inpatient Certification and Utilization Management. Maintaining dated originals of official PIHP documents is imperative.

Subpart Recommendations

1. Develop policy and procedures that stipulate PIHP standards and expectations related to the use of Mental Health Specialists in the delivery of culturally competent services.

2. Update PIHP and provider client materials to comply with PIHP policy #1515.00. In addition, clarify specific standards related to client materials that pertain to all major sensory impairments.

3. Institute formal, annual monitoring of written and oral translation of client materials; include facility checks for required, posted client materials and review provider use of **certified** translators.

4. Incorporate into the PIHP's grievance system policies and procedures related to the requirement for continuation of benefits while a State fair hearing is pending.

5. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).

6. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the WAEQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The crosswalk between local codes and the codes required by the State is maintained by Sound Data Systems (SDS). SDS provides services to the provider network and acts as coordinator for this function. Codes not mapped in the crosswalk are not accepted by the PIHP's Raintree system.

2. Unique member ID
   The PIHP searches for possible duplicate members and eliminates them by merging duplicates with the originals.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   PIHP staff can track individuals across product lines using client financial data in their IT system. By using the three (3) year history of eligibility data offered by the State, and by querying their own data imported into an SQL database, the PIHP is able to track individuals through the process of enrollment, disenrollment, and re-enrollment.

4. Calculating member months
   The PIHP calculates member months using data made available by the MHD. Staff is working to better understand this data and how it relates to other State-published statistics, as well as internal measures generated by their own data.

5. Member database
   The PIHP presently maintains an SQL database containing member data made available by the MHD. They are using this data as a first step in eligibility checks and for calculating various performance indicators used in management reports.

6. Provider Database
   The PIHP maintains a provider database and has begun using it to manage their provider network.

7. Data easily under-reported
   The PIHP has a policy that governs out-of-network services.

PM Summary

North Sound PIHP has fairly strong data screening processes but fared poorly in the comprehensive encounter validation exercise conducted by APS in the 2005 review. In this year's analysis and encounter validation review (described below), the PIHP's efforts were fairly comprehensive but fell short of the contract requirements. but were fairly comprehensive. With the previous EV results and current overall score of Partially Met, the general state of the PIHP's data is evaluated as "fair". The PIHP is taking steps to bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- The PIHP expends considerable effort to ensure that its data is timely, accurate, and complete.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two submitted PIPs for NSMHA PIHP: Restraint and Seclusion at E&Ts, which was identified by the PIHP as clinical. Included in the document request were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006. (See, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

NSMHA developed this PIP based on risk analyses and investigation of consumer incidents, including a death, while in seclusion and/or restraints at their Evaluation and Treatment Centers (E&T); the documentation submitted reflected progress on this PIP during Study Year 2. Initially the PIHP identified two related study topics: reduction of injury and illness while in seclusion/restraint, and reduction of incidence of seclusion/restraint. The topic related to injury and illness was ultimately dropped (per discussion with the PIHP at the site visit) due to data analysis problems they recognized (described below); however, the summary and analyses submitted for EQRO review retained the description and data related to that question. The PIHP implemented three (3) important interventions – intensified monitoring of consumers while in seclusion/restraint, adoption of JACHO-recommended procedures for minimizing threatening behaviors, and inclusion of a thorough medical assessment at admission. Their analysis yields a strong correlation between a reduction in the use of S/R and implementation of the JCAHO procedures; the EQRO review validated those findings.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				High-acuity, complex, and involuntarily detained consumers in seclusion and/or restraint in an evaluation and treatment center (E&T).
1.2. Is selected following collection and analysis of data (or was selected by the State).	X				Review of “incidents” during periods of restraint/seclusion, including one death; discovery during case reviews that medical assessments were lacking or incomplete at intake.
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	PIP topic selected in response to a specific incident that raised seclusion/restraint issues to several operations and oversight committees.
1.4 Includes all eligible populations that meet the study criteria.	X				100% of consumers admitted to two E&T centers were examined in this study.
1.5. Does not exclude members with special health care needs.				X	All mental health consumers are considered to have special healthcare needs.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
1.6 Has the potential to affect member health, functional status, or satisfaction.	X				Decrease in both incidence of seclusion/restraint and incidents of illness, injury, or death at E&Ts will have a positive effect on consumer health and functional status.
Totals for Step 1:	**4**	**0**	**0**	**2**	
Number of shaded critical evaluation elements met for Step 1: 1/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.		X			Two questions are presented, each related to separate, distinct interventions with different outcome measures. Study Question #1 resists statistical confirmation because the desired incidence of death is zero. Moreover, baseline counts of illness/injury have not been captured. As a result, only Study Question #2 is viable. Questions are formulated clearly around specific impact of the intervention(s) on the population/process being studied.
2.2 Is answerable/provable.		X			Study Question #1 resists statistical confirmation because the desired incidence of death is zero. Moreover, baseline counts of illness/injury have not been captured. As a result, only Study Question #2 is viable.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Totals for Step 2:	**0**	**2**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 2: 0/2					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.		**X**			More complete description of "clients restrained/secluded" and "incidents of injury/illness or death" would enhance clarity. Clarity is also compromised because indicators are variously described as targeting *events*, *admissions*, *clients*, and *incidents*.
3.2. Are based on practice guidelines, with sources identified.	**X**				Introduction includes references to most recent national efforts to reduce or eliminate use of seclusion/restraint as well as to related WA State regulatory changes. Specific citations are desirable with respect to initiatives in which these indicators have improved outcomes.
3.3 Allow for the study question/hypothesis to be answered or proven.		**X**			See comments in 3.1 above.
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	**X**				Seclusion and restraint events, as well as incidents of illness, injury, or death associated with such interventions are clear indicators of process alternatives and consumer health.
3.5 Have available data that can be collected on each indicator.		**X**			Documentation of incidents of illness or injury during the baseline period (Jan 2004 – Apr

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					2005) is not provided, suggesting comprehensive records were not available as they were for the post-intervention period (May 2005 – Nov 2006).
3.6 Include the basis on which each indicator was adopted, if internally developed.	X				Adopted based on emerging national standards and internally desirable changes in practice and outcomes.
Totals for Step 3:	**3**	**2**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 3: 0/0					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					
4.1. Is accurately and completely defined.	X				Population includes all admissions to E&T during the study period.
4.2. Includes requirements for the length of a member's enrollment in the MCP.				X	Study covers all admissions, including uninsured consumers, rather than just Medicaid-eligible enrollees.
4.3 Captures all members to whom the study question applies.	X				All consumer admission data is contained in information systems; critical incident database and daily seclusion/restraint reporting governed by policy and monitored by PIHP.
Totals for Step 4:	**2**	**0**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 4: 2/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).	X				100% of consumers admitted to two E&T centers were examined in this study. Study covers all admissions, including uninsured consumers, rather than just Medicaid-eligible enrollees.
5.2. Identify the sample size (or use the entire population).				X	Population includes all admissions to E&T during the study period.
5.3. Specify the confidence interval to be used (or use the entire population).				X	See 5.3
5.4 Specify the acceptable margin of error (or use the entire population).				X	See 5.3
5.5 Ensure a representative sample of the eligible population.				X	See 5.3
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.				X	See 5.3
Totals for Step 5:	**1**	**0**	**0**	**5**	
Number of shaded critical evaluation elements met for Step 5: N/A					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.	X				Desired data elements not present in electronic information systems were abstracted from paper-based records.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
6.2. Identification of specified sources of data.	X				Sources include critical incident database; daily seclusion and restraint tally reports; electronic information systems for number of admissions and length of stay.
6.3. A defined and systematic process for collecting baseline and remeasurement data.		X			Documentation of incidents of illness or injury during the baseline period (Jan 2004 – Apr 2005) is not provided, suggesting comprehensive records were not available as they were for the post-intervention period (May 2005 – Nov 2006). Additional detail regarding collection and assembly of all relevant data is desirable. Summary does not make clear who coordinates data assembly, validates it, and prepares it for analysis.
6.4. A timeline for collection of baseline and remeasurement data.	X				Baseline defined as period between January 2004 and April 2005. Remeasurement period is May 2005 through November 2006.
6.5. Qualified staff and personnel to abstract manual data.			X		Not addressed
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.		X			Documentation of incidents of illness or injury during the baseline period (Jan 2004 – Apr 2005) is not provided, suggesting comprehensive records were not available as they were for the post-intervention period (May 2005 – Nov 2006).

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					Daily seclusion/restraint report tallies event categories but not consumer-specific information, introducing opportunities for single, very acute, and complex cases to confound the time series.
6.7 A manual data collection tool that supports inter-rater reliability.		X			Poor inter-rater reliability in the daily seclusion/restraint tally report might influence study results. The report design pre-dates the study, suggesting that user training issues may be insignificant. Although the study's summary documents some instances of counting errors between nursing shifts, an examination of user reporting bias with this reporting tool would boost reliability confidence.
6.8 Clear and concise written instructions for completing the manual data collection tool.		X			User uncertainty surrounding incident counting rules occurred when adopting the pre-existing daily seclusion/restraint report as a data collection tool.
6.9 An overview of the study in written instructions.			X		Existing operational reports were employed as manual data collection instruments; study-related instructions do not appear to have been incorporated into these documents.
6.10 Automated data collection algorithms that show steps in the production of indicators.		X			Study Summary provides an "analyst's eye" narrative overview of how the analysis unfolded over time. Greater detail and consistency of how the data was manipulated is desirable; for example:

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					• Give p-values for the correlation analysis (as was provided in the regression model) • Add descriptive clarity for independent variables such as "time period to allow for month to month trends to be accounted for" used in regression model • Specify methods of converting month totals to moving averages, particularly at extremes of the time period in question.
6.11 An estimated degree of automated data completeness.			X		Not addressed
Totals for Step 6:	**3**	**5**	**3**	**0**	
Number of shaded critical evaluation elements met for Step 6: 0/1					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.	X				Summary of PIP development identifies consideration of potential causes and barriers, and interventions were developed to address those hypotheses.
7.2 System changes that are likely to induce permanent change.	X				Changes in intake procedures and seclusion/restraint monitoring have a strong chance of impacting outcomes.
7.3 Revised if original interventions are not successful.				X	Continued monitoring of events will be required to assess success of interventions.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
7.4 Standardized and monitored if interventions are successful.				X	Continued monitoring of events will be required to assess success of interventions.
Totals for Step 7:	**2**	**0**	**0**	**2**	
Number of shaded critical evaluation elements met for Step 7: 1/1					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					
8.1. Is conducted according to the data analysis plan in the study design.			X		Data collection design and activities were carried out during or before the analysis plan was developed.
8.2. Allows for generalization of the results to the study population if a sample was selected.				X	100% of consumers admitted to two E&T centers were examined in this study.
8.3. Identified factors that threaten internal or external validity of findings.	X				Investigators reasonably conclude that external validity may have limited application because of consumer demographics that vary significantly from typical inpatient facility experience. Identified threats to internal validity are noteworthy and may constitute uncontrolled variables in the study design.
8.4. Includes an interpretation of findings.	X				Results are interpreted using at least three different and separate approaches: correlation of incident count to policy adoption; regression modeling of incident count based on independent variables; and control charting and analysis.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
8.5 Is presented in a way that provides accurate, clear, and easily understood information.		X			See comments in 6.10 above and 9.2 below.
8.6 Identifies initial measurement and remeasurement of study indicators.	X				Study describes a baseline period and a remeasurement period; however, a second, post-intervention measurement period has not yet occurred.
8.7 Identifies statistical differences between initial measurement and remeasurement.		X			See comments in 9.2 below.
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.	X				Separate but related initiatives launched during the post-implementation period may constitute uncontrolled variables in the study design.
8.9 Includes the interpretation of the extent to which the study was successful.	X				See related comments in 9.2 below.
Totals for Step 8:	**5**	**2**	**1**	**1**	
Number of shaded critical evaluation elements met for Step 8: 0/1					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.				X	A second, post-intervention measurement has not yet occurred.
9.2. There is documented improvement in		X			Reduction in illness/injury is not known

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
processes or outcomes of care.					because baseline counts are not presented. Absence of death in measurement period is a positive finding, but is not amenable to statistical analysis. Correlation analysis suggests desirable declines in both monthly seclusion and restraint incidence, but p-values were not provided. Regression model has extraordinary variance explanation, but variable definitions lack clarity, and documentation of precise data preparation/manipulation is not provided.
9.3. The improvement appears to be the result of planned intervention(s).		X			See comments in 9.2 above.
9.4. There is statistical evidence that observed improvement is true improvement.		X			See comments in 9.2 above.
Totals for Step 9:	**0**	**3**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.				X	Continued monitoring of events will be required to confirm that measured change is persisting.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Totals for Step 10:	**0**	**0**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 10: N/A					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS

***Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported**

**** Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported**

***** Not Met = Reported PIHP PIP results or plan/activities not credible**

Summary of Aggregate Validation Findings

* ☐ **Met** * * ☒ **Partially Met** *** ☐ **Not Met**

Summary of PIP validation findings:

This study examines restraint and seclusion incidence with an admirable commitment to improvement, as reflected in the range of analytic tools employed to detect evidence of change. The study design was not completely specified when data collection commenced, and symptoms of this are apparent retrospectively.

Reduction in illness/injury during seclusion or restraint is not known because baseline counts appear to have been unavailable. The absence of death during measurement period is a positive finding, but is not amenable to statistical analysis, as the Summary indicates. Hence, the predominant focus of this project is the effort to reduce incidents of seclusion and restraint.

The correlation analysis of adopting the new policy suggests desirable declines in both monthly seclusion and restraint incidence, but p-values were not provided. Using work files supplied by the investigators, p-values were reconstructed for these favorable correlations and found to be significant at the 95% level. The regression model explains an extraordinary amount of variance, but definitions of the introduced variables lack clarity; in addition, the preparatory data manipulation for this model is not well documented. A guideline might be to provide enough specificity to allow a third party to duplicate the analysis with the same starting data set. Nevertheless, given the favorable and significant results from the policy correlation study, the more elaborate, multivariate confirmation may be unnecessary.

PIP Strengths

- Commitment to employing tools and techniques from social and health service research and statistical quality control.
- Appreciation of study design aspects influencing reliability, validity, significance, and sources of bias.
- Topic of study has clear implications for quality of care, especially consumer safety and emphasis on patient-centric affairs.

PIP Challenges

- Design appears to have evolved during execution of the analysis, contributing to some procedural inconsistencies.
- Individual patients experiencing multiple seclusion/restraint events appear to confound the data.
- Due to lack of data, Study Question #1 does not lend itself to statistical analysis.

PIP Recommendations

1. Remove Study Question #1 from scope because of difficulty measuring the significance of unobserved events.
2. To reduce the confounding impact of individual, high-utilizing consumers, explore revising results metric to "number of unique consumers experiencing at least one seclusion (restraint) event."
3. Given activities to manage seclusion/restraint events that parallel this study, one might consider evaluating three different periods: Baseline (Jan 2004 – April 2005), Implementation Period (May 2005 – Nov 2005), and Post-Intervention Period (Dec 2005 – Nov 2006).

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentation was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff and, in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs' encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide reviewers with responses that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation
Process Review

Item	*Rating*	*Comments*
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	The PIHP defines its data requirement in a single reference document it maintains. When changes are made, this document is revised and sent to all PIHP network providers. With the exception of defining completeness standards, the documentation satisfies relevant requirements.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Partially Met	Data standards are developed with Sound Data, the entity that manages the PIHP's provider IT systems. When changes are made, the reference document is updated and all parties receive copies. Missing from this document is inclusion of a completeness standard.
2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	The NS PIHP did not conduct an evaluation of its providers' capability to produce timely, accurate, and complete data.
3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that	Partially Met	The PIHP employs an array of pre and post submission processes to

PIHP Encounter Validation
Process Review

Item	Rating	Comments
include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.		ensure that data is accurate and complete. A specific data analysis to validate the entire data set for completeness and accuracy is being accomplished. Through use of various reports, the PIHP looks for issues of data completeness and accuracy. These reports identify issues, but do not provide information needed to calculate actual completeness values needed for this analysis. The reports do not provide trend data that would help gauge progress toward eliminating reported issues. There is no mechanism to evaluate or provide a rationale for the selection of data elements for review. The various processes used for pre and post submission screening are documented and scheduled in a yearly master calendar.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Partially Met	The PIHP uses standardized queries on an established schedule to analyze their data. No evidence was submitted indicating that report results are reviewed and analyzed, or that they trigger follow-up activity.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data was not frozen prior to conducting the analysis.
4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation.	Met	The data elements checked by the PIHP were: • Client Number • Client Name

PIHP Encounter Validation
Process Review

Item	Rating	Comments
At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.		• Client DOB • Client Gender • Service Date • CPT/HCPCS • Minutes of Service The method used to select the records reviewed ensured that the provider was checked and that the service actually took place.
PIHP includes additional data elements in matching exercise.	Partially Met	Additional data elements were present in the PIHP review. If the PIHP had a method to identify data that is seldom (if ever) verified, such data could be added to reviews on a rotating basis to ensure its eventual scrutiny.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Met	The PIHP tool supported the capture of the results required,

5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report to the state lists number of encounters per provider agency audited, the number of minutes matching (or not), number of procedure codes matching/not matching, and the number successfully cross-walked. Ideally, the report should contain the information requested by this tool. At a minimum, documentation should contain:

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		• A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Not Met	No evidence was submitted indicating that results were shared with their provider agencies.
PIHP regularly reports internally for quality improvement activities.	Not Met	No evidence was submitted indicating that results were shared internally.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP	Not Met	No evidence was submitted to satisfy this item.

PIHP Encounter Validation Process Review

Item	*Rating*	*Comments*
maintains focus of oversight through to completion of requirements.		
If warranted, evidence of follow-up activity was presented.	N/A	

Summary of Encounter Validation Findings

Score Met _17_ %

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

Met **Partially Met** **Not Met**

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP met the requirements set forth in the contract between the MHD and the PIHP. The PIHP does a good analysis of its data for completeness and accuracy, but information is missing in the reports relative to the status and progress of these items.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 17% of all items meeting a score of Met, 33% at Not Met, and the remaining 50% at Partially Met.

EV Strengths

- The PIHP reviews data integrity on a scheduled basis.
- The standardization of reports employed by the PIHP to check its data ensures consistency and comparability of results.
- The PIHP requires documentation with respect to errors they or their providers identify in data analysis.

EV Challenges

- With the PIHP's implementation of a new contracting model, provider network operation becomes more complex from an IT standpoint.
- Lack of analysis and trending of data reviews constrains the PIHP in its understanding of the true status of its data integrity.

EV Recommendations

1. Define a data completeness standard.
2. Analyze provider network capability to produce accurate and complete encounter data.
3. Incorporate trend data into accuracy and completeness reports to enable analysis and tracking in this area.
4. Develop a method to freeze data when calculating its completeness.
5. Develop and document a selection process and create a matrix to ensure that all data is eventually checked.
6. Document efforts with provider agencies to evaluate and address problematic data uncovered in report.
7. Document internal PIHP discussions relative to encounter validation efforts; these results should be discussed in the PIHP's quality management forum.
8. Define a policy and procedure to capture triggers and processes for corrective actions based on these results. Ideally, a broader corrective action policy could be referenced in a data completeness standard.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

APS HEALTHCARE
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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		**3**		• The QAI Plan includes most components of a comprehensive plan, such as: mission, vision and guiding principles, goals, and scope of program. reporting processes and its • Language reflects a consumer-driven process and recovery model. • Plan describes the scope of activities of the QAI Program; however, detail is scattered and difficult to track. • Flow charts depict structure of the internal and external QAI process, which is somewhat complex and possibly redundant.

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• Plan stipulates that final decisions are made by Board of Directors. • The Quality Management Oversight Committee (QMOC) is responsible for oversight of the QAI Plan and receives reports from internal and external committees. This committee is chaired by a Board member. • The duties of the Quality Manager are not included in either the plan or related policies, nor were other explanatory documents submitted which relate to that position. • Plan includes description of development and implementation of Performance Improvement Projects (PIPs). • Plan includes a table of performance indicators under heading, “Work Plan”; however, detail regarding measurement and benchmarks is not consistently included. • Work Plan table of indicators states that the QM Department generates an Annual QM Report; however, the Plan does not specifically state how this report is to be used or when it will be produced. • Missing from the Plan are an annual

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				work plan and a process for an annual update and review of the QAI Plan (see below).
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		**1**		• The Integrated Report includes some elements of a plan review; however, the QAI Plan does not specifically address the annual review and approval process.
C. Plan includes annual work plan and process for review of associated activities and progress.			**0**	• PIHP did not provide an annual work plan that includes targeted, focused, quality improvement activities to be addressed for the specific year.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		**3**		• Plan includes references of annual clinical and administrative record reviews of all providers in the Work Plan section. • The "Work Plan" section of the Plan references annual clinical and administrative reviews of all providers and monthly and bi-annual reporting of clinical chart review findings to QMOC. The Plan also states that the QMOC decides what recommendations to forward to the Board of Directors (BOD). • Follow up on chart reviews is described as a function of the CQIP Committee, using the External Monitors Matrix (EMM) for reporting and tracking purposes. • The plan references use of corrective

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				actions (CA) to address review deficiencies. Details of the CA process are not included. • The Plan does not describe the use of reports to ensure effective operational oversight of improvement activities.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	**4**			• Plan describes use of provider and consumer satisfaction surveys. • Consumer/family involvement in North Sound Quality Management is expressed in the mission, principles, and advocacy sections of the plan. • Committee membership includes providers, consumers, family members, and advocates at every level of the QAI system.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**3**		• Consumers and advocates are well represented at committee meetings. • IQMC minutes reflect several specific and focused quality assurance activities which could be included in an annual Work Plan. • Provider management reported that PIHP conducts site visits as defined in plan. • Committees such as QMC, QMOC, and IQMC meet regularly as reflected in the Plan and discuss consumer satisfaction,

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				PIPs, grievances and appeals, and quality improvement activities. • The 4th biennial Quality Management Plan Integrated Report submitted for the period June-Dec, 2005 includes: o A review of most indicators on the QM Plan and comparison of data from administrative audits; o Recommendations for quality improvement activities that were adopted, such as proposed PIPS and a medication management study. • The PIHP did not submit clear evidence of Board approval of the Plan. The QM Plan cover page indicates that the Plan was approved by the Board in 12/05. However; no board signature of approval, committee minutes, or Board minutes confirmed this approval. • Practice does not reflect the current plan in the following areas: o PIHP does not track performance indicators using the External Monitors Matrix (EMM) as described in the plan. o PIHP stated that the CQIP Committee described in the Plan does not exist.

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				○ Committee meeting notes do not reflect participation of fiscal staff.
Standard 1 **Count (Target 6 Met):**	**1**	**4**	**1**	**Target Points: 24 Actual: 14**
<u>**Standard**</u> **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			• Schedules indicate that all providers annually receive one audit each for Administrative and Clinical Record Reviews. • Evidence that site visits and chart reviews occur as scheduled includes: ○ Reports to providers of site visits; ○ Completed chart review summaries for each provider; ○ Updates on reviews at QMOC meetings; and, ○ Confirmation by provider management and direct service staff that reviews are conducted as described in the plan.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**3**		• The tool, together with the interpretive guide is structured for clear evaluation of timeliness, eligibility, treatment planning,

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				and service provision. • Review tool is used for 4 types of reviews (initial authorizations, concurrent reviews, high-need utilizers, and retrospective). Reports provided for reviews indicate that scores are tallied and reported for individual providers and the overall system in each category. • Although IT staff verbally described methodology, evidence of intermediate methodology to arrive at scores was not provided.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**3**		• Report submitted by PIHP depicting scores of all review items for all reviewers supports PIHP capacity to compare scores of individual reviewers; however, no documentation was provided related to use of the information. • Comprehensive scoring guide assists with consistency of scoring across reviewers. • No evidence of a training plan for the review tool was submitted; however, RSN staff confirmed that new reviewers are trained by current reviewers prior to conducting their first review. • Neither the QM Plan nor the QM Policy addresses reliability of scores across

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				reviewers and over time.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**3**		• QM policies provide a thorough description of the system for following up on required charting changes as well as agency-wide recommendations and corrective actions. • “Request for Change” letter and samples submitted for review support the procedure for chart corrections. • The RSN submitted documentation of corrective action plan requests and follow-up that is consistent with staff description. • Providers described the general framework for recommendations and corrective actions; however, specific thresholds for action related to types/severity of quality of care issues are not documented in submitted materials. • The RSN did not submit evidence of a systematic monitoring mechanism for Corrective Action plans and implementation.
Standard 2 Count (Target 4 Met):	**1**	**3**	**0**	**Target Points: 16 Actual: 13**

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PIHP:

Requirement	Met	PM	Not Met	Findings Comments
Standard **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		3		• QMOC minutes across the year document discussions of reports and data related to customer satisfaction survey results, updates for the Integrated Report, complaints and grievances, and clinical and administrative chart reviews. Recommendations from the QMOC to the Planning Committee and the Board are included in the minutes. • The monthly Internal Quality Management Committee (IQMC) minutes focus on quality of care issues, generated from review of complaints and grievances and comparison of data from administrative and clinical audits. Recommendations are made to QMC and progress is tracked on quality improvement efforts, such as medication management, assessment evaluations, and creation of review process templates. • Meeting minutes from QMC, QMOC,

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				and IQMC submitted do not reflect discussion of corrective action oversight activities.
B. PIHP analyzes and trends individual provider performance.		**2**		• PIHP submitted for review a system-wide report of 2006 chart review scores, which documents each provider's performance on each review; however, the PIHP did not submit evidence related to use of the report for analyzing provider performance. • PIHP submitted individual provider summary reports, describing both positive and problematic performance areas that are sent to providers following the reviews. • The PIHP did not submit evidence of trending individual provider scores over time.
C. PIHP analyzes and trends system-wide performance.		**2**		• PIHP submitted for review a system-wide report of 2006 chart review scores, which documents each provider's performance on each review and aggregates performance of the system; however, the PIHP did not submit evidence related to the use of the report for analyzing and trending the information.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and		**3**		• Evidence that clinical quality is shared across the system:

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
improvement activities.				o IQMC meeting minutes include discussion of clinical chart reviews and recommendations that are forwarded to the QMC for action. o Provider management and staff confirmed that agency and system chart review findings are discussed at the PIHP level and in internal meetings. o Provider management and direct service staff were able to describe recent PIHP quality improvement activities. o QMOC reviews critical incidents and barriers to service. o The PIHP maintains a website, posting dashboard utilization reports as well as Integrated Reports as they are produced. • Because the PIHP did not submit minutes of Board meetings, the WAEQRO is unable to ascertain the extent to which results of clinical oversight activities are discussed and/or acted upon at the Board level.
Standard 3 Count (Target 4 Met):	**0**	**4**	**0**	**Target Points: 16 Actual: 10**

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
<u>Standard</u> **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**2**		• PIHP provided, for the review year, complete records of all appeals and grievances and follow-up related to findings contained in those records. • PIHP reviews activities related to grievance findings in the administrative audits. • No evidence was provided related to system-wide documenting and tracking compliance with requirements such as timeliness for these activities.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.	**4**			• QMC and IQMC minutes reflect discussion of Exhibit N reports. • Exhibit N report includes follow-up on issues from previous reports, as well as a description of system improvement activities such as an IQMC plan to study medication issue and RSN training of providers on the complaint process. • Ombuds reports presented at QMOC, QMC, IQMC meetings are incorporated into the Integrated Report as recommendations. Several quality improvement activities identified by the

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PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				Ombuds became formal quality improvement activities and PIPs.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	**4**			• PIHP provides staff, providers, and Ombuds training on the grievance and appeal system. Evidence includes: o Training schedules, attendance sheets, and curriculum information; o PIHP administrative audit checklist includes documentation of required training from staff files. o Providers (managers and direct service staff) reported receiving training by the RSN on grievance and appeal system in 10/06. • Provider management accurately described the grievance, appeal and fair hearing process and documentation. • Line staff reported little involvement with grievances and appeals, as they occur infrequently. They referenced knowledge of availability of policies, access to supervisors, and referral to Ombuds for such matters. • Telephone interview with Ombuds reviewed knowledge of their job and involvement in QAI: o The two Ombuds accurately described the grievance and appeal process and their role in assisting

PIHP:				
Requirement	Met	PM	Not Met	Findings Comments
				clients. o Both attend many meetings, such as ICMC, QMC, QMOC, CIRC, Training, and the Policy sub-committees. o Both Ombuds participate in and provide training for the system. o One person contributed sections to QM Plan. • Both provide input in many forums which resulted in action to address issues in the system.
Standard 4 **Count (Target 3 Met):**	**2**	**1**	**0**	**Target Points: 12 Actual: 10**
Grand Totals **Count (Target 17 Met):**	**4**	**12**	**1**	**Target Points: 68 Actual: 47**

Summary Quality Assurance and Improvement Findings

NSMHA achieved the highest score possible on 4 items. Another 12 items were partially met. Of these, all but 4 rated at the high end of partially met. Only 1 item was unmet: the expectation of having an annual plan to track quality improvement activities during the course of the year. NSMHA achieved a total score of 47/68 (69%), of items possible on the first year of review of the Quality Assurance and Improvement Plan. Two key changes recommended are to revise the Quality Management Plan to reflect current practices and use data collected to analyze and report trends at both the provider and system levels. Data analysis capacity combined with the abilities of individual staff and consumer representatives form a strong quality assurance and improvement

program with documented implementation.

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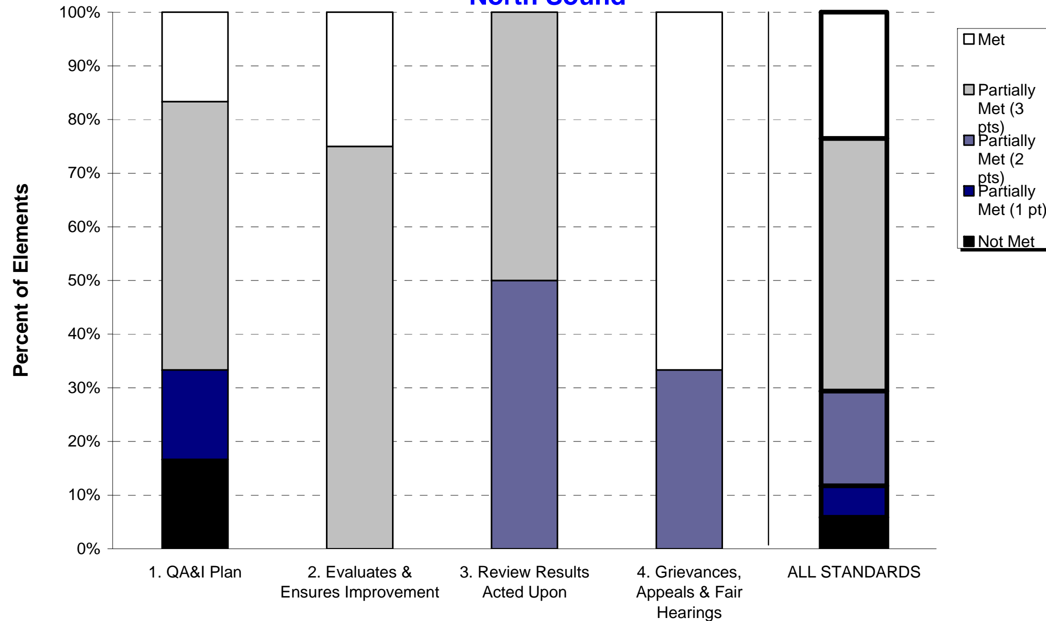


I. Frequency of Scores

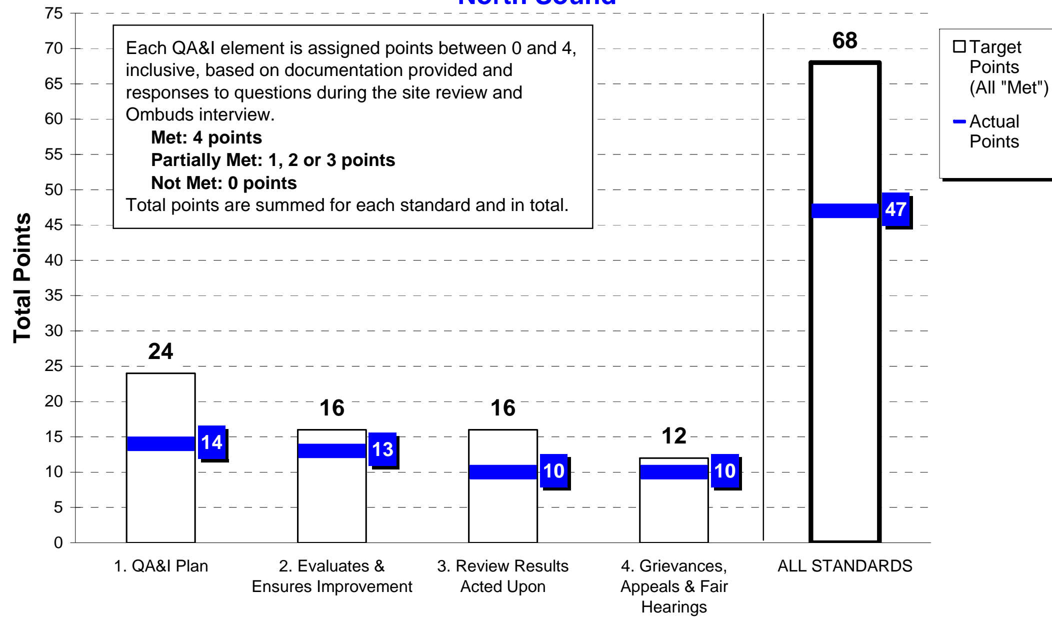
Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	1	3	0	1	1
2. Evaluates & Ensures Improvement	4	1	3	0	0	0
3. Review Results Acted Upon	4	0	2	2	0	0
4. Grievances, Appeals & Fair Hearings	3	2	0	1	0	0
ALL STANDARDS	**17**	**4**	**8**	**3**	**1**	**1**

QAI Strengths

- The scoring tools created for clinical chart reviews, along with the interpretive guides and data collection system, provide a good base for an inter-rater reliability process.
- The PIHP has benefited from having on staff Ombuds who are confident in working throughout the system to meet the needs of consumers.
- The Biennial Quarterly Integrated Report provides considerable information to assess on-going and planned quality improvement activities over the course of six months.
- Information Services staff routinely attend the QMC.

QAI Challenges

- The Quality Assurance and Improvement Plan is not consistent with practice and/or current policy and procedure and does not include important detail.
- Use of the External Monitoring Matrix was dropped as too



II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	14
2. Evaluates & Ensures Improvement	16	13
3. Review Results Acted Upon	16	10
4. Grievances, Appeals & Fair Hearings	12	10
ALL STANDARDS	**68**	**47**

cumbersome as long ago as 2005; however, no replacement monitoring tool has been approved.

- The placement of the Quality Manager in the organizational chart may affect his/her authority to ensure implementation of the plan as written.
- Annual quality improvement activities, including ongoing follow-up, are discussed in the Integrated Report; however, the PIHP does not have an annual work plan that defines and focuses these activities.

QAI Recommendations

1. Revise QAI Plan to eliminate inaccuracies and increase clarity of structure and process.

2. Annually identify several quality improvement activities based on data from the previous year as the base for an annual quality improvement work plan.

3. Consider change in structure to ensure that the Quality Manager has the decision-making and oversight authority needed to effectively manage the QAI system.

4. Including Finance representation on the Quality Management Committee would ensure that all aspects of RSN operations are integrated and participating in the QAI process.

5. Increase detail of meeting minutes relative to discussions of data analysis and recommendations.

6. Create a matrix of indicators that clearly and specifically defines performance measures, measurement calculations, targets for performance, thresholds for further action, and reporting frequency and responsibility.

7. Continue to develop data analysis capabilities to support effective use of gathered and reported information. Develop reports that trend results of quality oversight activities over time, for individual agencies and for the system as a whole.

8. Add information to reports documenting the authors, the date the report was written, relevant information regarding how the data was collected and analyzed, and any reliability/validity issues.

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Recommendations

Subpart Recommendations

1. Develop policy and procedures that stipulate PIHP standards and expectations related to the use of Mental Health Specialists in the delivery of culturally competent services.

2. Update PIHP and provider client materials to comply with PIHP policy #1515.00. In addition, clarify specific standards related to client materials that pertain to all major sensory impairments.

3. Institute formal, annual monitoring of written and oral translation of client materials; include facility checks for required, posted client materials and review provider use of **certified** translators.

4. Incorporate into the PIHP's grievance system policies and procedures with respect to the requirement for continuation of benefits while a State fair hearing is pending.

5. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).

6. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. Remove Study Question #1 from scope because of difficulty measuring the significance of unobserved events.
2. To reduce the confounding impact of individual, high-utilizing consumers, explore revising results metric to "number of unique consumers experiencing at least one seclusion (restraint) event."
3. Given activities to manage seclusion/restraint events that parallel this study, one might consider evaluating three different periods: Baseline (Jan 2004 – April 2005), Implementation Period (May 2005 – Nov 2005), and Post-Intervention Period (Dec 2005 – Nov 2006).

EV Recommendations

1. Define a data completeness standard.

2. Analyze provider network capability to produce accurate and complete encounter data.

3. Incorporate trend data into accuracy and completeness reports to enable analysis and tracking in this area.

4. Develop a method to freeze data when calculating its completeness.

5. Develop and document a selection process and create a matrix to ensure that all data is eventually checked.

6. Document efforts with provider agencies to evaluate and address problematic data uncovered in report.

7. Document internal PIHP discussions relative to encounter validation efforts; these results should be discussed in the PIHP's quality management forum.

8. Define a policy and procedure to capture triggers and processes for corrective actions based on these results. Ideally, a broader corrective action policy could be referenced in a data completeness standard.

QAI Recommendations

1. Revise QAI Plan to eliminate inaccuracies and increase clarity of structure and process.

2. Annually identify several quality improvement activities based on data from the previous year as the base for an annual quality improvement work plan.

3. Consider change in structure to ensure that the Quality Manager has the decision-making and oversight authority needed to effectively manage the QAI system.

4. Including Finance representation on the Quality Management Committee would ensure that all aspects of RSN operations are integrated and participating in the QAI process.

5. Increase detail of meeting minutes relative to discussions of data analysis and recommendations.

6. Create a matrix of indicators that clearly and specifically defines performance measures, measurement calculations, targets for performance, thresholds for further action, and reporting frequency and responsibility.

7. Continue to develop data analysis capabilities to support effective use of gathered and reported information. Develop reports that trend results of quality oversight activities over time, for individual agencies and for the system as a whole.

8. Add information to reports documenting the authors, the date the report was written, relevant information regarding how the data was collected and analyzed, and any reliability/validity issues.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

North Central Washington Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

North Central Washington (NCW) PIHP is responsible for managing mental health care and services for Medicaid consumers in Adams, Grant, Okanogan, Ferry, Lincoln, Pend Oreille, and Stevens counties in the state of Washington. The PIHP is located in Ephrata, Washington and is governed by a board comprised of one Commissioner from each county. The PIHP Administrator reports to Governing Board. The PIHP contracts with 6 community mental health centers and specialty providers, which serve approximately 2,400 adult and child consumers monthly. Total annual Medicaid enrollment in the PIHP is about 35,100. The PIHP delegates prior authorization of voluntary inpatient, residential and outpatient services, notification of denials and appeals, and some training, quality improvement, credentialing to Behavioral Health Options, a private managed care organization.

This report covers the period between February 24, 2006 and February 23, 2007, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);

4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts	June-August, 2006	

Activity	Timeline	Documents/Content
• Review of 2004 Corrective Actions		
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	January 23, 2007	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	February 15, 2007	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	March 5, 2007	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	March 15 and 16, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	March 20, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	April 18, 2007	
4. Debrief conference call	April 27, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	May 1, 2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities.

Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. NCW PIHP submitted a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the NCW PIHP, significant events include:

- Having contractually managed the system since June, North Central RSN formally incorporated the Northeast Washington RSN (NEWRSN) into its operation in September, 2006. Staff have been working on legal and operational issues related to board expansion, assumption of provider contracts, the development of an expanded PIHP management structure, and incorporation of the NEWRSN information system.

- During the review year the PIHP brought their IT operations totally in-house and hired an IT manager. They also developed an in-house data repository using SQL Server, which is fully under their control. Managing this migration, as well as incorporating systems from the former NEWRSN, appears to have impacted their ability to effectively meet contract requirements.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- The documentation submitted as PIPs by NCW PIHP reflect very little understanding of, or conformity to, the CMS protocol; therefore, they were not validated. A description of activities and related documents can be found in the PIP section of this report.

- The policies and procedures submitted for review contained approval dates; however, they lacked place holders for dates they were reviewed, revised, and effective. In addition, some policies were signed and dated by the RSN Administrator, while others had no approval signature. Consequently, the WAEQRO was unable to determine if all the new and revised policies and procedures submitted for review had been officially adopted. They were, however, considered in scoring the subparts.

- Document submission was disorganized and not well mapped, particularly for the Subparts, and also failed to include much of the material required for review. It appears that PIHP staff is challenged to understand and effectively organize their materials for a review such as that conducted by the WAEQRO.

4. 2006 Review Results

This report provides results and a summary of NCW PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. NCW PIHP achieved "Expected Performance" for all 2004 corrective actions by the conclusion of the 2005 EQR.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the North Central PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

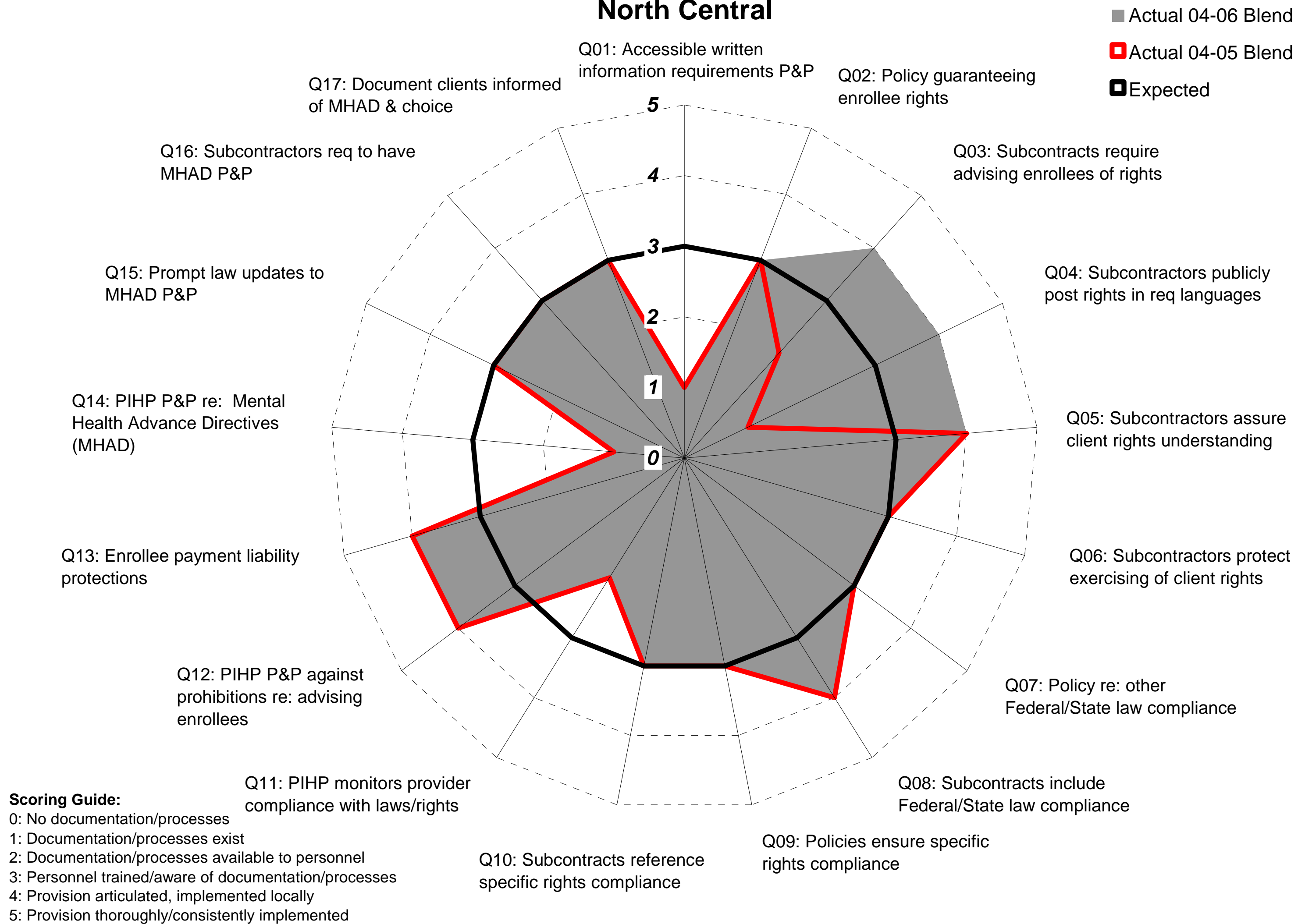
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



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2004-2006 Subpart Scoring Trend and Detail for North Central

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Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	1	1	1
Q02: Policy guaranteeing enrollee rights	3		3
Q03: Subcontracts require advising enrollees of rights	2	4	4
Q04: Subcontractors publicly post rights in req languages	1	4	4
Q05: Subcontractors assure client rights understanding	4		4
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	3		3
Q08: Subcontracts include Federal/State law compliance	4		4
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	3		3
Q11: PIHP monitors provider compliance with laws/rights	2	2	2
Q12: PIHP P&P against prohibitions re: advising enrollees	4		4
Q13: Enrollee payment liability protections	4		4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	1	1	1
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	3		3

NCW PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
438.100(b)	**Specific Enrollee Rights**	
[Q1]	**Written policies and procedures addressing accessible information requirements** Evidence: • Choice of Mental Health Provider & Agency, Education About Mental Health Services to Medicaid Eligible Persons, General Information Requirements, Medicaid Enrolled Client Rights & Responsibilities, Provision of Service to Limited & Non-English Speaking Clients and Medicaid Enrollees, Public Awareness of Mental Health Services, RSN Contracting As A Mental Health Prepaid Health Plan, and Standards for Administration policies and procedures collectively contain majority of requirements for this provision with the exception of 438.10(f)(4&5). • DSHS Public Mental Health System Benefits Booklet in 8 DSHS-required languages. • English version of the North Central WA Regional Support Network Client Rights and Responsibilities brochure. • 3-Language Line billings exhibiting the provision of interpreter services in the languages of Russian, Vietnamese, Somali, Amharic, Bosnian, Korean, and Spanish. • PIHP Training Data and related follow-up memo indicating PIHP provision of mental health service education to the deaf community. • No evidence submitted by PIHP of provider training related to this review element. • Provider management and direct service staff were familiar with the DSHS Public Mental Health System Benefits Booklet and were able to identify the languages in which the booklet is translated. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
[Q3]	**Subcontracts require advising enrollees of their rights in their primary language** Evidence: • 2006 PIHP Provider Contract states, “The Contractor must have mechanisms in place to notify enrollees of, and ensure that enrollees understand, their rights and how to access services	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	and must ensure that direct service staff fully understand enrollee rights and take them into consideration when furnishing services… make available and provide: enrollee general rights in the DSHS prevalent languages, including posting client rights in the DSHS prevalent languages…Ensure that mental health professionals and MHCPs have an effective method of communication with enrollees who have sensory impairments." • Nov-Dec 2006 North Central Reports News Letter—includes a list of client rights in English. • No evidence submitted by PIHP of provider training related to this review element. • Network Provider staff articulated their understanding that rights must be provided to consumers in their primary language. Additionally, one agency reported the use of TTD and TTY and the other has rights translated in Braille. (Substantial Compliance)	4
[Q4]	**Subcontract requires providers to post client rights in public places in all prevalent languages** Evidence: • 2006 PIHP Provider Contract states, "Make available and provide: enrollee general rights in the DSHS prevalent languages, including posting client rights in the DSHS prevalent languages…Post a multilingual notice that advises consumers that all written materials are available in Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese. Provide translations of the mental health consumer rights…readily accessible in public areas and conspicuously marked." • 2007 PIHP Provider Contract states, "Post a multilingual notice that advises consumers that all written materials are available in Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese." • No evidence submitted by PIHP of provider training related to this review element. • Provider management and direct service staff had knowledge of where client rights were posted and in what languages. • PIHP staff reported that they conducted a facilities check and reviewed provider policies and procedures pertaining to posting of enrollee rights during their July/August provider contract audits. No evidence of auditing this provision was submitted by the PIHP. (Substantial Compliance)	4
438.100(d)	**Compliance with Other Federal and State law**	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
[Q11]	**PIHP monitors subcontractor compliance with Federal and State laws and client rights** Evidence: • Revised Quality Management Process and Standards for RSN Contracts & Provider Subcontracts policies and procedures state, "The RSN will demonstrate that it monitors contracts and notifies the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements." In addition, Standards for RSN Contracts & Provider Subcontracts policy and procedures states, "The RSN will monitor the contracted provider on a regular basis to determine that delegated functions and responsibilities are being carried out according to contract, rules, regulation or statute." • Above policies do not specifically address how the PIHP monitors the provider's compliance with the antidiscrimination laws and the 3-client rights. • PIHP staff reported during their provider audits that they review policies and procedures associated with this provision. In addition, staff look for "client voice" in the assessment and treatment plan during clinical record reviews. Staff reported that all requests for second opinions have to go through the PIHP. • The PIHP submitted no evidence of monitoring the antidiscrimination laws or the 3 client rights listed in this provision. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.10(g) **438.6(l)**	**Advance Directives**	
[Q14]	**PIHP has Mental Health Advance Directive policies and procedures** Evidence: • Community Support Services policy and procedures include only 1 of the 6-MHD required procedures. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1

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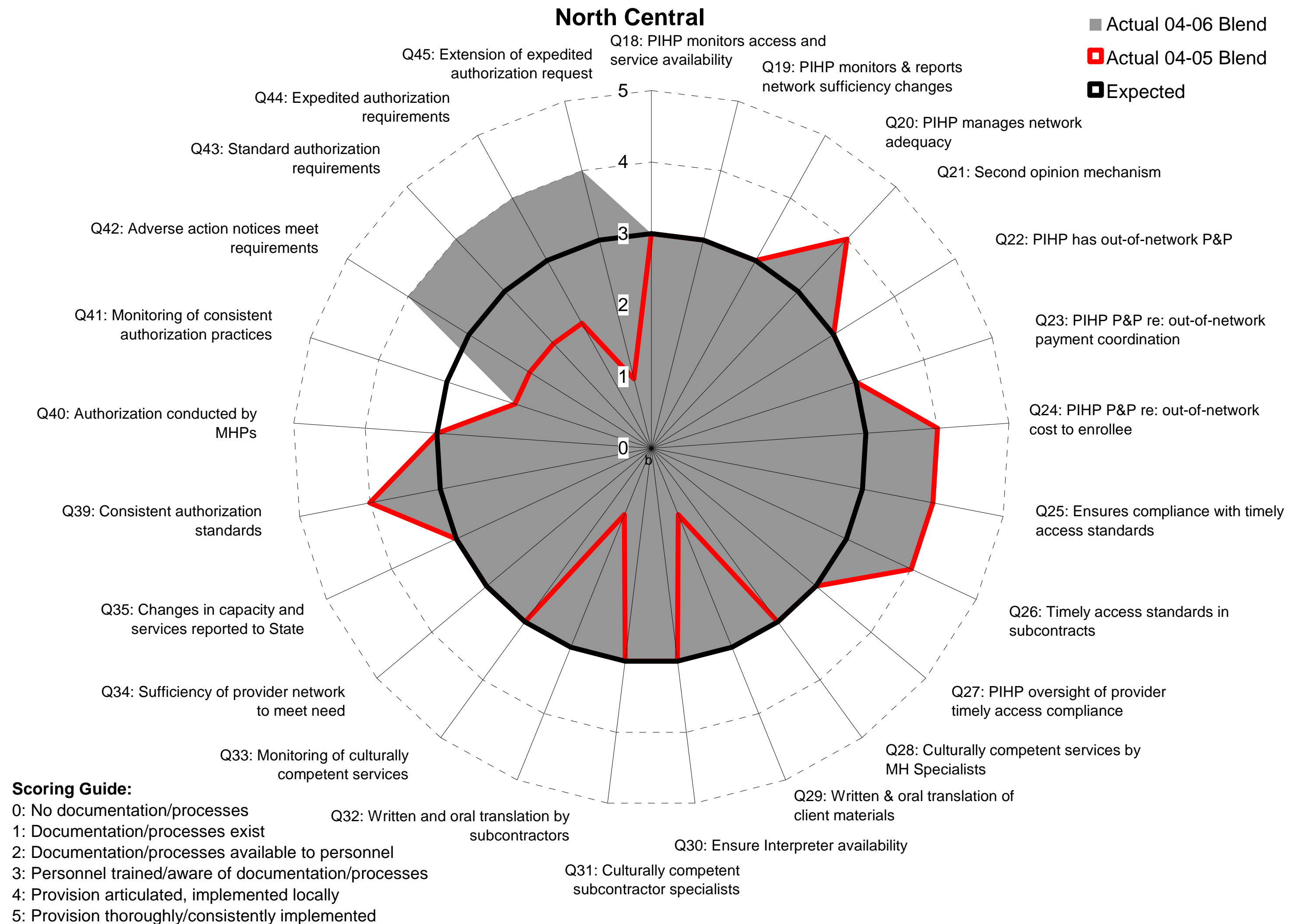
Subpart D (Part 1): Access Standards



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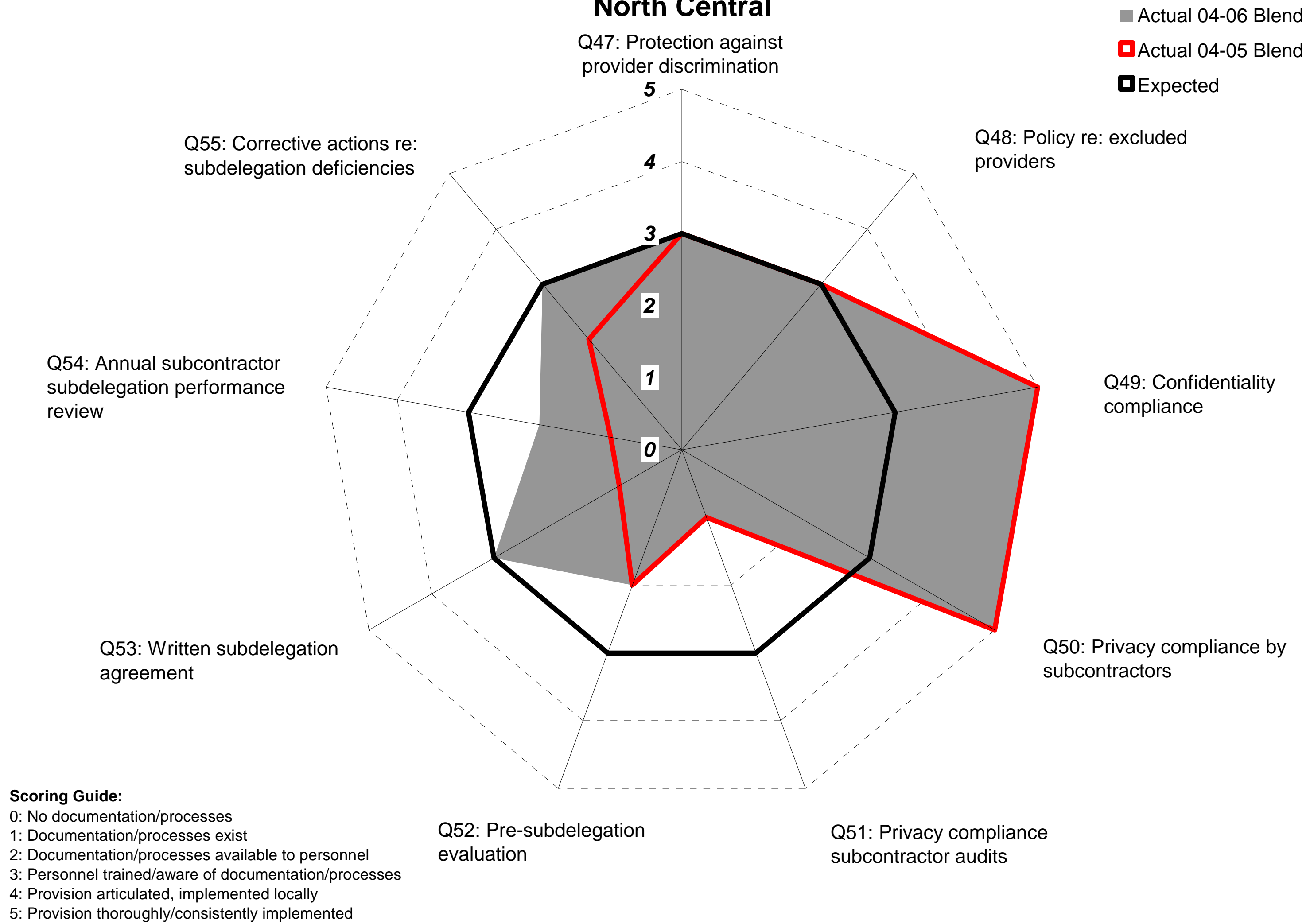
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	4		4
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	3		3
Q24: PIHP P&P re: out-of-network cost to enrollee	4		4
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	4		4
Q27: PIHP oversight of provider timely access compliance	3		3
Q28: Culturally competent services by MH Specialists	3		3
Q29: Written & oral translation of client materials	1	3	3
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	3		3
Q32: Written and oral translation by subcontractors	1	3	3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	3		3
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	4		4
Q40: Authorization conducted by MHPs	3		3
Q41: Monitoring of consistent authorization practices	2	2	2
Q42: Adverse action notices meet requirements	2	4	4
Q43: Standard authorization requirements	2	4	4
Q44: Expedited authorization requirements	2	4	4
Q45: Extension of expedited authorization request	1	4	4



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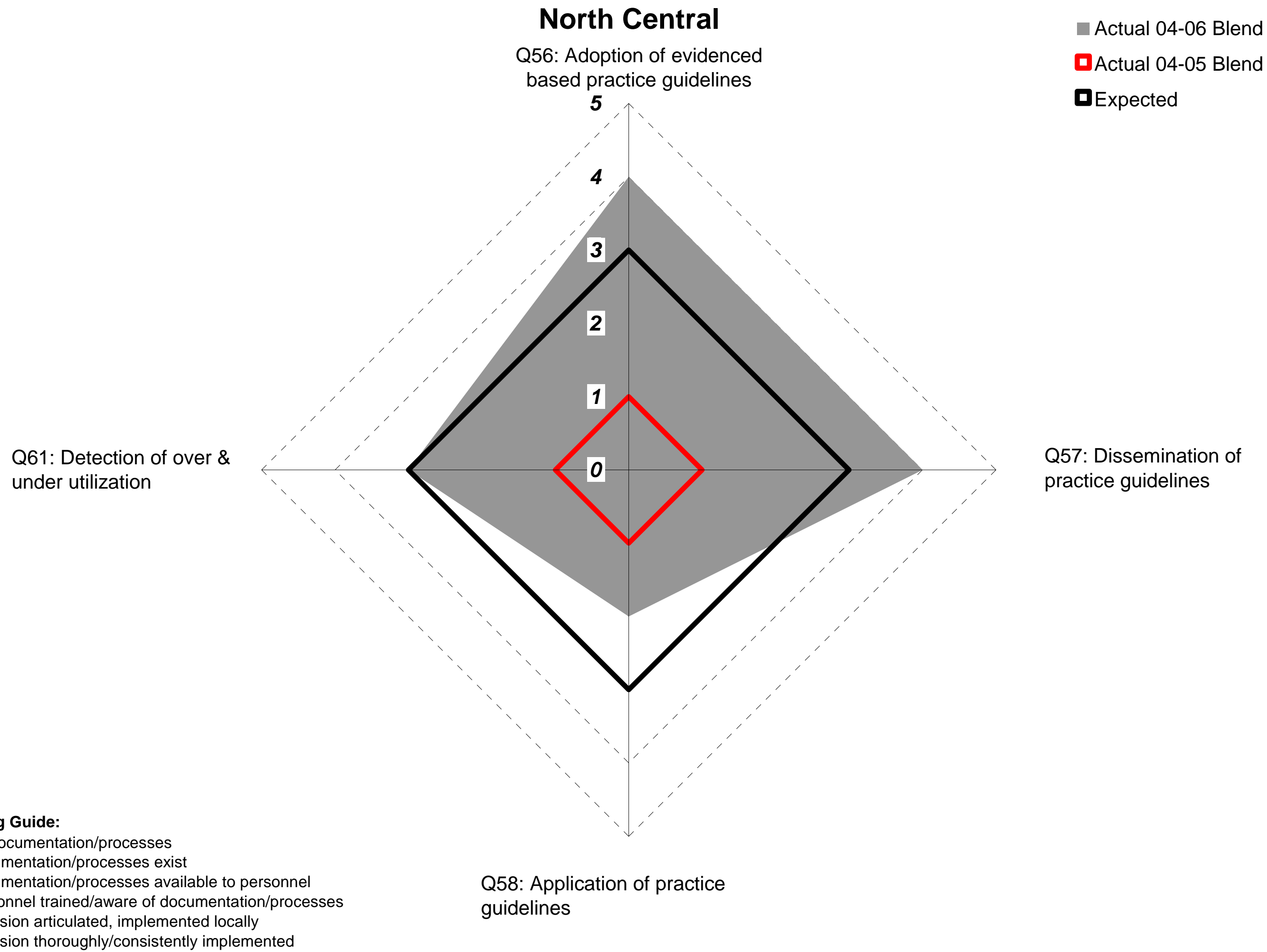
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	5		5
Q51: Privacy compliance subcontractor audits	1	1	1
Q52: Pre-subdelegation evaluation	2	2	2
Q53: Written subdelegation agreement	1	3	3
Q54: Annual subcontractor subdelegation performance review	1	2	2
Q55: Corrective actions re: subdelegation deficiencies	2	3	3

Subpart D (Part 3): Measurement and Improvement Standards



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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	1	4	4
Q57: Dissemination of practice guidelines	1	4	4
Q58: Application of practice guidelines	1	2	2
Q61: Detection of over & under utilization	1	3	3

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
438.206 (c)(2)	**Furnishing of Services Continued**	
[Q29]	**Written and oral translation of client materials** Evidence: • General Information Requirements and Provision of Services to Limited English & Non-English Speaking Clients & Medicaid Enrollees policies and procedures include basic requirements for oral interpretation in all languages and written interpretation in the 6 languages (should be 7). In addition policies mention client materials available in alternative formats and the availability of services through the use of a TTY. • 3-Language Line billings exhibiting the provision of interpreter services in the languages of Russian, Vietnamese, Somali, Amharic, Bosnian, Korean, and Spanish. • PIHP Training Data and related follow-up memo indicating PIHP provision of mental health service education to the deaf community. • PIHP staff reported they have trained providers on resources and materials related to the Eastern WA Center for Hard of Hearing and the Lilac Blind foundation; however, the PIHP submitted no evidence of provider training related to this review element. • Provider management report that client rights, grievance procedures, HIPAA privacy practices, and DSHS benefits booklet must be available to clients in required DSHS languages. Management from one provider reported that they have their benefits booklet and client rights available in Braille and audio. • Direct service staff were able to articulate languages that must be available in oral translation and how to access interpreters with the exception of American Sign Language interpreters. • 3-PIHP 2006 Annual Provider Administrative Contract Reviews (conducted 8/18-31/06) included review agency policies and procedures, intake packets, and provider staff interviews to show compliance with the requirements of this provision. All providers achieved a score of "Met". • Recommend the PIHP include in their policies specific reference to the client materials available to enrollees with sensory impairments and the available formats.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	(Moderate Compliance)	3
[Q32]	**Client materials translated according to WAC 388-865-0330 requirements related to language thresholds** Evidence: • 2006 PIHP Provider Contract includes requirements for oral interpretation in all languages and written interpretation in the 7 DSHS-required languages. • General Information Requirements and Provision of Services to Limited English & Non-English Speaking Clients & Medicaid Enrollees policies and procedures include basic requirements for oral interpretation in all languages and written interpretation in the 6 languages (should be 7). In addition policies mention client materials available in alternative formats and the availability of services through the use of a TTY. • 3-Language Line billings exhibiting the provision of interpreter services in the languages of Russian, Vietnamese, Somali, Amharic, Bosnian, Korean, and Spanish. • PIHP Training Data and related follow-up memo indicating PIHP provision of mental health service education to the deaf community. • PIHP staff reported they have trained providers on resources and materials related to the Eastern WA Center for Hard of Hearing and the Lilac Blind foundation; however, the PIHP submitted no evidence of provider training related to this review element. • Provider management report that client rights, grievance procedures, HIPAA privacy practices, and DSHS benefits booklet must be available to clients in required DSHS languages. Management from one provider reported they have their benefits booklet and client rights available in Braille and audio. • Direct service staff were able to articulate languages that must be available in oral translation and how to access interpreters with the exception of American Sign Language interpreters. • Recommend the PIHP include in their policies specific reference to the client materials available to enrollees with sensory impairments and the available formats. (Moderate Compliance)	3
438.210(b)	**Authorization of Services**	
[Q41]	**PIHP audits subcontractors for consistent authorization practices and evidence of policy** Evidence: • PIHP sub-delegates authorization and utilization management	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	(UM) to Behavioral Health Options (BHO) of Nevada. Unsigned BHO Contract (11-1-05) and BHO Amendment 1 (October 1, 2006) and 2005 BHO UM Plan incorporate structure, operations and PIHP requirements related to authorization of services. • CQI Minutes (9-25-06 and 1/29/07)—Indicate discussions related to authorization processes, practices, distribution of new and revised forms, training on expedited authorizations, etc. • Completed Outpatient and Inpatient Authorization Forms—gave evidence to authorization processes and practices. • RSN Utilization Review (UR) Summary Report (Sept-Dec '06)—gives percentages of intakes that support diagnosis and establish medical necessity. • (10/13/05) Due Diligence Audit Requirements Memo and Summary related to PIHP Pre-Delegation Review of BHO—internal memo outlines suggested review protocol and list of recommended documentation. The PIHP submitted no completed pre-delegation review for this review element. • (2/20/07) Due Diligence Audit Memo—informed BHO of upcoming audit (no date specified) with identified review target period of October 2005 through December 2006. Memo outlined the purpose and expected topics. The PIHP submitted no completed audit review or report for this review element. • BHO Inter-rater Reliability Sample Audit Report—the PIHP submitted no completed audit/report for review. Reviewer was unable to determine if inter-rater reliability audit has been implemented on authorizations conducted for this PIHP and, if so, to what frequency. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees and Authorization to Inpatient & Outpatient Care – Medicaid Clients policies and procedures collectively incorporate the Notice of Action (NOA) requirements contained in this provision. • BHO Subcontract—PIHP delegates authorization and utilization management (UM), and responsibility for sending Notice of Actions to Behavioral Health Options (BHO) of Nevada. Subcontract specifies that BHO "will identify cases	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	with the potential need for adverse determination and forward to RSN for consideration and will assist RSN in Notice delivery. Delegate will use RSN's Notices. RSN will make final decision regarding adverse determination." • 12-BHO PIHP denial notifications with NOA letters attached. Upon review of the NOAs, reviewer was unable to determine if required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs were submitted for review (detailing timeframes from request of service forward). • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider management and direct service staff generally described the basic purpose and procedures related to NOAs. Direct service staff had differing reports as to whether the provider receives copy of NOA in addition to the enrollee. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • Revised Authorizations to Inpatient & Outpatient Care-Medicaid Clients policy and procedures for standard authorization decisions. • Intake Evaluation and covered Services policy and procedures includes timeframes for authorization of routine care. Recommend that PIHP clarify timeframes to ensure policy reflects that standard authorizations for routine care occur within the maximum of 28 calendar days, including granted extensions. • 4-Completed Outpatient Authorization Forms—include date of request for service, date of first offered appointment. authorization date, and start/end date of authorization. Included information allowed Reviewer to determine that all but one authorization occurred within required timeframes. • Reviewer noted that outpatient authorization forms differ amongst network providers. Recommend PIHP ensure that the same information is captured on all authorization forms.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• 2-Completed Authorization Extension Approval Letters—show evidence of provider extension requests when authorization is going to occur outside of 14 calendar days. The PIHP submitted no evidence to indicate that BHO utilizes extension requests as required. • January 2007 PIHP CQI Outpatient Authorization Training—included attendance rosters, relevant policies and procedures, revised authorization letter, and training evaluations. • Provider management and direct service staff reported that ongoing training for authorization practices occurs in team meetings. All interviewed staff were knowledgeable and able to articulate the standard authorization practices and procedures. • The PIHP submitted no standard authorization tracking data/logs for review. (Substantial Compliance)	4
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Revised Authorizations to Inpatient & Outpatient Care-Medicaid Clients policy and procedures contains procedures for expedited authorization requests. • January 2007 PIHP CQI Outpatient Authorization Training—included attendance rosters, relevant policies and procedures, revised authorization letter, and training evaluations. • PIHP and provider management reported that "most likely" there had not been any expedited authorization requests due to the availability of crisis services with no required authorization. • Outpatient Authorization Forms include a placeholder for an expedited authorization request and related date. • Provider management and direct service staff reported that ongoing training for authorization practices occurs in team meetings. All interviewed staff were able to articulate the basic expedited authorization practices and procedures. • The PIHP submitted np expedited authorization tracking data/logs for review. (Substantial Compliance)	4
[Q45]	**Extension of expedited authorization request** Evidence: • Revised Authorizations to Inpatient & Outpatient Care-Medicaid Clients policy and procedures contains procedures for extensions of expedited authorization requests. • January 2007 PIHP CQI Outpatient Authorization Training—included attendance rosters, relevant policies and procedures, revised authorization letter, and training evaluations. • PIHP and provider management reported that "most likely"	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	there had not been any expedited authorization requests due to the availability of crisis services with no required authorization. As a result, there has also been no need for extensions related to expedited authorizations. • Provider management and direct service staff reported that ongoing training for authorization practices occurs in team meetings. All interviewed staff were able to articulate the basic expedited authorization practices and procedures. • No expedited authorization tracking data/logs submitted by PIHP for review. (Substantial Compliance)	4
438.224	**Confidentiality**	
[Q51]	**PIHP audits subcontractors for privacy compliance** Evidence: • Privacy Notification policy and procedures states, "The North Central Washington Regional Support Network, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for providing notice to clients of our privacy practices." • Completed 2006 PIHP Provider Contract Monitoring (Adams-Grant-Okanogan providers)—shows PIHP staff review provider HIPAA policies and procedures and enrollee's rights and responsibilities pertaining to enrollee rights to privacy and to request and receive copy of their medical record and make amendments. • PIHP staff reported that signed enrollee Notice of PHI is not always reviewed during clinical record reviews. • Provider management reported that during clinical record reviews, PIHP staff look to see if client rights are posted, and review clinical record for signed client rights. Management were not sure if PIHP staff review for signed Release of Information and Notice of PHI. • PIHP staff and provider management reported facility and work station security reviews have not yet been conducted by the PIHP. • The PIHP submitted no evidence of related training for PIHP or network provider staff. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • Standards for RSN Contracts and Provider Subcontracts policy and procedures includes the basic requirement that before any delegation, the PIHP evaluates the prospective subcontractor's ability to perform the activities to be delegated. • (10/13/05) Due Diligence Audit Requirements Memo and Summary related to PIHP Pre-Delegation Review of BHO—internal outlines suggested review protocol and list of recommended documentation. • (10/13/05) Due Diligence Audit Memo to BHO—briefly mentions preliminary information submitted by BHO and lists additional documentation PIHP is requesting BHO to submit. The memo stipulated no submission deadline. • (6/21/05) BHO Response to the PIHP's Due Diligence Review Questions. Reviewer notes the BHO response is dated prior to PIHP request for documentation. In addition, the PIHP included no PIHP evaluation of the BHO response to the review questions in documents submitted for this review element. PIHP staff reported that they did not document their evaluation of BHO. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • Standards for RSN Contracts and Provider Subcontracts policy and procedures contains basic requirements for written delegation agreements. • Unsigned BHO Contract (11-1-05), BHO Amendment 1 (October 1, 2006), and Unsigned BHO Business Associates Agreement (11/01/05)—PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. Subcontract specifies the activities and responsibilities delegated to BHO. Contract provides for revoking delegation or imposing corrective actions; and requires subcontractor to submit a corrective action plan for PIHP approval. • RSN Contracting As A Mental Health Prepaid Health Plan policy and procedures states, "The RSN retains responsibility to ensure that applicable standards of state and federal statutes and regulations and WAC are met, even when it delegates duties to providers."	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	(Moderate Compliance)	3
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • Standards for RSN Contracts and Provider Subcontracts policy and procedures contains the basic requirement to annually monitor subcontractor performance related to delegated functions. • Unsigned BHO Contract (11-1-05), BHO Amendment 1 (October 1, 2006) with 2 additional amendments dated January 2007—PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. Subcontract specifies the activities and responsibilities delegated to BHO. Amendment includes requirements and processed related to annual monitoring of subcontractor performance. • 03-05 Biennium Quality Management Plan—document is outside review period and does not include review processes for non-provider subcontractors to which the PIHP has delegated specific functions. • (2/16/07) PIHP email to providers clarifying the authorization extension request process. • (2/20/07) Due Diligence Audit Memo—informed BHO of upcoming audit (no date specified) with identified review target period of October 2005 through December 2006. Memo outlined the purpose and expected topics. The PIHP submitted no completed audit review or report for this review element. PIHP staff reported that a review was scheduled the week after their EQR. (Partial Compliance)	2
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • Standards for RSN Contracts and Provider Subcontracts policy and procedures incorporates the basic requirements of this provision. • Unsigned BHO Contract (11-1-05) states the PIHP can terminate the contract with BHO if, “Upon thirty-one (31) days prior written notice to the Company in the event of the Company's material breach of any other terms or provisions of the Agreement and the Company has failed to reasonably cure such breach within twenty (20) days of notice of such breach.” • PIHP reported no subcontractor deficiencies or corrective actions have been issued to BHO.	

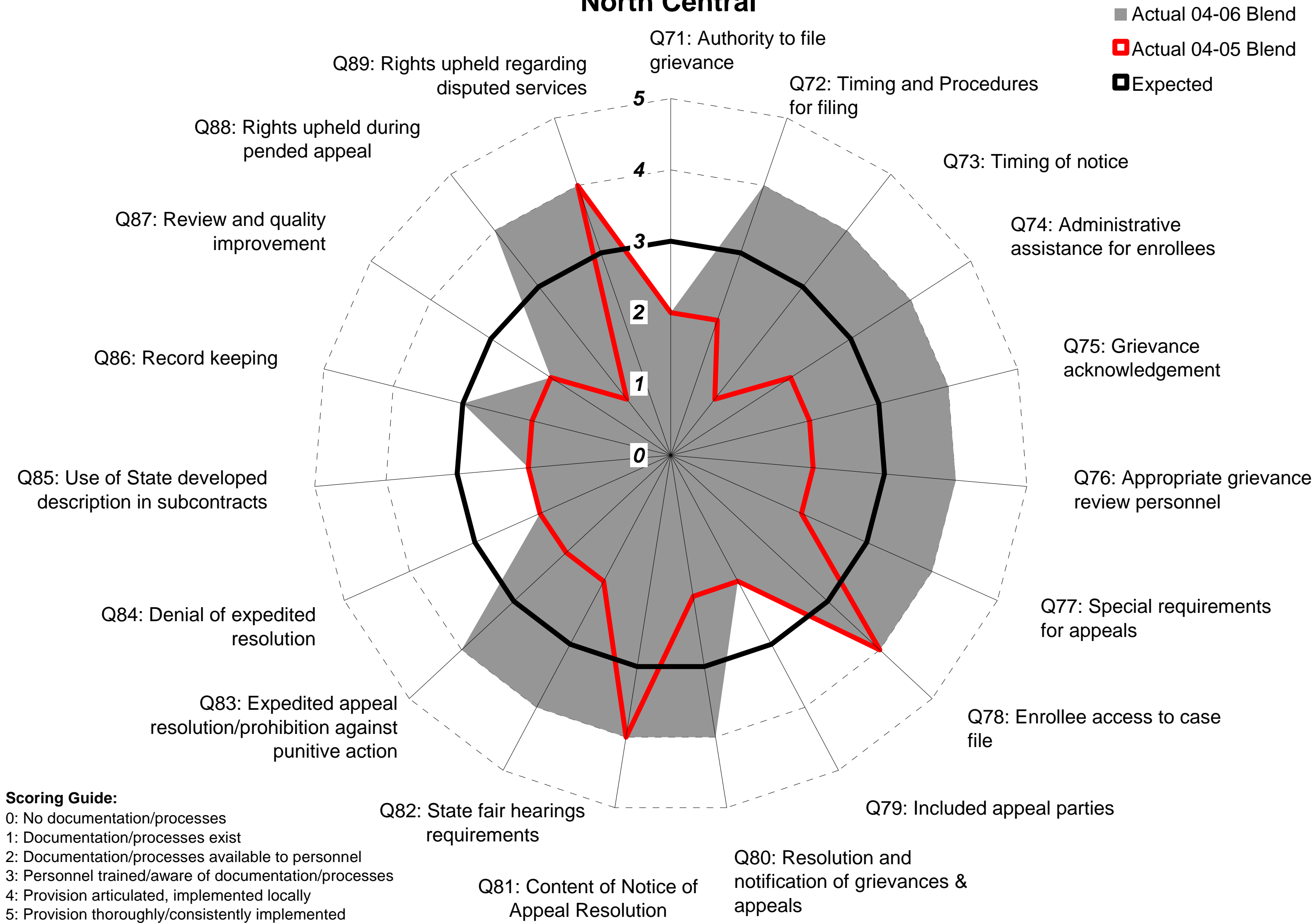
CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	(Moderate Compliance)	3
438.236	**Practice Guidelines**	

[Q56]	**Adoption of practice guidelines meets established requirements**
	Evidence:
	• Practice Guidelines policy and procedures contains the basic requirements of this provision.
	• Identification of adopted practice guidelines:
	  o Acute Stress Disorder-Post Traumatic Stress Disorder Quick Reference Guide
	  o Borderline Personality Disorder Quick Reference Guide
	  o Major Depressive Disorder Quick Reference Guide
	  o Schizophrenia Quick Reference Guide
	  o Best Practice Guidelines for Behavioral Interventions
	• Multiple CQI minutes verify adoption of all practice guidelines listed above.
	• WIMIRT provider trainings on Multi-Family Psychoeducation and Motivational Enhancement therapy—include attendance rosters, curriculum, handouts, PowerPoint and training evaluations.
	• Provider management and direct service staff were able to identify the practice guidelines adopted by the PIHP. In addition, staff reported that they attended the WIMIRT trainings and are implementing treatment modalities referenced in the guidelines.
	(Substantial Compliance)
		4

[Q57]	**Dissemination of practice guidelines to providers and enrollees upon request** Evidence: • Practice Guidelines policy and procedures contains the basic requirements of this provision. • CQI Minutes from (3/13/06), (5/15/06) and (1/29/07) show evidence of dissemination of guidelines to provider network. • Provider management reported they were involved in the selection of the practice guidelines through CQI meetings, and that they provided a leadership role due to their own emphasis on best practices over the years. (Substantial Compliance)	4
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • Practice Guidelines policy and procedures contains the basic requirements of this provision.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• (1/29/07) CQI Minutes show evidence of discussion and planning for provider staff training on the adopted practice guidelines. The decision was that PIHP would conduct training at CQI for provider Clinical Managers who would then train direct service staff. • (12/4/06) CQI Minutes indicate plan for January 2007 start-up of Co-Occurring program for majority of providers. • RSN UR Summary Report-Sept-Dec 2006—shows evidence of PIHP monitoring for "Clinical Appropriateness of Service Delivery Within Current Standards of Mental Health Practice". Report does not include monitoring criteria or standards, show evidence of monitoring tool, or identify which practice guidelines are being monitored. • Provider management reported the PIHP is beginning to look at continuity of care and outcomes related to identified model of practice. Management indicated that this is in the early stages and are not sure if the concept of fidelity is understood. (Partial Compliance)	2
438.240	**Quality Assessment and Performance Improvement Program**	
[Q61]	**Effective mechanisms to detect under and over utilization** Evidence: • Utilization Management policy and procedures, states, "The intent of utilization management and reviews is to monitor access to quality care, to evaluate the levels of care provided to ensure adequate quality of care and manage resources… The RSN and its providers assure capacity sufficient to deliver appropriate quality and intensity of services to enrolled clients without a waiting list consistent with RSN and mental health division agreements… Collect data that measures the effectiveness of the criteria in ensuring that all eligible people get services that are appropriate to his/her needs." • Quality Management Process policy and procedures states, "Procedures to ensure that quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to: Collect, analyze and display information regarding: The capacity to manage resources and services…intensity of services…service utilization." • Management Information policy and procedures states, "The RSN and its providers must be able to demonstrate that it collects and manages information that shows the effectiveness and cost effectiveness of mental health services… The RSN will collect data related to utilization of services… Electronically received eligibility information will be used to establish or	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	terminate client eligibility." • Other relevant policies and procedures submitted by the PIHP for review include Resource Management, and Denials & Appeals. • Data reports submitted by the PIHP for review include: o Multiple ESH Discharge Reports covering review period—show patients admitted from NCRSN and outside NCRSN and discharged to NCRSN or outside NCRSN. No analysis was provided with respect to this data, or explanation of how it relates to mechanisms to detect over and under utilization. o Outpatient Denial Data (1/06-3/06) shows evidence of disallowed services, does not give reasons for denials or analysis of data. o Completed sample of Inpatient Screening Form—demonstrates that DMHP monitors medical necessity and front door for inpatient services. Considers appropriate alternative options to inpatient services based on acuity of enrollee. o Provider Monthly Hospital Reports—lists who is hospitalized, admit date, discharge date, or if still detained. These reports did not include a data analysis. o ESH Referral Status Report—shows patients awaiting screening and placement the report did not include a data analysis. o RSN UR Summary Report-Sept-Dec 2006—shows evidence of monitoring over and under utilization via LOC and service sufficiency, with hours of service per LOC and average per client. The report included no identified thresholds or analysis of data. • PIHP has demonstrated the ability to effectively collect data and develop reports related to monitoring over and under utilization. The PIHP faces challenges in conducting a thorough analysis of data in order to identify trends of over and under utilization, and develop related quality improvements. (Moderate Compliance)	3


Subpart F: Grievance System
North Central
Actual 04-06 Blend
Actual 04-05 Blend
Expected
Q71: Authority to file grievance
Q72: Timing and Procedures for filing
Q73: Timing of notice
Q74: Administrative assistance for enrollees
Q75: Grievance acknowledgement
Q76: Appropriate grievance review personnel
Q77: Special requirements for appeals
Q78: Enrollee access to case file
Q79: Included appeal parties
Q80: Resolution and notification of grievances & appeals
Q81: Content of Notice of Appeal Resolution
Q82: State fair hearings requirements
Q83: Expedited appeal resolution/prohibition against punitive action
Q84: Denial of expedited resolution
Q85: Use of State developed description in subcontracts
Q86: Record keeping
Q87: Review and quality improvement
Q88: Rights upheld during pended appeal
Q89: Rights upheld regarding disputed services
0
1
2
3
4
5
Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for North Central

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	2	2	2
Q72: Timing and Procedures for filing	2	4	4
Q73: Timing of notice	1	4	4
Q74: Administrative assistance for enrollees	2	4	4
Q75: Grievance acknowledgement	2	4	4
Q76: Appropriate grievance review personnel	2	4	4
Q77: Special requirements for appeals	2	4	4
Q78: Enrollee access to case file	4		4
Q79: Included appeal parties	2	2	2
Q80: Resolution and notification of grievances & appeals	2	4	4
Q81: Content of Notice of Appeal Resolution	4		4
Q82: State fair hearings requirements	2	4	4
Q83: Expedited appeal resolution/prohibition against punitive action	2	4	4
Q84: Denial of expedited resolution	2	2	2
Q85: Use of State developed description in subcontracts	2	2	2
Q86: Record keeping	2	3	3
Q87: Review and quality improvement	2	2	2
Q88: Rights upheld during pended appeal	1	4	4
Q89: Rights upheld regarding disputed services	4		4

Subpart F – Grievance System

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
438.402	**Grievance System**	
[Q71]	**Authority to file a grievance, appeal, or State fair hearing** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures stipulates the PIHP grievance, appeal, and fair hearing process and contain all filing requirements with the exception of "A Community mental health agency may request a State fair hearing on behalf of an enrollee and act as the enrollee's authorized representative." • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate basic understanding of who can file a grievance and appeal. • Score remains the same as 2005 EQR due to missing requirements from PIHP policy and procedures. (Partial Compliance)	2
[Q72]	**Timing and Procedures for filing a grievance, appeal, or State fair hearing** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures stipulates the PIHP enrollee grievance and appeal processes, and access to the State's fair hearing system, with accurate filing, timing, authority, and procedural requirements of this provision. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate basic	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	understanding of how to file a grievance and appeal and related timeframes. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
438.404	**Notice of Action-Timing of Notice**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees and Authorization to Inpatient & Outpatient Care – Medicaid Clients policies and procedures collectively contain the Notice of Action (NOA) requirements. • BHO Subcontract—PIHP delegates authorization and utilization management (UM), and responsibility for sending Notice of Actions to Behavioral Health Options (BHO) of Nevada. Subcontract specifies that BHO "will identify cases with the potential need for adverse determination and forward to RSN for consideration and will assist RSN in Notice delivery. Delegate will use RSN's Notices. RSN will make final decision regarding adverse determination." • 12-BHO PIHP denial notifications with NOA letters attached. Upon review of the NOAs, reviewer was unable to determine if required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs were submitted for review (detailing timeframes from request of service forward). • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider management and direct service staff generally described the basic purpose and procedures related to NOAs. Direct service staff had differing reports as to whether the provider as well as the enrollee receives a copy of the NOA. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
438.406	**Handling of Grievances and Appeals**	
[Q74]	**PIHP ensures enrollees are provided assistance in completing forms and taking procedural steps**	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	• Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures incorporates language that ensures enrollees are provided reasonable assistance in completing forms and taking other procedural steps related to grievances and appeals. • 12-BHO PIHP denial notifications with NOA letters attached. NOAs include a section describing the help available to an enrollee when filing an appeal. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate a variety of assistance available to enrollees if needed. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
[Q75]	**Acknowledgement of receipt of each grievance and appeal** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures includes requirements related to acknowledgement of receipt of each grievance and appeal. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • PIHP staff and provider management were generally aware of requirements related to this provision. • PIHP submitted a prototype of a Grievance Log-Mailing List they are planning to implement in the future. (Substantial Compliance)	4
[Q76]	**Review personnel have clinical expertise and no involvement in previous review or decision making** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	incorporate the requirement that review personnel must have relevant clinical expertise and no involvement in previous review or decision making. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider management was able to articulate that review personnel must have clinical expertise and no previous involvement in the review. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
[Q77]	**Oral appeal inquiries treated as appeals; opportunity to present evidence and allegations of fact or law in person and in writing** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures incorporates requirements of oral appeals and an enrollee's right to present evidence and allegations of fact or law in person and in writing. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate basic understanding of enrollee's right to present evidence during an appeal. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
[Q79]	**Included parties to the appeal** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures does not include the parties to the appeal requirements of this provision.	

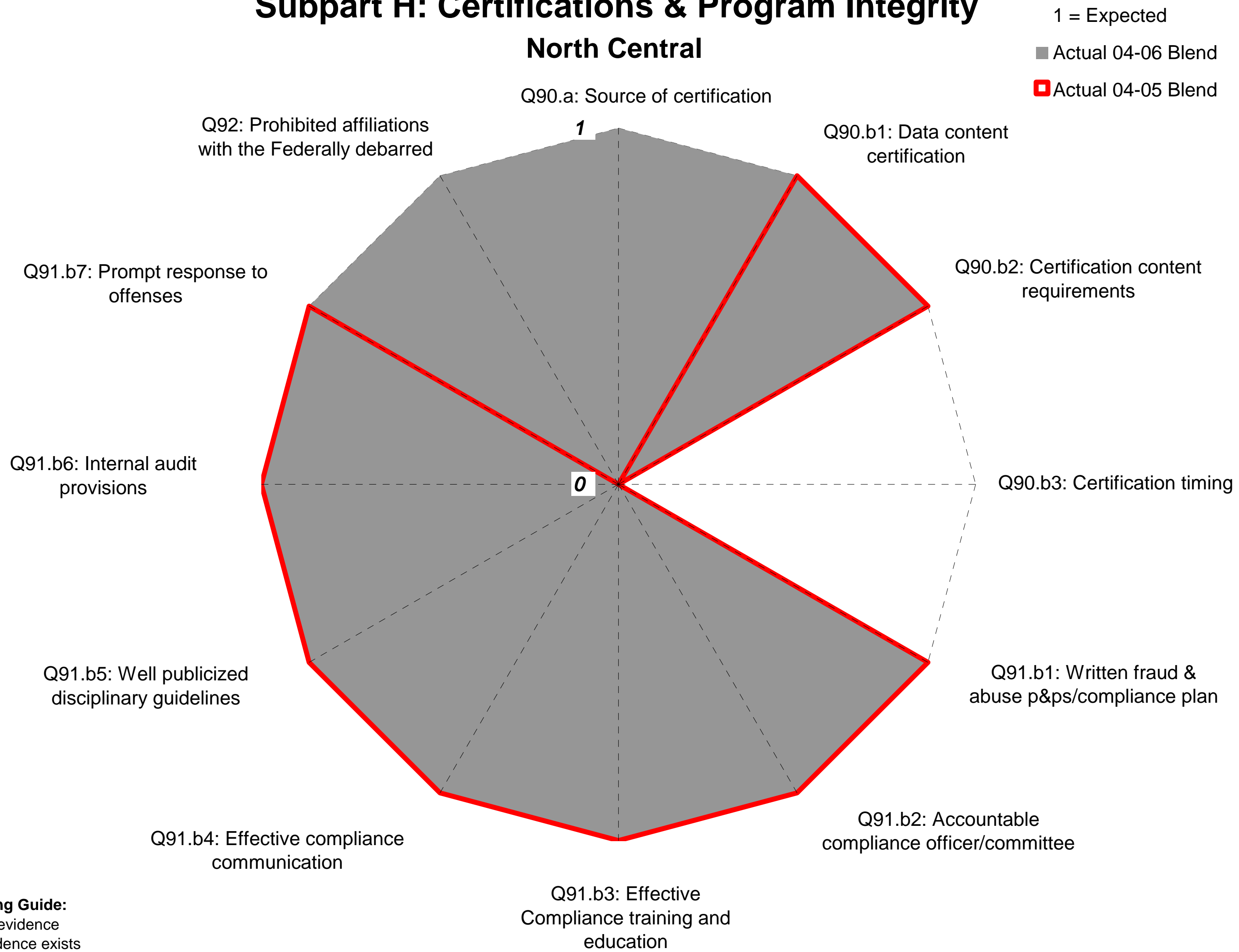
CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	• Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate parties that can be included in an appeal. • Score remains the same as 2005 EQR due to the absence of related requirements in the PIHP policy. (Partial Compliance)	2
438.408	**Resolution and Notification of Grievances and Appeals**	
[Q80]	**Resolution and notification for grievance and appeals** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures contains format requirements and timeframes related to resolution and notification for grievances and appeals. • Blank sample of an Outpatient Extension Letter. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate basic understanding of resolution and notification processes for grievances and appeals. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
[Q82]	**State fair hearings requirements** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures accurately stipulates the State Fair Hearing requirements. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate basic understanding of State Fair Hearings and their purpose. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
438.410	**Expedited Resolution of Appeals**	
[Q83]	**Expedited resolution of appeals and assurance of no punitive action** Evidence: • Revised <u>Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees</u> policy and procedures incorporates requirements related to expedited resolution of appeals and assurance of no retaliation toward enrollees or providers acting on behalf of enrollees. • <u>Grievance System training materials</u>—PIHP Grievance System PowerPoint, <u>Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees</u> policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate basic understanding of expedited resolution of appeals. • The PIHP submitted no relevant QA&I activities for review. (Substantial Compliance)	4
[Q84]	**Denial of expedited resolution** • Revised <u>Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees</u> policy and procedures does not incorporate requirements related to denial of expedited resolution. • <u>Grievance System training materials</u>—PIHP Grievance System PowerPoint, <u>Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees</u> policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff reported that they would seek	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	supervisor input and direction related to this provision. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.414	**Information About the Grievance System to Community Mental Health Agents of the PIHP**	
[Q85]	**Use of State developed description in subcontracts** Evidence: • The PIHP submitted no evidence to show that it provides information about the grievance system as specified in 438.10(g)(1) to all subcontractors at the time they enter into contract using a State-developed description. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.416	**Record Keeping and Reporting Requirements**	
[Q86]	**Mechanism to maintain records of grievances and appeals** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures states, "Full records of complaints, grievances and appeals will be kept for six years after completion of the process in confidential files separate from clinical records. These records will not be disclosed without the client's written authorization, except as necessary, to resolve the grievance, to DSHS if a fair hearing is requested, or for review as part of the NCWRSN's compliance activities." • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider staff were unclear as to how and where complaint, grievance, appeal, and fair hearing records are maintained and stored. • PIHP Provider Memo—addressing auditing changes related to complaints and grievances. • PIHP submitted a prototype of a Grievance Log-Mailing List they are planning to implement in the future.	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	(Moderate Compliance)	3
[Q87]	**Mechanisms for reviewing grievances and appeals and creating quality improvements** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees and Quality Management Process policies and procedures collectively incorporate the basic requirements of this provision. In addition, Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees and Quality Management Process policy states, "The providers and Ombuds will maintain records and submit semi-annual reports in compliance with the RSN timelines. The providers will utilize complaint, grievance, appeal and fair hearing information to analyze trends or identify areas for quality improvement." • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • PIHP Provider Memo—addressing auditing changes related to complaints and grievances. • PIHP submitted a prototype of a Grievance Log-Mailing List they are planning to implement in the future. • Provider management articulated a process for tracking complaints and grievances; however, they were not aware of how the PIHP develops and implements related quality improvements. • The PIHP did not submit a PIHP or provider complaint, grievance, appeal, or fair hearing data or analysis for review. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.420	**Continuation of Benefits while the PIHP Appeal and the State Fair Hearing are Pending**	
[Q88]	**Continuation of benefits while the appeal and State fair hearing are pending** Evidence: • Revised Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy and procedures	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	contains language to ensure the continuation of benefits during the time an appeal or State fair hearing is pending. • Grievance System training materials—PIHP Grievance System PowerPoint, Complaint, Grievance, Appeal & Fair Hearing Requirements – Medicaid Enrollees policy, Exhibit N sample reports, Ombuds Brochure, North Central WA Regional Support Network Client Rights and Responsibilities brochure, one network provider's attendance roster, and email indicating completion of the PIHP online grievance system training from one provider staff. • Provider direct service staff were able to articulate a basic understanding that enrollee benefits continue, pending the resolution of an appeal or State fair hearing. • PIHP submitted a prototype of a Grievance Log-Mailing List they are planning to implement in the future. (Substantial Compliance)	4



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for
North Central

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	0	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	0	0	0
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	1		1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	0	1	1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

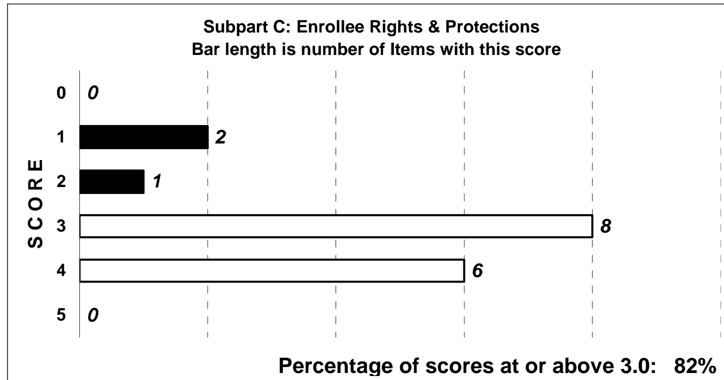
CFR Reference	Compliance Determination Report *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness and truthfulness of the data (Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification Although the PIHP submitted certification, they did not submit a transmission log. The PIHP must maintain transmission logs for the certificates to show the relationship between the certificates and the transmissions. Without this log, the WAEQRO is unable to determine compliance with this timing requirement. (No Compliance)	0
438.610	**Prohibited Affiliations with Individuals Debarred by Federal Agencies**	
[Q92]	**Prohibited affiliations with the Federally debarred** • 2006 and 2007 PIHP Provider Contract General Terms and Conditions stipulate the requirements of this provision for the network providers and with any entity they may subcontract. • PIHP submitted Excluded Parties List Searches and Office of Inspector General Fraud and Abuse Prevention/Detection Searches on all network providers, and for Protocall and BHO. (Compliance)	1

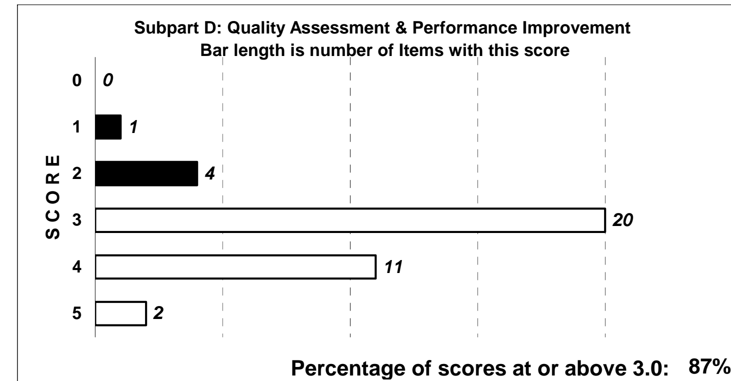
Scoring Frequency Overview

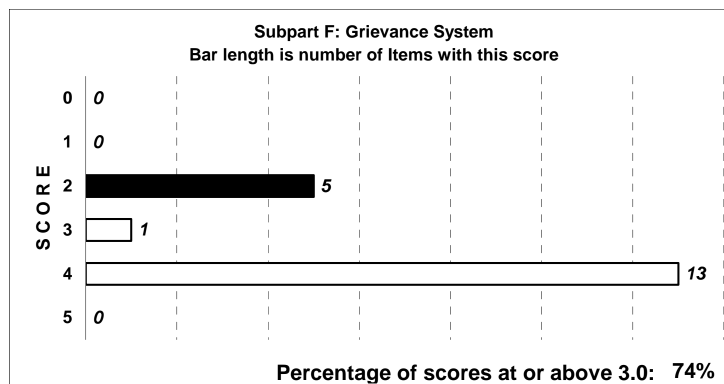
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for North Central

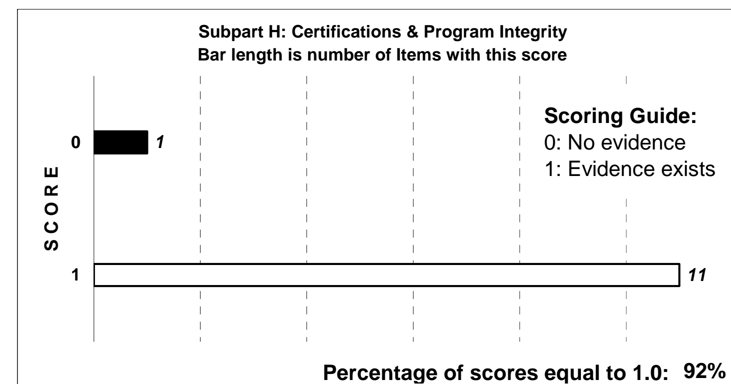
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 82%
Subpart D: 87%
Subpart F: 74%
Subpart H: 92%

The NCW PIHP staff have met nearly all of the minimum standards of Subpart H by ensuring that all program integrity requirements are in place and that all requirements for data certifications are met. The exception is the PIHP's ability to demonstrate compliance with timing requirements.

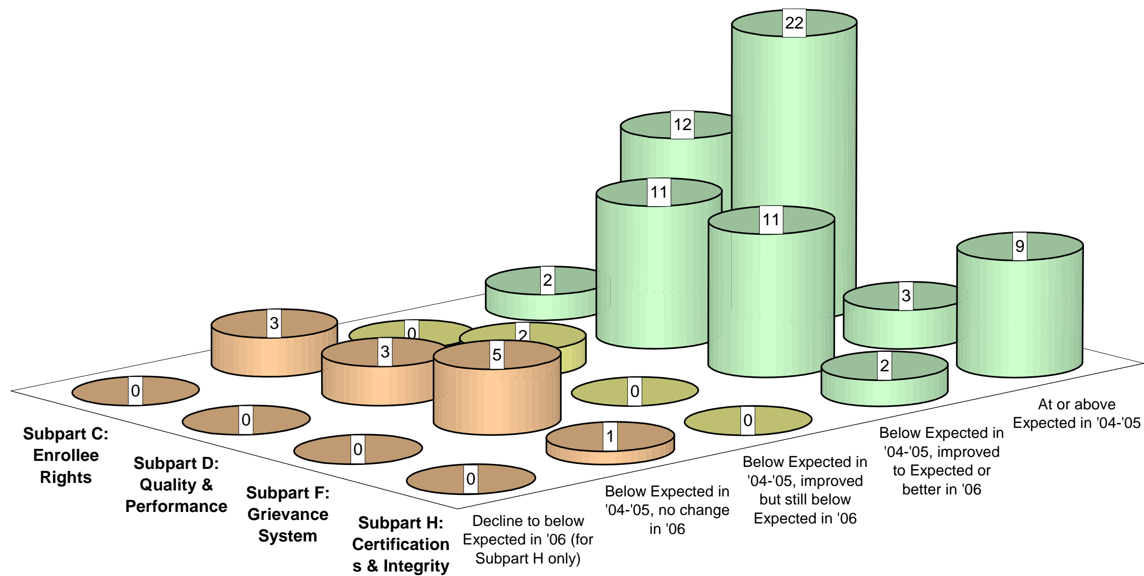
This year, NCW PIHP made the greatest improvement in Subpart F. PIHP staff have prioritized ongoing grievance system training with their network providers. Direct service staff know where to access policies and procedures and are able to articulate many of the expected requirements and standards.

The NCW PIHP continues to make progress with respect to Subpart C-Enrollee Rights and Protections and Subpart D-Quality Assessment and Performance Improvement. However, relevant policies and procedures remain underdeveloped and are missing key requirements. Moreover, WAEQRO was challenged to find evidence of their implementation. In addition, the North Central PIHP needs to increase knowledge and application of Subpart D requirements at the level of network providers and their staff.

Score Trend Summary for:
North Central

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights		Subpart D: Quality & Performance		Subpart F: Grievance System		Subpart H: Certifications & Integrity	
	Item Count	Percent	Item Count	Percent	Item Count	Percent	Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	3	17.6%	3	7.9%	5	26.3%	1	8.3%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	2	5.3%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	2	11.8%	11	28.9%	11	57.9%	2	16.7%
At or above Expected in '04-'05	12	70.6%	22	57.9%	3	15.8%	9	75.0%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, NCW PIHP performance relative to Subpart C (*Enrollee Rights*) showed 12 out of 17 items (70.6%) already at or above the Expected level of performance. After the 2006 review, 14 items (82.4%) are at the Expected level, reflecting improvement in 2 out of 5 elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), NCW PIHP entered the 2006 review with 3 of 19 items (15.8%) already at or above Expected. After the 2006 review, 14 items (73.7%) meet the Expected level of performance, indicating that 11 out of 16 elements improved to Expected or better from 2005 to 2006.

The improvement NCW PIHP has made in all four (4) Subparts reflects focused efforts on continuous quality improvement during 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- The PIHP has maintained a steady level of continuous quality improvement while expanding number of enrollees and providers, as well as geographical reach.
- The PIHP's adopted practice guidelines/evidence-based practices are relevant to the needs of the region's enrollee population, and are of value and interest to the provider network.
- Direct service staff interviewed during the provider site visit were generally well-informed about PIHP grievance system policies and procedures.

Subpart Challenges

- Procedures and protocols are deficient with respect to implementation of requirements stipulated in policies and procedures.
- PIHP policies and procedures lack effective monitoring mechanisms as well as quality assurance and improvement activities related to a majority of Subpart review elements.
- PHIP staff are challenged in effectively aggregating and analyzing the large volume of data they generate, and in using the information for quality improvement.

Subpart Recommendations

1. Create a procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of revisions, and effective date of the policy.

2. Develop and implement a process to ensure that each policy contains all required provisions referenced in the Code of Federal Regulation (CFR); give particular attention to grievance system policies and procedures.

3. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, requested extensions, and date Notice of Action (NOA) was sent.

4. Ensure that Mental Health Advance Directive policies and procedures contain all required provisions, including State standards.

5. Convey to providers the particular client materials expected to be made readily available in all prevalent languages, and alternative formats for individuals with sensory impairments. In addition, institute formal, annual monitoring of written and oral translation of client materials and use of certified interpreters.

6. Develop processes related to subcontractor delegation:
    - Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation; and
    - Review their related performance on an annual basis.

7. Expand privacy compliance audits of subcontractors to incorporate medical record review of protected personal health information practices, and a management

information security review.

8. Develop strategies and mechanisms to monitor fidelity of the practice guidelines and provide oversight to ensure their full utilization in clinical services.

9. Establish well-defined procedures for analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

10. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

11. Develop a policy and procedure for the generation and maintenance of data certifications and batch logs to ensure full compliance with this requirement.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited to a technical assistance review and, as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO which, if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The PIHP maintains the crosswalk and uses the Information System Quality Improvement Committee (ISQIC) to coordinate needed changes. The ISQIC meets quarterly or conducts business via e-mail on an as-needed basis.

2. Unique member ID
   The PIHP has a system to ensure that only one client ID is assigned to each individual. They use monthly MHD reports and their ISQIC to manage reported duplicates.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The PIHP can track members, regardless of changes in status, periods of enrollment and disenrollment, or changes across product lines.

4. Calculating member months
   The PIHP does not calculate member months.

5. Member database
   The PIHP maintains data made available by MHD in a SQL (Structured Query Language) database, and they allow access using active server pages through a secure web site.

6. Provider Database
   The PIHP does not maintain a provider database.

7. Data easily under-reported
   There is no specific procedure to capture easily under-reported data.

PM Summary

NCW PIHP did not fare well in the encounter validation conducted by the WAEQRO in the 2005 review. Their efforts in this year's review are rated as Partially Met, indicating a marginal effort. For this reason, the information system is rated as poor, indicating a low degree of confidence in their data. A minimum rating of fair is required to conclude that the information system is adequate to provide timely and reliable information. The terms "poor", "fair" and "good" are general measures, with "poor" indicating low confidence in the data, "fair" indicating mid-level confidence, and "good" indicating excellent confidence.

PM Strengths

- The changes implemented related to bringing IT in-house, along with system changes, have the potential to significantly improve the PIHP's overall information system management.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used whenever possible to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed both PIPs submitted by NCW PIHP: "Client Participation in Treatment Planning", identified by the PIHP as clinical, and "Penetration Rates", which was identified as non-clinical. Included in the document request were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post-measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and to evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006 (see, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

For validated PIPs ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

Neither of the PIPs submitted conformed to CMS protocols and therefore were not validated. Both were established as ongoing tracking processes the previous review year, and neither described specific problems nor interventions to affect the results. While the PIHP identified a general problem with penetration rates, it appears from the information provided that the focus of meeting discussion was on utilization rather than penetration. The only data provided for this PIP was the State Performance Indicator from 2004. Client satisfaction results rarely, if ever, dropped below the 90% target identified by the PIHP as the State's requirement; thus, there never was a problem to address. Summaries of both PIPs focused on reasons protocol activities could not be accomplished, as did both self-assessments.

During site visit discussion, the WAEQRO was advised that three PIHP staff members had attended both State-sponsored PIP training sessions; however, staff did not articulate details of training content that would be useful. They also indicated that they were waiting for the State to identify a topic and, therefore, had not prioritized their own. The WAEQRO referred PIHP staff to another PIHP for examples of well-designed PIPs and related assistance, including the possibility of sharing data analyst resources.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

PIP was not validated.

Activity 2: Evaluate Overall Validity and Reliability of Study Results

PIP was not validated.

PIP Strengths

- The PIHP has enlarged its organization and may now have resources available to undertake these projects.

PIP Challenges

- The PIHP will be starting at ground zero for the next review year and would be well-advised to begin analyzing their data to identify potential topics as soon as possible.

PIP Recommendations

1. Prioritize review and discussion of protocol with other PIHPs that are farther along to ensure accurate understanding of required steps.

2. Use available data to identify meaningful process of care and clinical improvement opportunities, and build data confidence factors into data analysis plan.

3. Create a prospective plan that includes specific, well-defined indicators, relevant interventions to address identified problems, and a data analysis plan that will provide meaningful information related to results of interventions.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with its providers, along with data dictionaries, and policies and procedures (and any memoranda of understanding); identify PIHP requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of its providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHP's encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation, as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers with responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	The PIHP uses the State data dictionary and Encounter Reporting Instructions manual as the foundation for its data requirements. There is no completeness standard defined.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The policies and procedures submitted as evidence by the RSN were also in evidence at the providers visited.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	No evidence was presented to support that the RSN has made efforts to document its provider network IT capabilities and vulnerabilities. Such evidence would include documentation of processes used by provider staff to accurately enter, maintain, and transmit data in a timely manner.

3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set	Not Met	Data analysis specific to an encounter validation is not done.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
submitted by the provider agencies for accuracy and completeness.		
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Not Met	Data analysis specific to an encounter validation is not done.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data analysis specific to an encounter validation is not done.
4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Partially Met	Although the PIHP provided a high-level description of their encounter validation process which meets basic PIHP-MHD contract requirements, the level of detail missing makes reliable duplication of the process impossible.
PIHP includes additional data elements in matching exercise.	Not Met	No additional data elements were checked.
Effective tools are defined and used by	Partially Met	A tool was provided that shows how the encounter selection process

PIHP Encounter Validation
Process Review

Item	Rating	Comments
the PIHP to capture the results of this exercise.		worked out for each provider. Using this tool in follow-up reviews will make this step in the process easily repeatable. An additional sheet on this tool shows raw data used for collecting validation information. Without instructions or other notes on the tools, it is difficult to understand its specific use or meaning.
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report submitted to the state is the tool used to collect the raw data described above. Although this tool represents work accomplished by the PIHP for their encounter validation requirement, it does not provide information in a report format. A reader would have trouble understanding the meaning of the information in this document. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions

PIHP Encounter Validation Process Review

Item	Rating	Comments
		requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Not Met	No evidence was submitted indicating how results of the encounter validation were shared with the PIHP's provider network.
PIHP regularly reports internally for quality improvement activities.	Not Met	No evidence was submitted indicating how results of the encounter validation were shared internally.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Not Met	A document submitted describing the encounter validation process states: "follow-up and/or corrective action being per policy." No policies governing follow-up and/or corrective action were submitted supporting this statement.
If warranted, evidence of follow-up activity was presented.	N/A	

Summary of Encounter Validation Findings

Score **Met _7.5_%**

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ **Met** ☒ **Partially Met** ☐ **Not Met**

Summary of encounter validation findings:

The encounter validation efforts meet requirements set forth in the PIHP-MHD contract. The documentation submitted for review was very brief (3 short documents). More effort by the PIHP is needed with respect to documenting processes and results in this area. No efforts were made to validate other data elements, nor were additional steps taken to ensure that encounters checked actually took place. An encounter validation analysis of the PIHP's data was not conducted.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the above tool. Had the entire tool been used to compute the score, the PIHP would not have fared as well, with 7.5% of all items meeting a score of Met, 61.5% at Not Met, and the remaining 31% at Partially Met.

EV Strengths

- No strengths noted

EV Challenges

- Building an IT structure while adding the responsibilities of new provider agencies will be a difficult task.

EV Recommendations

1. Define a data standard against which to measure data completeness.

2. Assess and document the processes, capabilities, and vulnerabilities of the provider agency IT systems.

3. Conduct a data analysis specifically for the encounter validation. At a minimum, analyze data for the time period under review.

4. Define tools to be used in conducting the data analysis. Tools enhance process repeatability and enable others to view raw results of a review.

5. Freeze data to be analyzed. This helps to ensure that it is not altered under study, and makes the process repeatable, thus allowing third party evaluation of the results.

6. Define in a policy and procedure the processes used in the encounter validation exercise. Detail the steps at a level which allows them to be repeated by others.

7. Develop a method to ensure that encounters being checked actually took place.

8. Incorporate other data elements into the encounter validation process. Develop a matrix that lists all data collected and in what process those elements are checked. Using such a tool will enable the PIHP to rotate seldom-checked fields into their review process, thus ensuring that all data is checked over time.

9. Continue developing the encounter validation process tools. Additional instructions and descriptive information would be helpful.

10. Enhance information in the report to the State. These are public documents; information therein should be readily understandable by an independent party. Follow the sample outline listed in the tool as guidance for these reports.

11. Ensure that internal and provider agency encounter validation communication is well-documented and clear with respect to encounter validation results.

12. Create a policy and procedure with respect to follow-up activities and corrective actions.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully Met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully Met; and Not Met indicates that the element is not present or is very

inconsistent or incomplete. *Achieving the target score of 4 on all elements would indicate that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.*

PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		1		• The QM Plan submitted for biennial 2003-2005 is outdated. PIHP staff reported that the QM Plan would be reviewed in March 2007 to reflect changes in the system, including the additional four counties and those providers. • According to the 2003-2005 Plan, independent oversight is provided by the Governing Board, which is responsible to approve and adopt the QM Plan biennially. • Composition of the QMC (old terminology), includes RSN

PIHP: NCW PIHP				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				Administrator and Resource Manager and at least 3 representatives from each of the three providers. • The QM Plan states that all information sources reporting QAI activities are intended to flow to the QMC; however, the mechanism to assure that the committee has needed information is not clearly described: o QRT, Ombuds, Provider Directors and Advisory Board (AB) are not standing members of QMC. o PIHP staffing beyond the chair position is not defined. o Provider participation is not required in the Plan. • Included components of a comprehensive QAI Plan: annual review, scope of plan, and discussion of performance improvement plans. • Some components of the Plan are limited in description, such as quality indicators, monitoring methods, and reporting improvement processes. The use of information and fiscal systems to address efficiencies and effectiveness is not described. • The QM Policy approved by the Board in 11/05 has considerably more detail

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
				regarding monitoring responsibilities than are found in the Plan; the policy should be referenced in the QM Plan. • Missing elements: mission/vision and guiding principles, goals of plan, and an annual work plan. • The updated Quality Committee Organization Chart (9/1/07) varies from QM Plan Committee structure in the following ways: o The Resource Manager chairs the Clinical Quality Improvement Committee (CQIC) and attends the Governing Board meetings. o The RSN Administrator is no longer on the committee
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		1		• Inconsistent language about an annual review is evident from two statements: o The QM Plan Program Structure states that the Plan and process are evaluated on a biennial basis. o The section titled, "Effectiveness of the QM Plan" states that the RSN prepares an annual report for the Governing Board which contains information about the quality improvements that have been made throughout the RSN.

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
C. Plan includes annual work plan and process for review of associated activities and progress.			0	• No annual work plan is described or referenced.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		3		• QM Plan describes monthly chart review activities, including review categories, submission of results to providers, quarterly reports at Quality Management meeting of aggregated results. Reviews are conducted by Utilization Manager. • QM Plan lists 14 general indicators to be monitored through clinical chart review. Clinical indicators lack: o Numerator/denominator o Performance goals expressed as percentages or numerical targets o Thresholds defined for taking action o Measurement methodology • Chart review and contract monitoring tools provide data in a manner that allows for trending. • The Corrective Action process is referenced in Plan with a general statement related to inclusion of timeframes for provider response. Detail of process is found only in provider contracts, which are not referenced in Plan. • Details of chart review process are included in a policy submitted for review;

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
				however, this policy is not referenced in the Plan.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.		1		• Regular involvement of consumers in all aspects of QA and I appears limited: o Consumers are represented on the Advisory Board and QRT; o Ombuds, QRT, and Advisory Board Chair report only at the quarterly Governing Board meetings.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		1		• Some elements of the outdated QM Plan continue to be implemented (committee now referenced as CQIC): o CQIC and Board minutes document that the Resource Manager monitors implementation of PIPS. o Evidence was provided of chart reviews conducted for each provider for one quarter in 2006, with results tallied in Excel spreadsheets. Included also was the total for 2005. o QRT allied systems satisfaction surveys were provided for review. • Implementation difficulties were evidenced by the following: o Six CQIC meeting minutes were provided; most lacked the detail needed to confirm implementation of the QM Plan and related policies. o One CQIC member from provider

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
				management staff reported routine difficulty attending meetings due to commuting distance to the RSN. o QRT indicated that she conducted all surveys alone, being the only QRT member at the time. o PIHP staff indicated at the site visit that the QRT was not functioning for part of the review year. PIHP staff stated that the NEWRSN QRT was a funded position while NCRSN QRT is voluntary. o No evidence of review by CQIC of Allied Coordination Plan as stated in the Allied policy.
Standard 1 Count (Target 6 Met):	**0**	**5**	**1**	**Target Points: 24 Actual: 7**
<u>Standard</u> 2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care. (2006-7 Contract, Section 7.2)				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.		**2**		• The QM Plan indicates at least 10% of all cases will be reviewed on an annual basis, with a targeted goal of 90% compliance. • Documentation of several "Utilization

PIHP: NCW PIHP				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				Reviews" for individual consumers was submitted for review. • Provider management staff reported that monthly chart reviews had been conducted in recent months, with considerable direct consultation about findings and required changes. • Direct service staff from both provider agencies stated that recent and frequent chart reviews were conducted by the PIHP. • Excel files were submitted documenting findings from 157 chart reviews, for one quarter of the review period (2006). No evidence was submitted reflecting chart reviews during the remainder of the review year. • Some evidence was submitted to suggest that the activities were not conducted as scheduled. The Board minutes of July 2006 reflected an MHD finding that the PIHP was out of compliance regarding provider reviews. • The QM Plan, UM, and QM policies do not include clinical chart review process and procedures.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**2**		• Two tools collect data for clinical review: the Utilization Review Tool and the Contract Monitoring Guide.

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
				• Utilization Review Tool includes items from domains of access, utilization, outcomes, EPSDT, Intake assessment, treatment/crisis planning, and service provision. • The Utilization Review tool was provided, demonstrating a format structure for ease of administration and reporting. • The response options are limited to 20 broad conceptual categories that lack the detail needed to assess and compare performance from chart to chart. • The tool does not include an interpretive guide for definitions of terms, criteria for scores, or directions for reviewers for scoring. • A sample Contract Monitoring Guide with 120 options supports the UR Tool by monitoring for items, such as: o Use of research-based treatment interventions, o Use of evidence-based practices, o Inclusion of discharge planning and coordination with aftercare resources. • The Contract Monitoring Guide also lacked an interpretive guide that would

PIHP: NCW PIHP				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				lend itself to reliable and valid scores. • No summary data was provided from results of contract monitoring. • Chart review results in Excel spreadsheets provide evidence of ability to aggregate data by provider and across the system. • No written documentation of scoring methodology was provided; PIHP utilization staff stated that scores are simple yes/no items that do not require any description for scoring.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**2**		• No documentation was provided to address variation by reviewer over time and across settings; however, only one person conducts reviews. • The Resource Manager reported that he trained the UR Specialist in the use of the UR Tool, although the standards were not documented in writing.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**2**		• Reflecting the policy as written, provider management staff identified specific corrective actions and reported the timeframes for compliance and feedback from the RSN. • Contract monitoring letters reporting findings were submitted. In the case of one provider, the letter required a "quality improvement"; however, the

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
				expected improvement was not quantified. • QM Plan states that reports to Clinical Directors are sent "within days of review." Of two examples provided, one was sent in 12 calendar days, and the other was sent three months after the review. • Although several significant compliance issues were identified in chart review results, PIHP staff and CQIC minutes indicated that while bringing the four new Counties into the system, the policy for corrective action is not being implemented.
Standard 2 **Count (Target 4 Met):**	**0**	**4**	**0**	**Target Points: 16 Actual: 8**

Standard

3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)

Requirement	Met	PM	Not Met	Findings Comments
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		**3**		• Quarterly Board meeting minutes included discussion of quality oversight activities. • One provider management staff

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments

				reported discussion of data generated from reviews such as over/under utilization in CQIC and IS committee meetings.
				• CQIC minutes submitted indicate routine discussion of utilization reviews.
				  o Minutes lacked important detail: attendees, standing agenda items, and detailed discussion.
				  o No copies of written reports were attached or referenced in the minutes.

B. PIHP analyzes and trends individual provider performance.		**2**		• Provider management staff reported receiving graphical reports of agency clinical quality reviews.
				• Excel files submitted for one quarter of the review period included totals from chart reviews. No discussion of reports, trends, or analysis was provided.
				  o Graphs show percentage comparisons across providers on each indicator.
				  o Data indicates a high rate of non-compliance on several indicators; however, the CQI meeting minutes do not reflect discussion.
				  o Governing Board minutes do not indicate that the Board reviewed the submitted data.

PIHP: NCW PIHP				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• No trend analysis was provided for review.
C. PIHP analyzes and trends system-wide performance.			**0**	• Excel report of clinical chart review data for all providers for calendar year 2005 supports the capacity to analyze and trend system-wide performance over time; however, no trended data was provided. • No narrative analysis or meeting minutes provided evidence of discussion and recommendations based on the data.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		**1**		• Minutes from Board meetings support communication with network, consumer advocates, and others based on results of chart reviews. • Little evidence of regular communication related to system-wide analysis was submitted: o Minutes of meetings are brief and insufficient to confirm system-wide communication of findings. o No written review of the QM Plan or discussion of a review of the QM Plan in minutes. • No copies were submitted of any written reports attached to or referenced in the minutes.

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PIHP: NCW PIHP				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard 3 Count (Target 4 Met):	**0**	**3**	**1**	**Target Points: 16 Actual: 6**
<u>Standard</u> **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.	**4**			• Evidence submitted of tracking timeliness of action on complaints, grievances/appeals: o Authorization and Grievance policies include timeframes for action. o Blank grievance log with date fields to track through system; no grievances/ appeals reported for the year per Exhibit N. o Ombuds reported providing verbal reports at Board meeting which was documented in the minutes. • One provider management staff indicated that few complaints are made by phone; however, complaints received by phone are not tracked. • Another provider maintains a complaint log and discusses issues in a committee.

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.		3		• The Contract Monitoring Tool includes items for review of polices, procedures, and actual grievances and appeals. • The new Grievance policy states that aggregate data will be used to identify trends, identify system issues for improvement, and annually review the system. • The PIHP Compliance Officer stated that she is responsible for implementing and tracking the Grievance policy, which was approved 1/25/07. • April-September 2006 Exhibit N was provided as evidence that no grievances or appeals were reported to MHD for that time period. • PIHP noted at site visit that twenty-three CMHA level grievances that were reported on Exhibit N were actually complaints. • Since the policy is new, regular incorporation is not yet in evidence.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	4			• PowerPoint presentation on Grievance and Appeals system was included in update of trainings provided for review. • The Ombuds referred to the intranet PowerPoint training in his interview as an example of training provided by the

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
				PIHP. • Policies on authorizations and grievance system provided for review, along with update from PIHP with training schedule, supports 2006 compliance training for Adams and Grant Counties, Governing and Advisory Boards, Ombuds, and QRT. • NCWRSN Client Rights and Responsibilities booklet conveys information on grievance and appeals. Provider line staff referenced the new booklets as a resource. • Provider contracts include requirements to make enrollee rights information available and ensure that grievance/appeal policies are consistent with the RSN. • Provider management staff accurately described the grievance process. • Provider management and direct service staff reported March 2007 internal training on grievance system. • Two of three Ombuds interviewed have long-term experience in the system and conveyed exceptional knowledge of the process. • Ombuds stated at interview that they provide and receive information at QRT,

PIHP: NCW PIHP

Requirement	Met	PM	Not Met	Findings Comments
				Advisory Board, and Governing Board. The Ombuds expects to be involved now at CQIC. • Ombuds stated that they are very involved in reviewing and updating the QM Plan. • Ombuds stated that although there was a time the QRT was not functioning effectively, system issues continued to be addressed effectively.
Standard 4 Count (Target 3 Met):	**2**	**1**	**0**	**Target Points: 12 Actual: 11**
Grand Totals Count (Target 17 Met):	**2**	**13**	**2**	**Target Points: 68 Actual: 32**

Summary Quality Assurance and Improvement Findings
North Central Washington Regional Support Network (NCWRSN) achieved the highest score possible (Met = 4 points) on 2 out of 17 possible items. Another 13 items were Partially Met and, of these, 3 items were nearly met. Two items were unmet: an annual work plan describing a few specific quality improvement activities that the NCWRSN is pursuing each year; and, evidence of system-wide analysis and trending of chart review data. NCWRSN achieved a total score of 32 points (47%) for the first review of Quality Assurance and Improvement Plan and activities. Findings reflect a system that may not have sufficient resources or effective staff assignment to meet the requirements of a quality management program.

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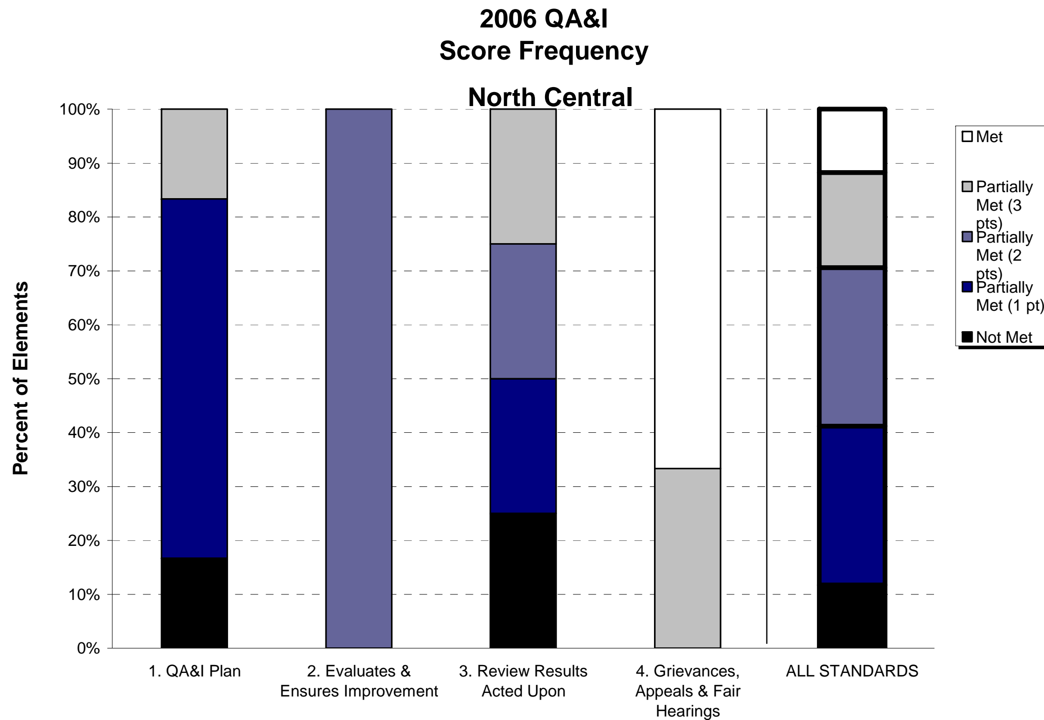


I. Frequency of Scores

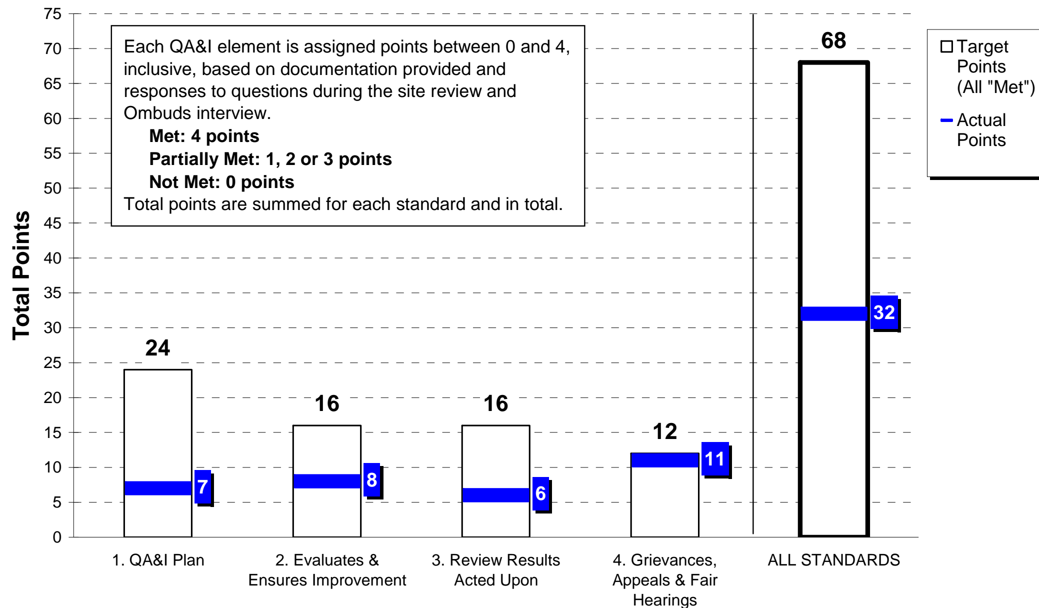
Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	0	1	0	4	1
2. Evaluates & Ensures Improvement	4	0	0	4	0	0
3. Review Results Acted Upon	4	0	1	1	1	1
4. Grievances, Appeals & Fair Hearings	3	2	1	0	0	0
ALL STANDARDS	**17**	**2**	**3**	**5**	**5**	**2**

QAI Strengths

- Provider management staff from a newly incorporated county noted that they are pleased with the responsiveness of the RSN staff to their needs.
- The clinical chart review feedback process appears to be very quality focused and is well-received by provider management and direct service staff.
- The PIHP has well-trained, experienced Ombuds committed to providing strong advocacy for consumers.
- Identification of a Compliance Officer strengthens the oversight of the service delivery system.

QAI Challenges

- Distance between providers poses challenges to participation in committee forums.
- Because system changes and improvements are more often verbally communicated, written documentation is insufficient to fully support the extent of RSN quality assurance activities.
- Although some staffing has been added, the RSN does not appear to have sufficient resources assigned to quality management.



II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	7
2. Evaluates & Ensures Improvement	16	8
3. Review Results Acted Upon	16	6
4. Grievances, Appeals & Fair Hearings	12	11
ALL STANDARDS	**68**	**32**

QAI Recommendations

1. The revised QM Plan would be improved by incorporating or attaching a matrix of indicators that specifically defines what will be measured, how it will be measured, target results, level of performance requiring further action, and reporting frequency and responsibility. Reference the QM Policy in the QM Plan or incorporate it into the QM Plan.

2. Annually review the QM Plan and update it based on results of the review as a product of the annual report to the Governing Board.

3. Devise an annual work plan that consists of 2-4 focused projects generated from results of the previous year's indicator performance.

4. Consider developing items for the Utilization Review tool that lend themselves to qualitative data analysis, that reflect the detail for compliance described in State and Federal requirements, and that provide a mechanism for corrective action when quality of care is not

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sufficiently demonstrated in the clinical chart. Include the chart review interpretive guide and scoring methodology in QM procedures or in a policy/procedure related to conducting clinical chart reviews and annual provider audits.

5. Continue to develop data analysis capabilities to support effective use of information gathered and reported. Develop trend reports which display data in a manner that facilitates identification of problems or potential problems and can provide results over time for individual agencies and the system as a whole.

6. Develop a standard format for meeting minutes to ensure that necessary information is routinely reported. Expand meeting minutes to reflect greater detail of discussions and attach copies of reports.

7. Include on CQIC PIHP Finance and IT representation, as well as consumer representatives such as Ombuds, QRT, and Advisory Board members to ensure that input and planning encompasses all stakeholders involved in the quality management program.

8. Ensure that audit results are provided in a timely fashion and that CAP requirements are addressed expeditiously; create a plan to track required time frames for submission, response, and implementation; confirm completion in writing to provider.

Recommendations

Subpart Recommendations

1. Create a procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of revisions, and effective date of the policy.

2. Develop and implement a process to ensure that each policy contains all required provisions referenced in the Code of Federal Regulation (CFR); give particular attention to grievance system policies and procedures.

3. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, requested extensions, and date Notice of Action (NOA) was sent.

4. Ensure that Mental Health Advance Directive policies and procedures contain all required provisions, including State standards.

5. Convey to providers the particular client materials expected to be made readily available in all prevalent languages, and alternative formats for individuals with sensory impairments. In addition, institute formal, annual monitoring of written and oral translation of client materials and use of certified interpreters.

6. Develop processes related to subcontractor delegation:
   - Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation; and
   - Review their related performance on an annual basis.

7. Expand privacy compliance audits of subcontractors to incorporate medical record review of protected personal health information practices, and a management information security review.

8. Develop strategies and mechanisms to monitor fidelity of the practice guidelines and provide oversight to ensure their full utilization in clinical services.

9. Establish well-defined procedures for analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

10. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.
11. Develop a policy and procedure for the generation and maintenance of data certifications

and batch logs to ensure full compliance with this requirement.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. Prioritize review and discussion of protocol with other PIHPs that are farther along to ensure accurate understanding of required steps.

2. Use available data to identify meaningful process of care and clinical improvement opportunities, and build data confidence factors into data analysis plan.

3. Create a prospective plan that includes specific, well-defined indicators, relevant interventions to address identified problems, and a data analysis plan that will provide meaningful information related to results of interventions.

EV Recommendations

1. Define a data standard against which to measure data completeness.

2. Assess and document the processes, capabilities, and vulnerabilities of the provider agency IT systems.

3. Conduct a data analysis specifically for the encounter validation. At a minimum, analyze data for the time period under review.

4. Define tools to be used in conducting the data analysis. Tools enhance process repeatability and enable others to view raw results of a review.

5. Freeze data to be analyzed. This helps to ensure that it is not altered under study, and makes the process repeatable, thus allowing third party evaluation of the results.

6. Define in a policy and procedure the processes used in the encounter validation exercise. Detail the steps at a level which allows them to be repeated by others.

7. Develop a method to ensure that encounters being checked actually took place.

8. Incorporate other data elements into the encounter validation process. Develop a matrix that lists all data collected and in what process those elements are checked. Using such a tool will enable the PIHP to rotate seldom-checked fields into their review process, thus ensuring that all data is checked over time.

9. Continue developing the encounter validation process tools. Additional instructions and descriptive information would be helpful.

10. Enhance information in the report to the State. These are public documents; information therein should be readily understandable by an independent party. Follow the sample outline listed in the tool as guidance for these reports.

11. Ensure that internal and provider agency encounter validation communication is well-documented and clear with respect to encounter validation results.

12. Create a policy and procedure with respect to follow-up activities and corrective actions.

QAI Recommendations

1. The revised QM Plan would be improved by incorporating or attaching a matrix of indicators that specifically defines what will be measured, how it will be measured, target results, level of performance requiring further action, and reporting frequency and responsibility. Reference the QM Policy in the QM Plan or incorporate it into the QM Plan.

2. Annually review the QM Plan and update it based on results of the review as a product of the annual report to the Governing Board.

3. Devise an annual work plan that consists of 2-4 focused projects generated from results of the previous year's indicator performance.

4. Consider developing items for the Utilization Review tool that lend themselves to qualitative data analysis, that reflect the detail for compliance described in State and Federal requirements, and that provide a mechanism for corrective action when quality of care is not sufficiently demonstrated in the clinical chart. Include the chart review interpretive guide and scoring methodology in QM procedures or in a policy/procedure related to conducting clinical chart reviews and annual provider audits.

5. Continue to develop data analysis capabilities to support effective use of information gathered and reported. Develop trend reports which display data in a manner that facilitates identification of problems or potential problems and can provide results over time for individual agencies and the system as a whole.

6. Develop a standard format for meeting minutes to ensure that necessary information is routinely reported. Expand meeting minutes to reflect greater detail of discussions and attach copies of reports.

7. Include on CQIC PIHP Finance and IT representation, as well as consumer representatives such as Ombuds, QRT, and Advisory Board members to ensure that input and planning encompasses all stakeholders involved in the quality management program.

8. Ensure that audit results are provided in a timely fashion and that CAP requirements are addressed expeditiously; create a plan to track required time frames for submission, response, and implementation; confirm completion in writing to provider.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

King County
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

King County PIHP is responsible for managing mental health care and services for Medicaid consumers in King County, Washington. The PIHP is located in Seattle and is governed by a board comprised of all 11 Metropolitan King County Council members. The PIHP Administrator reports to the director of the Mental Health, Chemical Abuse and Dependency Services Division, which is part of the Community and Human Services Department of the County. The PIHP contracts with 16 community mental health centers and specialty providers, which serve approximately 27,800 adult and child consumers on a yearly basis. Total annual Medicaid enrollment in the PIHP is about 229,600. The PIHP delegates voluntary inpatient authorization to the Crisis Clinic of King County.

This report covers the period between March 27, 2006 and March 26, 2007, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;

5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	

Activity	Timeline	Documents/Content
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	February 26, 2007	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	March 9, 2007	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	March 19, 2007	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	April 10 &11, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	April 12, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	May 4, 2007	
4. Debrief conference call	May 14, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	May 17, 2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. King County PIHP submitted a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the

PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

- There were no significant changes in the King County environment in the last year.

2006 Review Process Barriers

- The WAEQRO did not experience any barriers to conducting a comprehensive review of King County PIHP.

4. 2006 Review Results

This report provides results and a summary of King County PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of King County PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.106 [Q13]	**Subcontracts ensure enrollee payment liability protections**			
	Liability for Payment. No PIHP monitoring mechanism.	Submit a corrective action plan to the MHD by 3/2/05.	CAP submitted 3/9/05.	Relevant PIHP policies and procedures include the requirements of this provision. PIHP and provider management were able to describe the PIHP monitoring procedures. PIHP has attained a score of **4-Substantial Compliance**.
438.210(b) [Q40]	**Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise**			
	Policy and procedure missing the requirement that a Mental Health	Submit a corrective action plan to the MHD by	CAP submitted 3/9/05.	Relevant policies and procedures include requirements of

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	Professional must perform authorizations of care.	3/2/05.		this provision. In most cases, PIHP staff were able to show evidence of adherence to this requirement, per PIHP policy. PIHP has attained a score of **3-Moderate Compliance**.
438.242	**Health Information Systems**			
	Screening the data for completeness, logic and consistency. A system was not in place to ensure data submitted and kicked back to the Providers due to errors is resubmitted and accepted leaves data completeness as an issue.	Submit a corrective action plan to the MHD by 3/2/05	CAP submitted 3/9/05	The King County PIHP has developed an error tracking system that tracks errors in a database, assigning an error correction date to each error detected. This database is used to follow-up on these errors and to ensure that any associated data is resubmitted correctly and in a timely manner.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite

reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the King County PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

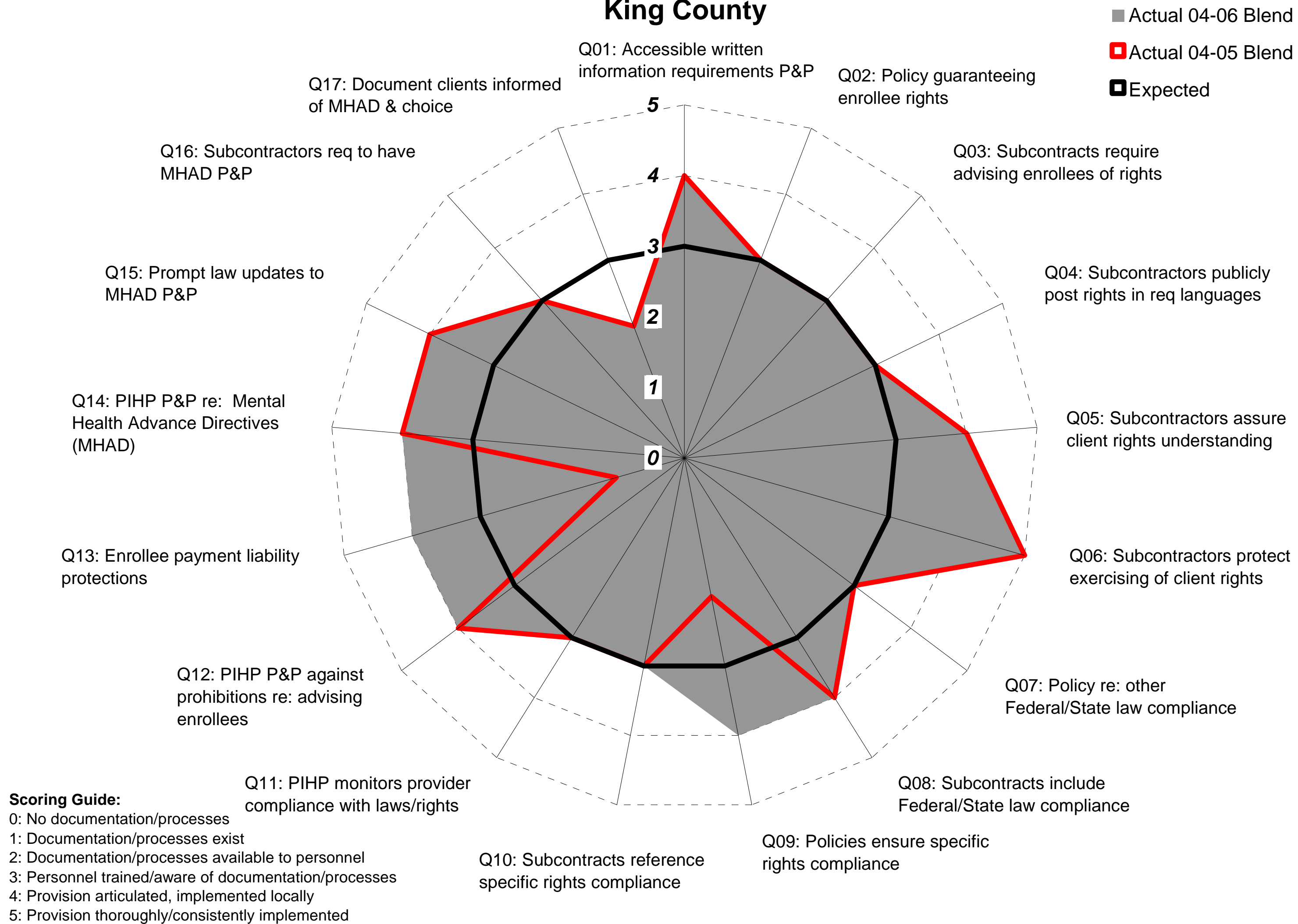
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



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1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for King County

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Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	4		4
Q02: Policy guaranteeing enrollee rights	3		3
Q03: Subcontracts require advising enrollees of rights	3		3
Q04: Subcontractors publicly post rights in req languages	3		3
Q05: Subcontractors assure client rights understanding	4		4
Q06: Subcontractors protect exercising of client rights	5		5
Q07: Policy re: other Federal/State law compliance	3		3
Q08: Subcontracts include Federal/State law compliance	4		4
Q09: Policies ensure specific rights compliance	2	4	4
Q10: Subcontracts reference specific rights compliance	3		3
Q11: PIHP monitors provider compliance with laws/rights	3		3
Q12: PIHP P&P against prohibitions re: advising enrollees	4		4
Q13: Enrollee payment liability protections	1	4	4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	4		4
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	2	2	2

King County PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
438.100(d)	**Compliance with Other Federal and State law**	
[Q9]	**PIHP policies assure compliance with right to a 2nd opinion, client participation in treatment, and access to clinical records** Evidence: • Revised Client Services and Confidentiality and Securities policies and procedures collectively reference/incorporate the client rights of access to a second opinion, participation in treatment decisions, and access to clinical records. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memos inform PIHP providers that intranet access to the updated policies and procedures will be effective the first of the year with hard copy to follow in a few weeks. • Clinical Directors Meeting Minutes (11/17/06)—included evidence of training provider Clinical Directors: The final grid for changes to the King County Policy and Procedure Manual was disseminated and reviewed. • Two completed 2006 Provider Contract Compliance Reviews-Administrative Review Findings—show PIHP review of agency policy indicating "Enrollee right to a second opinion and to out-of-network MHP if access to second opinion not available within network." • Multiple completed 2006 Provider Contract Compliance Reviews-Outpatient Clinical Site Findings—show that PIHP review for evidence of client and/or parent voice in the ISP, as well as the ISP addresses all client and family needs as identified and prioritized by the consumer, and others identified by the consumer. • Completed 2006 Agency Credentialing Application Form—indicates requirement for the provider to show compliance with HIPAA and Protection of PHI. The Provider Privacy and	

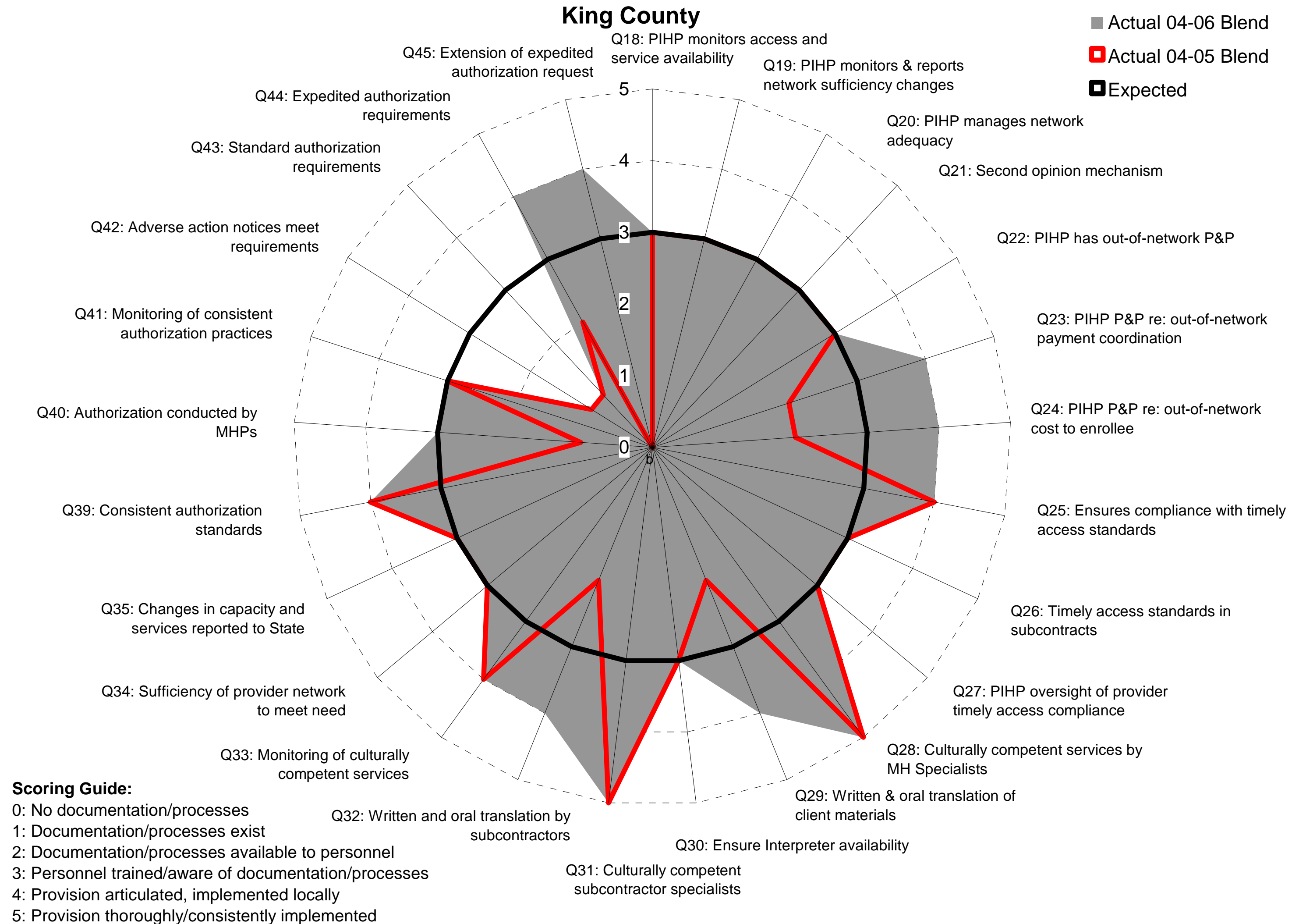
CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	Security Protected Health Information policy and procedure is attached to the application. • Network provider management reported that the PIHP monitors client participation in treatment decisions via regular chart reviews, and by ensuring that the provider has relevant policies and procedures. Management also reported that the PIHP did a review of their HIPAA policies and set stiff requirements for including HIPAA and PHI-related material in client handbooks. Management was not certain as to how the PIHP monitors client access to second opinions. • Direct service staff were knowledgeable regarding procedures related to access to a second opinion, and client involvement in treatment decisions. Staff reported that client requests to access their clinical records were handled through medical records and were able to describe the related procedures. (Substantial Compliance)	4
438.106	**Liability for Payment**	
[Q13]	**Subcontracts ensure enrollee payment liability protections** Evidence: • Revised Financial Management of the King County Mental Health Plan (KCMHP) Policy and Procedures includes relevant language meeting the requirements of this provision. • Signed and executed 2006 & 2007 PIHP Provider Contracts require compliance with KCMHP policies and procedures. The 2007 contract states that the Subcontractor shall ensure that Medicaid recipients are not charged for covered services. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing that the updated policy and procedure manual, effective January 1, 2006 & 2007, will be available on the intranet, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policy identified in this review element were included. • Two completed <u>2006 Provider Contract Compliance Reviews-Administrative Review Findings</u>—show PIHP review of agency policy and practice for ensuring Medicaid recipients are not charged for covered services. • PIHP staff reported that during Administrative site reviews of providers, they ask to see 5 enrollee payment records to ensure that they are not being billed. • Provider management reported that the PIHP monitors to ensure that Medicaid enrollees are not held liable for payment during their annual administrative audit by means of policy review and staff interview. Management could not recall if PIHP reviews enrollee payment records. (Substantial Compliance)	4
438.10(g) 438.6(l)	**Advance Directives**	
[Q17]	**Client informed in writing of Mental Health Advance Directives, and choice is documented** Evidence: • Revised <u>Client Services</u> policy and procedures states, "Providers shall assist adult and emancipated minor clients in learning about and accessing mental health advance directives for a client's mental health care in accordance with 42 CFR 438 and RCW 71.32. Neither MHCADSD nor a provider may condition the provision of care or otherwise discriminate against a client based on whether or not he/she has executed a mental health advance directive…All providers shall give written information to all adult and emancipated minor clients regarding their rights to make a mental health advance directive…A client's clinical chart shall contain prominent documentation on whether or not the client has executed a mental health advance directive." The policy does not include the required standard of a signed statement indicating enrollee's choice as to whether or not they would like to execute a Mental Health Advance Directive. • Signed and executed <u>2006 & 2007 PIHP Provider Contracts</u> require compliance with KCMHP policies and procedures. The 2007 contract states, "Individuals shall have a voice in developing their individualized service plans including their crisis plan and advance directives." In addition, the contract requires the provider to secure the client's signature indicating that client	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	has read (or been read) and understands their rights and obligations. The 2007 contract does not include the required standard of a signed statement indicating enrollee's choice as to whether or not they would like to execute a Mental Health Advance Directive. • DSHS Mental Health Advance Directives-Information for Consumers—in the 8 prevalent DSHS languages. • Incomplete Downtown Emergency Service Center-Advance Directive Notification—includes a signed statement indicating that the consumer chooses to (have/not have) an "Advance Directive on file." • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing that the updated policy and procedure manual, effective January 1, 2006 & 2007, will be available on the intranet, with hard copy to follow in the next few weeks. • Multiple completed 2006 Provider Contract Compliance Reviews-Outpatient Clinical Site Findings—show PIHP review of the notification of client rights with client signature indicating client has read and understands rights. In addition, PIHP reviews for updated crisis plans for individuals who have executed an Advance Directive. • Intake and crisis plan forms provided by one provider include a check box that indicates whether or not the client's Advance Directive is on file. The crisis plan form from the other provider includes a check box indicating whether or not the client has an advance directive. None of the submitted forms included the requirement to document the enrollee's choice as to whether or not they would like to execute a Mental Health Advance Directive. • The PIHP submitted the following statement with their documentation for this review element, "The KC PIHP does not require enrollees to sign records indicating their choice as whether or not they will develop an Advance Directive, nor does this specific requirement appear in CFR 438, WAC 388-865, or	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	MHD contracts. King County does require documentation that indicates whether or not a client has executed an Advance Directive (In accordance with P&P 6.13.4). King County PIHP believes it is not in the client's best interest to sign a one-time-only document and that client's should feel free to initiate an Advance Directive at any point during a benefit period." • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2

Subpart D (Part 1): Access Standards



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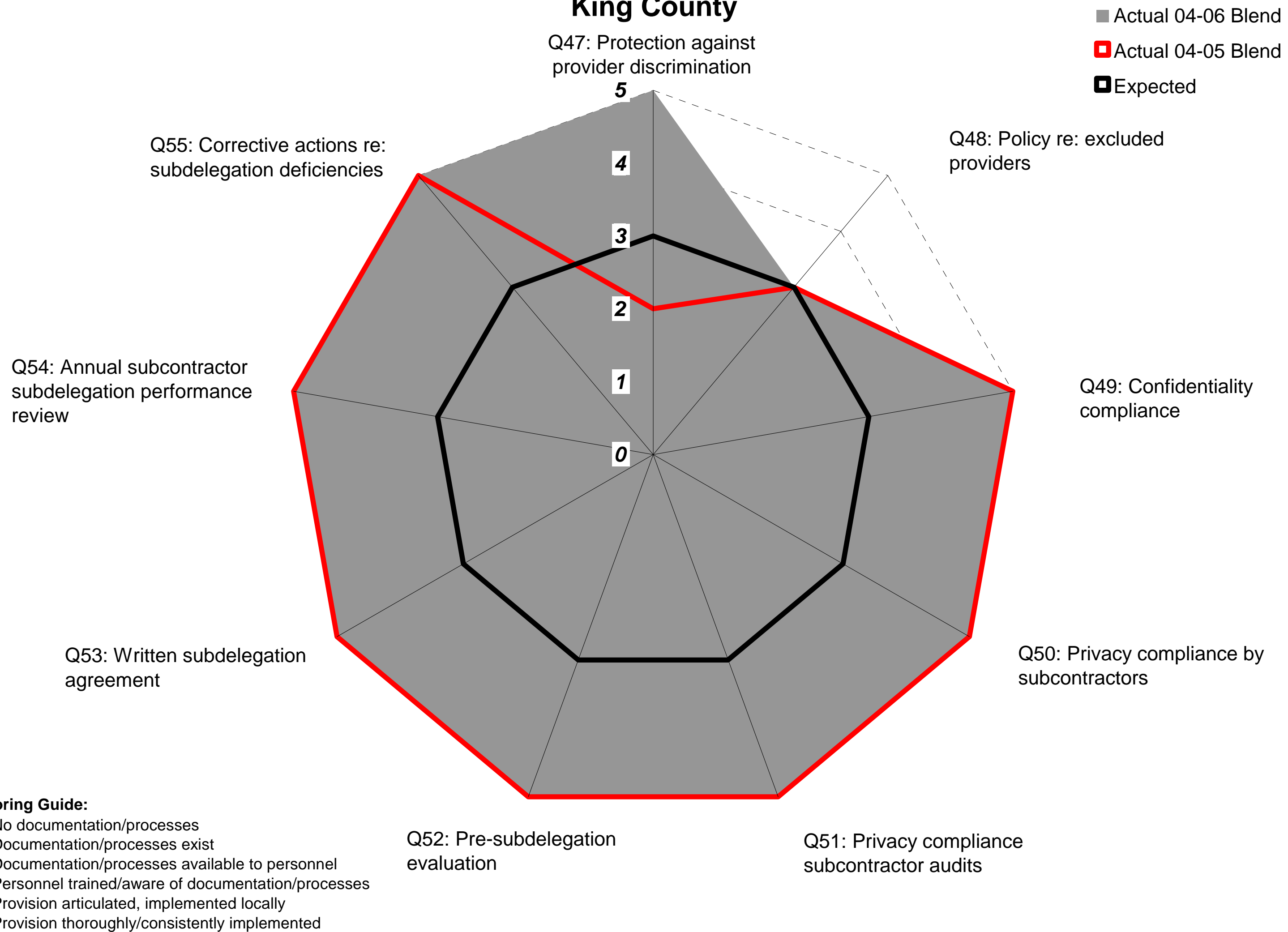
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	2	4	4
Q24: PIHP P&P re: out-of-network cost to enrollee	2	4	4
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	3		3
Q28: Culturally competent services by MH Specialists	5		5
Q29: Written & oral translation of client materials	2	4	4
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	5		5
Q32: Written and oral translation by subcontractors	2	4	4
Q33: Monitoring of culturally competent services	4		4
Q34: Sufficiency of provider network to meet need	3		3
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	4		4
Q40: Authorization conducted by MHPs	1	3	3
Q41: Monitoring of consistent authorization practices	3		3
Q42: Adverse action notices meet requirements	1	1	1
Q43: Standard authorization requirements	1	1	1
Q44: Expedited authorization requirements	2	4	4
Q45: Extension of expedited authorization request	0	4	4



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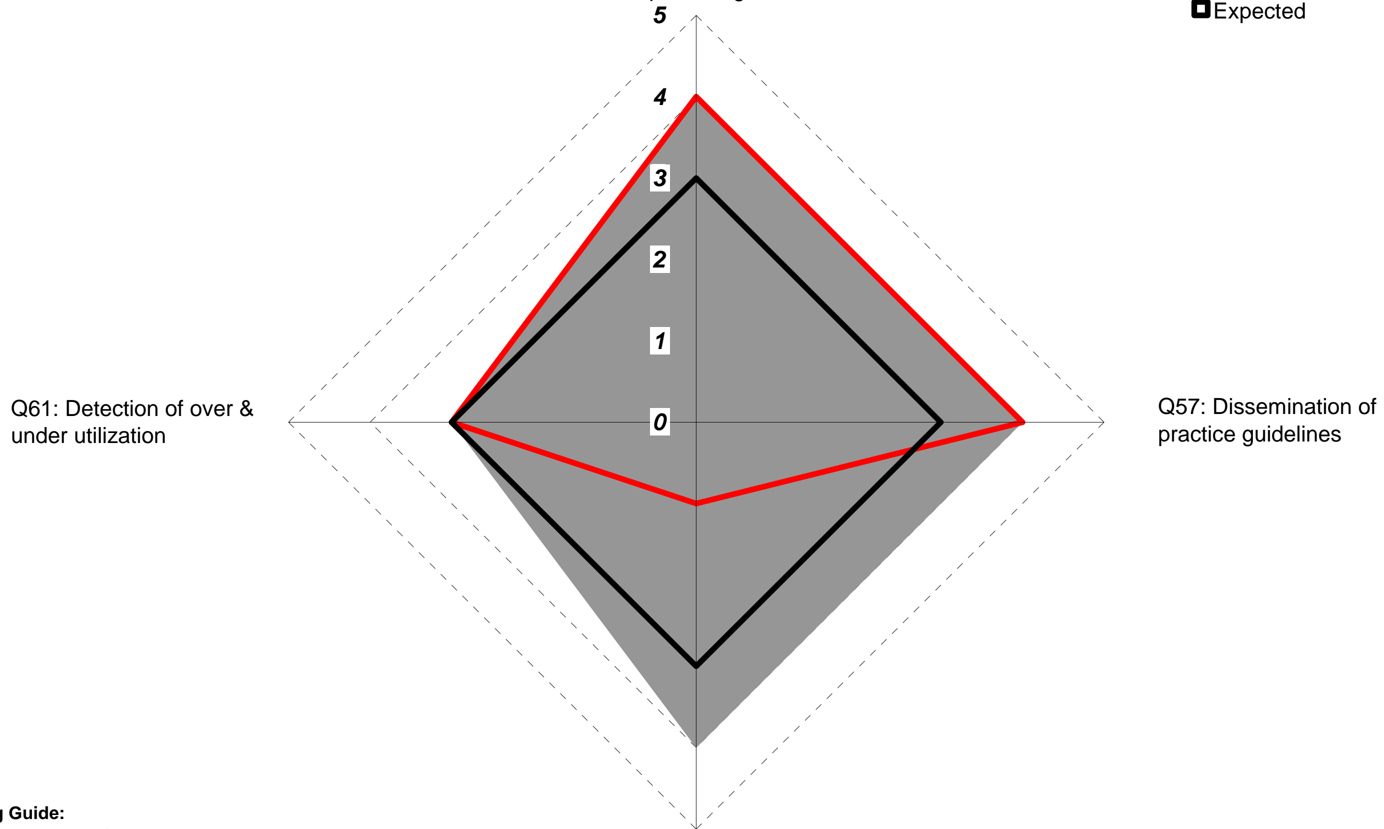
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	2	5	5
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	5		5
Q51: Privacy compliance subcontractor audits	5		5
Q52: Pre-subdelegation evaluation	5		5
Q53: Written subdelegation agreement	5		5
Q54: Annual subcontractor subdelegation performance review	5		5
Q55: Corrective actions re: subdelegation deficiencies	5		5

Subpart D (Part 3): Measurement and Improvement Standards

King County



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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	4		4
Q57: Dissemination of practice guidelines	4		4
Q58: Application of practice guidelines	1	4	4
Q61: Detection of over & under utilization	3		3

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
438.206 (b)(5)	**Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment**	
[Q23]	**Out-of-network policy and procedures include coordination with respect to payment** Evidence: • Revised Care Management for Outpatient Services within the Mental Health Plan, Client Services, Financial Management of the King County Mental Health Plan (KCMHP) policies and procedures collectively incorporate the requirement that network providers are contractually obligated to pay for a consumer's medically necessary services outside of the service area at no additional cost to the consumer. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policies identified in this review element were included. • Two completed 2006 Provider Contract Compliance Reviews-Administrative Review Findings—show PIHP review of agency policy and practice of ensuring that Medicaid recipients are not charged for covered services. • The PIHP submitted documentation related to a Corrective Action issued to one provider as their policies and procedures did not comply with this provision. Submitted documentation included communication of findings to the provider, the PIHP	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	Provider Corrective Action Letter, Provider Corrective Action Plan (CAP), PIHP response and partial approval of the CAP, Provider revised CAP response, and PIHP final approval of the provider revised CAP. • Provider management were aware of out-of-provider network policy and were able to articulate its basic purpose and processes for referral and payment. Management reported that the PIHP monitors to ensure that Medicaid enrollees are not held liable for payment during their annual administrative audit by means of policies review and staff interview. Management could not recall whether the PIHP reviews enrollee payment records. • Direct service staff described making out-of-network referrals for children that need medically necessary case aide services. When needed for reference, staff knew where to locate relevant PIHP policy and procedure. (Substantial Compliance)	4
[Q24]	**Cost of out-of-network provider is no greater for enrollee than services furnished within network** Evidence: • Revised Care Management for Outpatient Services within the Mental Health Plan, Client Services, Financial Management of the King County Mental Health Plan (KCMHP) policies and procedures collectively incorporate the requirement that network providers are contractually obligated to pay for a consumer's medically necessary services outside of the service area at no additional consumer cost. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process and, distributed the grid with	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	documented changes to policies. Amendments to the policies identified in this review element were included. • Two completed 2006 Provider Contract Compliance Reviews-Administrative Review Findings—show PIHP review of agency policy and practice of ensuring that Medicaid recipients are not charged for covered services. • The PIHP submitted documentation related to a Corrective Action issued to one provider as their policies and procedures did not comply with this provision. Submitted documentation included communication of findings to the provider, the PIHP Provider Corrective Action Letter, Provider Corrective Action Plan (CAP), PIHP response and partial approval of the CAP, Provider revised CAP response, and PIHP final approval of the provider revised CAP. • PIHP staff reported that, during Administrative site reviews of providers, they ask to see 5 enrollee payment records to ensure that they are not being billed. • Provider management were aware of out-of-provider network policy and were able to articulate its basic purpose and processes for referral and payment. Management reported that the PIHP monitors to ensure that Medicaid enrollees are not held liable for payment during their annual administrative audit by means of policies review and staff interview. Management could not recall whether the PIHP reviews enrollee payment records. (Substantial Compliance)	4
438.206 (c)(2)	**Furnishing of Services Continued**	
[Q29]	**Written and oral translation of client materials** Evidence: • Revised Client Services policy and procedures incorporates the basic requirements for written and oral translation of client materials. • Signed and executed 2006 & 2007 PIHP Provider Contracts require compliance with KCMHP policies and procedures, and that services be age appropriate, culturally relevant and linguistically competent. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5

	responses to provider questions/comments on the 2007 proposed policies and procedures.
	• December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks.
	• Submitted Translated Client Materials include:
	  o King County Mental Health Plan Brochures in 8 prevalent DSHS languages,
	  o HIPAA Privacy Notice and HIPAA Crisis Commitment Services Notice in 8 prevalent DSHS languages,
	  o King County Quality Review Team Brochure in 8 prevalent DSHS languages,
	  o Client Rights in 8 prevalent DSHS languages, and
	  o DSHS Mental Health Advance Directives-Information for Consumers—in 8 prevalent DSHS languages.
	• List of Communication Resources used by KCMHP Client Services includes:
	  o Resources for conversing with non-English speakers,
	  o Providing written communication to non-English Speakers,
	  o Providing interpretation for meetings with non-English speakers, and
	  o Resources for communicating with Deaf and Blind individuals.
	• Additional resources submitted that are used by the PIHP include:
	  o Tips for providing materials in Alternate formats,
	  o Using Sign Language Interpreters,
	  o Communicating with Deaf & Hard of Hearing,
	  o Providing Quality Services to Customers with Disabilities, and
	  o Telecommunications Relay Services from the Office of Civil Rights.
	• State Master Contract and Price Sheet for oral and written interpreter services.
	• Two completed 2006 Provider Contract Compliance Reviews-Administrative Review Findings—show PIHP review of CMHA posted client rights in 8 prevalent DSHS languages in prominent places.
	• 504 ADA Compliance Self Evaluation Questionnaire—includes provider self-evaluation of program access with respect to notification to public of meetings with available auxiliary aids and interpreters, TTY accessibility and trained staff, available written material in alternative formats when requested, and the like.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Provider management identified client materials required by the PIHP to be translated and available in all eight prevalent languages. In addition, management reported they did not know if the PIHP requires client materials be made available in specific alternative formats for enrollees with sensory impairments; however, stated that they would provide whatever was needed. Recommend that PIHP identify, in provider contracts, the required formats in which materials are to be made available. • Direct service staff were able to articulate languages that must be available in oral translation and how to access interpreters, including those for American Sign Language. (Substantial Compliance)	4
[Q32]	**Client materials translated according to WAC 388-865-0330 requirements related to language thresholds** Evidence: • Revised Client Services policy and procedures incorporates the basic requirements for written and oral translation of client materials. • Signed and executed 2006 & 2007 PIHP Provider Contracts require compliance with KCMHP policies and procedures, and that services be age appropriate, culturally relevant, and linguistically competent. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • Submitted Translated Client Materials include: o King County Mental Health Plan Brochures in 8 prevalent DSHS languages, o HIPAA Privacy Notice and HIPAA Crisis Commitment Services Notice in 8 prevalent DSHS languages, o King County Quality Review Team Brochure in 8 prevalent DSHS languages, o Client Rights in 8 prevalent DSHS languages, and	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	o DSHS Mental Health Advance Directives-Information for Consumers—in 8 prevalent DSHS languages. • List of Communication Resources used by KCMHP Client Services includes: o Resources for conversing with non-English speakers, o Providing written communication to non-English Speakers, o Providing interpretation for meetings with non-English speakers, and o Resources for communicating with Deaf and Blind individuals. • Additional resources submitted that are used by the PIHP include: o Tips for providing materials in Alternate formats, o Using Sign Language Interpreters, o Communicating with Deaf & Hard of Hearing, o Providing Quality Services to Customers with Disabilities, and o Telecommunications Relay Services from the Office of Civil Rights. • State Master Contract and Price Sheet for oral and written interpreter services. • Two completed 2006 Provider Contract Compliance Reviews-Administrative Review Findings—show PIHP review of CMHA posted client rights in 8 prevalent DSHS languages in prominent places. • 504 ADA Compliance Self Evaluation Questionnaire—includes provider self evaluation of program access with respect to notification to public of meetings with available auxiliary aids and interpreters, TTY accessibility and trained staff, available written material in alternative formats when requested, and the like. • Provider management identified client materials required by the PIHP to be translated and available in all eight prevalent languages. In addition, management reported they did not know if the PIHP requires client materials be made available in specific alternative formats for enrollees with sensory impairments; however, stated that they would provide whatever was needed. Recommend that PIHP identify, in provider contracts, the required formats in which materials are to be made available. • Direct service staff were able to articulate languages that must be available in oral translation and how to access interpreters, including those for American Sign Language. (Substantial Compliance)	4

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
438.210(b)	**Authorization of Services**	
[Q40]	**Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise** Evidence: • Care Management for Outpatient Services within the Mental Health Plan, Management of Inpatient Services for Psychiatric Hospitalizations, and Quality Assurance of the 3B Individualized Review Process policies and procedures stipulate that outpatient and inpatient authorization decisions are made by health care professionals with clinical expertise for authorizations that are not automatically authorized electronically. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policies identified in this review element were included. • Job Descriptions for Clinical Specialist and Care Manager—generally require that candidates be MHPs; however, they do not explicitly stipulate this requirement. • Resumes of the PIHP Clinical Specialist and Care Manager staff showing qualification for MHP status. MHP qualification was lacking in 1 of 3 resumes submitted. This information was conveyed to the appropriate PIHP leadership. • Inpatient MHP Verification—Crisis Clinic staff roster with credentials, and Clinical Director letter certifying that all staff responsible for authorizing voluntary inpatient stays are Mental Health Professionals. • Care Manager 3B Auths Tracking Data—shows comparative authorization data for each Care Manager performing 3B	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	authorizations. (Moderate Compliance)	3
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • Revised Client Services policy and procedures incorporates the majority of the Notice of Action (NOA) requirements with the exception of inaccurate policy language related to the timeframe notice that must be provided to the enrollee. The timeframe requirement for this provision is that the notice must be given as expeditiously as the client's condition requires and within 14 calendar days of the enrollee's initial request for service. The PIHP Client Services policy states, "For denial of services requested, the Notice shall be given/sent as expeditiously as the client's condition requires and within 14 calendar days of the submission of the information required to make a request for services." This policy language potentially allows for the NOA to occur outside the required timeframe. • Signed and executed 2006 & 2007 PIHP Provider Contracts requires compliance with KCMHP policies and procedures. In addition, the contract requires that when an authorization request has been approved, the provider shall deliver to the client the written notice of authorization provided by the KCMHP within 14 working days of the decision. This contract language potentially allows for the notice of authorization to occur outside the required timeframe. • Multiple Clinical Directors Meeting minutes and handouts from the review period cover training issues related to NOAs. • 2006 Provider Contract Compliance Review-Administrative Review Findings for one provider stated, "Reviewers looked for the documentation of written notification to enrollees of any decision to deny a service in five clinical records. The requirement for a Notice of Action applied in two cases. Documentation of the Notice of Action having been sent was found in one chart and not in the other. Agency internal policies and procedures already require this documentation to be completed, including appeal rights and a copy is filed in the clinical record. It is recommended that the clinician involved be refreshed on the policy and procedures." The stated findings imply that NOAs are sent by the provider rather than by the PIHP, as required. • Upon review of one inpatient and one outpatient NOA, reviewer was unable to determine if required timeframes were followed as notice does not contain pertinent dates for service junctures.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Inpatient and outpatient denial tracking logs contain date of service termination, date of PIHP notification, date NOA mailed, etc.; however, they do not contain the date of initial request for service. As a result, reviewer was unable to determine if required timeframes were met. • Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Provider staff had differing reports as to whether the provider receives a copy of the NOA. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • Score remains the same as 2005 EQR due to confounding documentation and evidence. (Insufficient Compliance)	1
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • Revised Care Management for Outpatient Services within the Mental Health Plan policy and procedures states, "Authorization requests shall be submitted as expeditiously as the client's health condition requires and no later than 7 calendar days of the date the intake was initiated." The timeframe requirement for standard authorization decisions is as expeditiously as the client's condition requires and within 14 calendar days of the enrollee's initial request for service. The above policy language potentially allows for the standard authorization decision to occur outside the required timeframes. • Mental Health Outpatient and Crisis Services to be Provided by KCMHP policy and procedures indicates that no authorization is needed for crisis services. • Signed and executed 2006 & 2007 PIHP Provider Contracts	

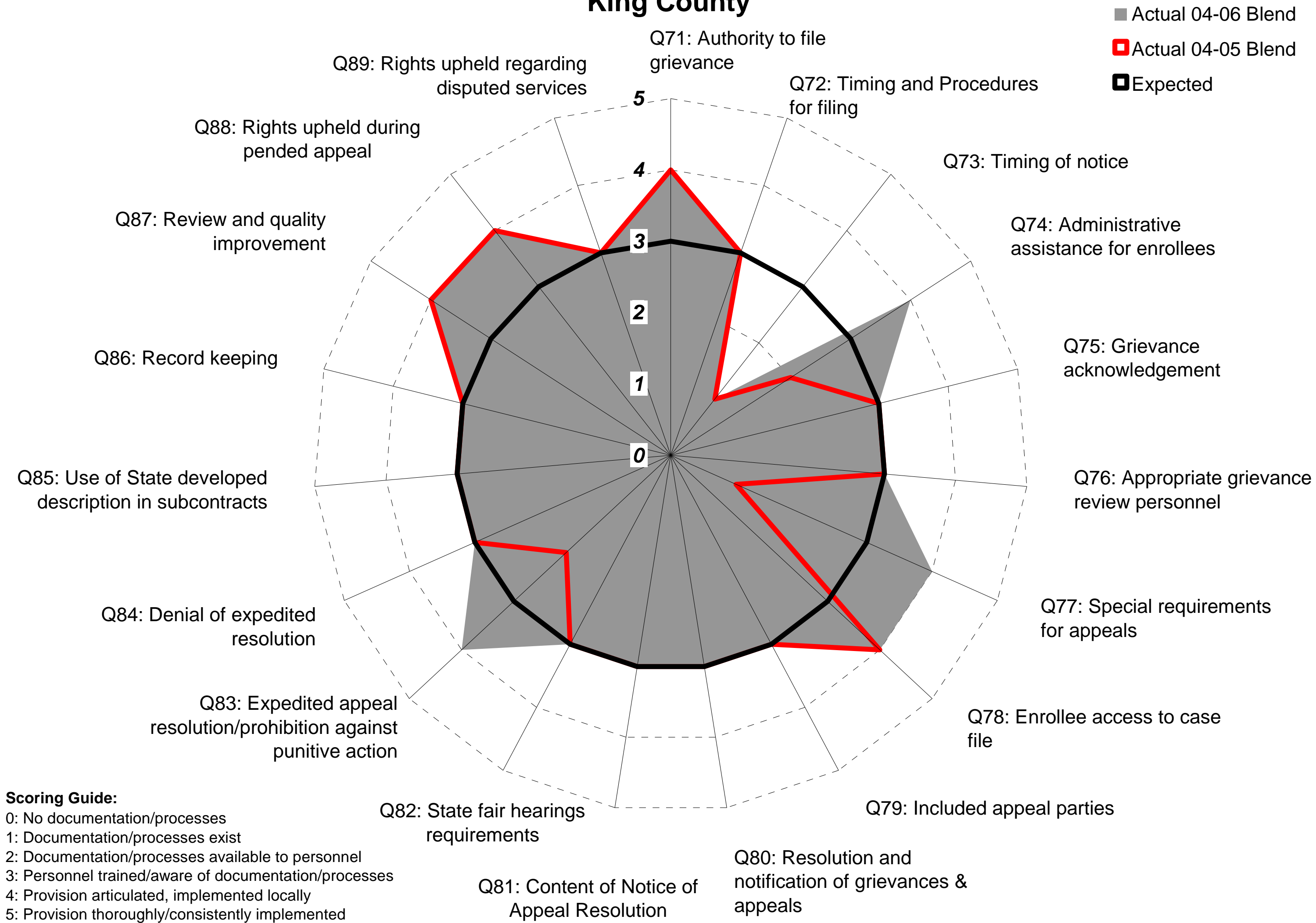
CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	require compliance with KCMHP policies and procedures. In addition, the contract requires an agency to provide the client with a notice of authorization of approved services with start and end date within 14 days of decision. This contract language potentially allows for the standard authorization decision and notification to occur outside the required timeframe. • Multiple Clinical Directors Meeting minutes and handouts from the review period cover training issues related to authorization procedures. • Multiple completed electronic Outpatient Authorization Reports—date of enrollee initial request for service is not included in reports; therefore reviewer was unable to determine if required timeframes were met. Submitted Notice of Authorization Letters also do not include date of enrollee initial request for service. • Provider management and direct service staff reported that they have 10 working days to complete an intake from the time the client requests services. In addition, staff reported that they have 7 calendar days after the intake to submit the authorization request to the PIHP. These reported timeframes allow for the standard authorization decision and notification to occur outside the required timeframes. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policies identified in this review element were included. • Score remains the same as 2005 EQR due to inaccurate policy language related to the required timeframes of this provision, and insufficient documentation and evidence to warrant an	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	increase. (Insufficient Compliance)	1
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Care Management for Outpatient Services within the Mental Health Plan policy and procedures contain the requirements for expedited authorization decisions and extensions, and stipulate the procedures related to implementing these requirements. • Mental Health Outpatient and Crisis Services to be Provided by KCMHP policy and procedures indicates no authorization is needed for crisis services. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policies identified in this review element were included. • Provider management and direct service staff reported that ongoing training for authorization practices occurs in team meetings. All interviewed staff were able to articulate the basic expedited authorization practices and procedures. • The PIHP submitted no expedited authorization tracking data/logs for review. The PIHP reported there have been no expedited authorization requests during the review period. (Substantial Compliance)	4
[Q45]	**Extension of expedited authorization request** Evidence: • Care Management for Outpatient Services within the Mental Health Plan policy and procedures contain the requirements for expedited authorization decisions and extensions, and stipulate	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	the procedures related to implementing these requirements. • Mental Health Outpatient and Crisis Services to be Provided by KCMHP policy and procedures indicates that no authorization is needed for crisis services. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policies identified in this review element were included. • Provider management and direct service staff reported that ongoing training for authorization practices occurs in team meetings. All interviewed staff were able to articulate the basic expedited authorization practices and procedures. • The PIHP submitted no expedited authorization tracking data/logs for review. The PIHP reported that there have been no expedited authorization requests during the review period. (Substantial Compliance)	4
438.214(c)	**Nondiscrimination**	
[Q47]	**Protection against provider discrimination** Evidence: • Revised Care Management for Outpatient Services within the Mental Health Plan, Financial Management of the King County Mental Health Plan (KCMHP), Provider Credentialing, Recredentialing and Contract Monitoring, policies and procedures collectively contain requirements related to protections against provider discrimination. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policies identified in this review element were included. • Signed and executed 2006 & 2007 PIHP Provider Contracts require compliance with KCMHP policies and procedures. In addition, the contract states, "The Agency shall participate in developing extraordinary treatment plans as necessary for eligible clients who require services that exceed existing provider contracted service reimbursement in order to remain in the community." • The PIHP maintains a Cultural and Language case rate differential. • Completed Credentialing Application Reviews—show evidence of the wide range of populations served and the employment of a non-discriminating application review process. • Provider network management reported that they have not experienced discrimination by the PIHP. (Maximum Compliance)	5
438.236	**Practice Guidelines**	
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • Revised Quality Management of the KCMHP policy and procedures includes references to provider compliance and PIHP monitoring of the following practice guidelines: Diagnosis Specific, Wraparound, and Developmental. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • Clinical Directors Meeting Minutes (3/17/06) state, "Susan McLaughlin presented on the wraparound guidelines and the developmental guidelines for children and youth. Both documents were developed by MHCADSD and providers as well as input from other community experts. These are resource documents designed for the staff to better understand the two concepts." • Senior Staff Meeting Minutes (4/10/06)—show evidence of discussions and planning for practice guidelines trainings. • Children's Services Meeting Minutes (8/22/06 and 2/16/07)—show evidence of discussions and planning for trainings related to the Developmental and Wraparound guidelines. Also, these minutes include provider concerns related to a lack of resources to implement a high fidelity model, as well as discussion of PIHP methods of monitoring the guidelines and expected outcomes. • 2006 Provider Contract Compliance Review-Administrative Review Findings for one provider states, "The Agency reports they have a fairly high fidelity to the Wrap Around Guidelines and are implementing them in practice. The Agency has provided some training internally regarding the Developmental Guidelines." • Completed 2007 Practice Guideline Review Instruments—2 for each of the Developmental, Wraparound, and Diagnosis Specific guidelines—show variable implementation of the guidelines throughout the provider network. • Provider management and direct service staff were able to identify the adopted practice guidelines. They reported that direct service staff were trained and are using the practice guidelines with consumers as appropriate. • Provider management reported that they were involved in the development of the practice guideline review instruments, and that PIHP staff have recently started using the instruments during their provider audits. (Substantial Compliance)	4



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for King County

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	4		4
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	1	1	1
Q74: Administrative assistance for enrollees	2	4	4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	1	4	4
Q78: Enrollee access to case file	4		4
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	2	4	4
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	3		3
Q87: Review and quality improvement	4		4
Q88: Rights upheld during pended appeal	4		4
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

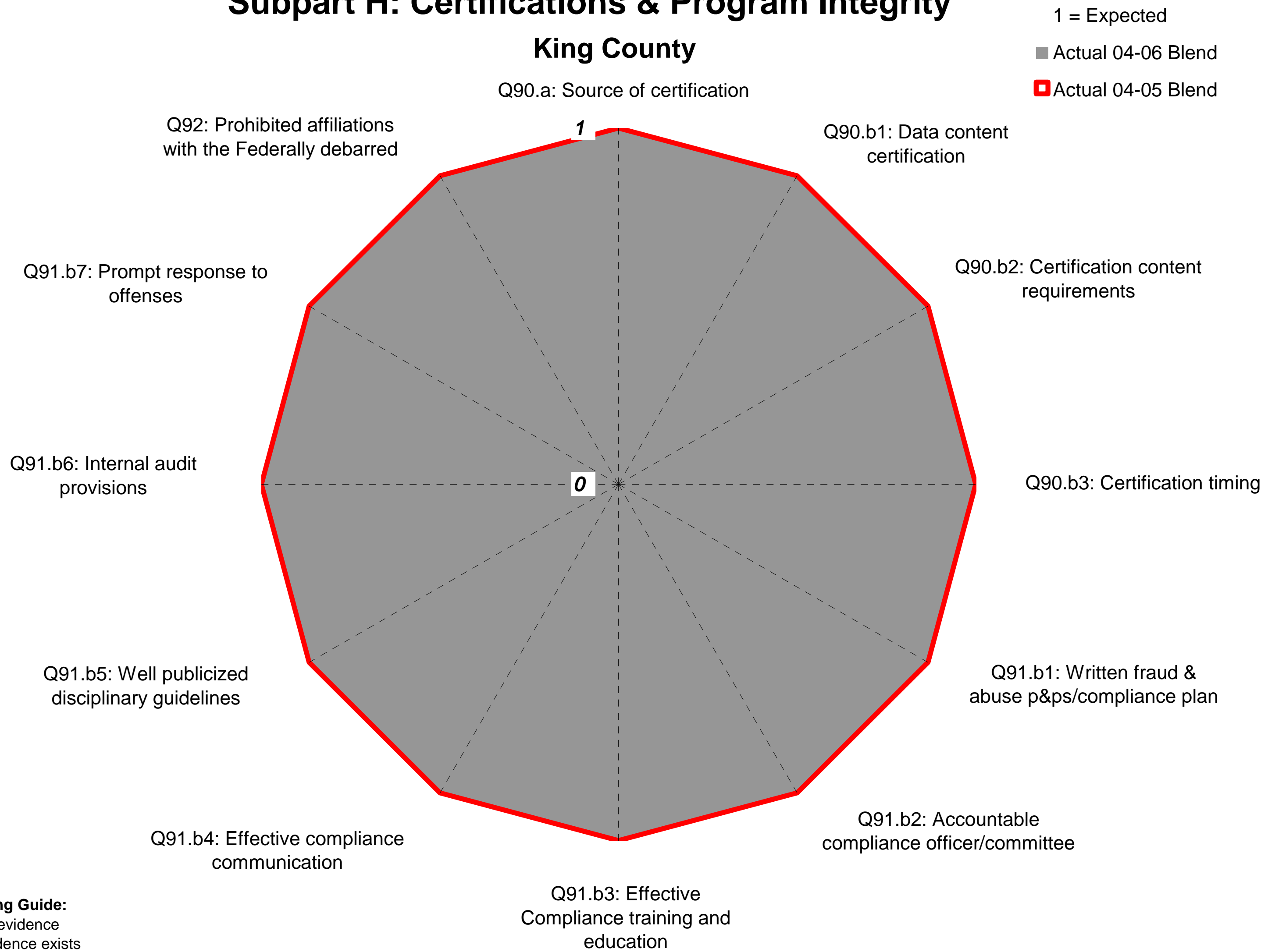
CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
438.404	**Notice of Action-Timing of Notice**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • Revised Client Services policy and procedures incorporates the majority of the Notice of Action (NOA) requirements with the exception of inaccurate policy language related to the timeframe notice must be provided to the enrollee. The timeframe requirement for this provision is that the notice must be given as expeditiously as the client's condition requires, and within 14 calendar days of the enrollee's initial request for service. The PIHP Client Services policy states, "For denial of services requested, the Notice shall be given/sent as expeditiously as the client's condition requires and within 14 calendar days of the submission of the information required to make a request for services." This policy language potentially allows for the NOA to occur outside the required timeframe. • Signed and executed 2006 & 2007 PIHP Provider Contracts requires compliance with KCMHP policies and procedures. In addition, the contract requires that when an authorization request has been approved, the provider shall deliver to the client written notice of authorization provided by the KCMHP within 14 working days of the decision. This contract language potentially allows for the notice of authorization to occur outside the required timeframe. • Multiple Clinical Directors Meeting minutes and handouts from the review period cover training issues related to NOAs. • 2006 Provider Contract Compliance Review-Administrative Review Findings for one provider stated, "Reviewers looked for the documentation of written notification to enrollees of any decision to deny a service in five clinical records. The requirement for a Notice of Action applied in two cases. Documentation of the Notice of Action having been sent was found in one chart and not in the other. Agency internal policies and procedures already require this documentation to be completed, including appeal rights and a copy is filed in the clinical record. It is recommended that the clinician involved be refreshed on the policy and procedures." The stated findings imply that NOAs are sent by the provider rather than the PIHP, as required. • Upon review of one inpatient and one outpatient NOA, reviewer was unable to determine if the required timeframes were followed as notice does not contain pertinent dates for service	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	junctures. • Inpatient and outpatient denial tracking logs contain date of service termination, date of PIHP notification, date NOA mailed, etc.; however, they do not contain the date of initial request for service. As a result, reviewer was unable to determine if required timeframes were met. • Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Provider staff had differing reports as to whether or not the provider receives a copy of the NOA. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • Score remains the same as 2005 EQR due to compounding documentation and evidence. (Insufficient Compliance)	1
438.406	**Handling of Grievances and Appeals**	
[Q74]	**PIHP ensures enrollees are provided assistance in completing forms and taking procedural steps** Evidence: • Revised Client Services policy and procedures incorporates language that ensures enrollees are provided reasonable assistance in completing forms and taking other procedural steps related to grievances and appeals. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures.	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	• December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • Signed and executed 2006 & 2007 PIHP Provider Contracts require compliance with KCMHP policies and procedures. In addition, they require providers to establish an internal complaint and grievance procedure, and to have a process for the filing and review of client complaints and grievances in accordance with WAC, RCW and KCMHP policies and procedures. • List of Communication Resources used by KCMHP Client Services includes: o Resources for conversing with non-English speakers, o Providing written communication to non-English Speakers, o Providing interpretation for meetings with non-English speakers, and, o Resources for communicating with Deaf and Blind individuals. • Additional resources submitted that are used by the PIHP include o Tips for providing materials in Alternate formats, o Using Sign Language Interpreters, o Communicating with Deaf & Hard of Hearing, o Providing Quality Services to Customers with Disabilities, and o Telecommunications Relay Services from the Office of Civil Rights. • Two completed 2006 Provider Contract Compliance Reviews-Administrative Review Findings—show that the PIHP monitors for the availability of interpreters to assist sensory impaired and/or non-English speaking enrollees with grievance processes. • 504 ADA Compliance Self Evaluation Questionnaire—includes provider self-evaluation of program access related to notification to public of meetings with available auxiliary aids and interpreters, TTY accessibility and trained staff, available written material in alternative formats when requested, and the like. • Training submitted by the PIHP for this review element was outside the review period. • Provider direct service staff were able to articulate a variety of assistance available to enrollees. • PIHP submitted no evidence related to assistance available via the Ombuds.	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	(Substantial Compliance)	4
[Q77]	**Oral appeal inquiries treated as appeals; opportunity to present evidence and allegations of fact or law in person and in writing** Evidence: • Revised Client Services policy and procedures incorporates the requirements of this provision. • October 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • Multiple Clinical Directors Meeting minutes and handouts from the review period cover training issues related to NOAs. • Grievance, Appeal, Administrative Hearing Tracking Log—tracks grievances at provider level, as well as PIHP grievances and appeals, and Fair Hearings. • MHD required Grievance, NOA Appeals and Fair Hearing Reports with analysis indicating a low number of grievances and appeals, and the conclusion of no current trends needing quality improvements. • Provider direct service staff were able to articulate basic understanding of an enrollee's right to present evidence during an appeal. (Substantial Compliance)	4
438.410	**Expedited Resolution of Appeals**	
[Q83]	**Expedited resolution of appeals and assurance of no punitive action** Evidence: • Revised Client Services policy and procedures incorporates requirements related to expedited resolution of appeals and assurance of no retaliation toward enrollees or providers acting on behalf of enrollees. • October 2005 & 2006 PIHP Administrator Memos to all King	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	County Contracted Mental Health Providers—include revised 2007 policies and procedures & Grid of Edits and Proposed Changes to the 2007 Policies and Procedures for review and comment within 15 days. • November 2005 & 2006 PIHP Administrator Memos to all King County Contracted Mental Health Providers—include PIHP responses to provider questions/comments on the 2007 proposed policies and procedures. • December 2005 & 2006 PIHP Administrator Memo to all King County Contracted Mental Health Providers, informing of the availability on the intranet of the updated policy and procedure manual, effective January 1, 2006 & 2007, with hard copy to follow in the next few weeks. • King County Partnership Meeting Minutes (2/23/07) and King County P&P Tracking Grid—minutes indicate that the PIHP Administrator reported a need to expedite the policy and procedures amendment process, and distributed the grid with documented changes to policies. Amendments to the policy identified in this review element were included. • APS Clarification Email (8/28/06)—provides clarification of provision and related expectations. • Grievance, Appeal, Administrative Hearing Tracking Log—tracks grievances at provider level, as well as PIHP grievances and appeals, and Fair Hearings. • The PIHP submitted no training documentation for this review element. • Provider management was able to articulate basic understanding of expedited resolution of appeals. (Substantial Compliance)	4



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for
King County

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	1		1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

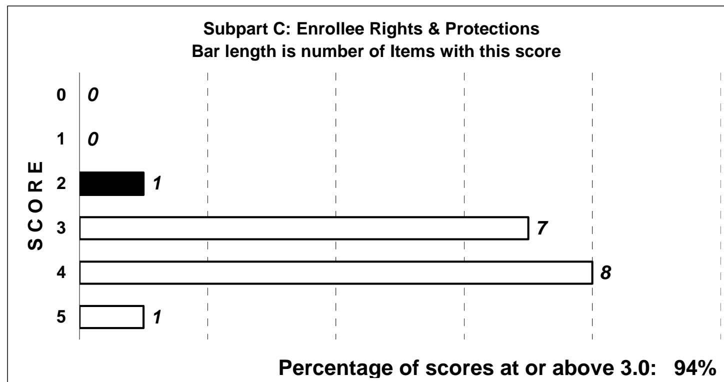
CFR Reference	Compliance Determination Report *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness and truthfulness of the data (Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (Compliance)	1

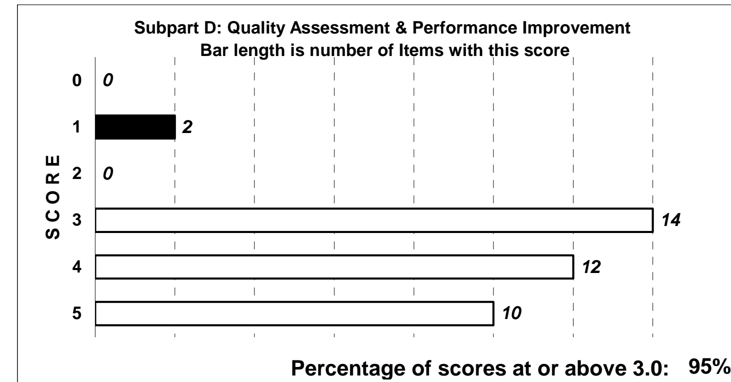
Scoring Frequency Overview

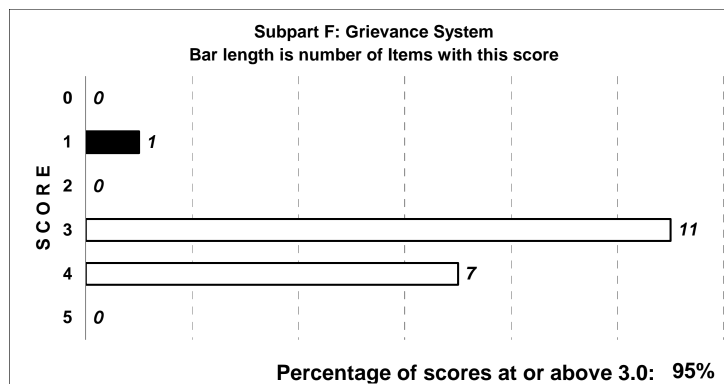
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for King County

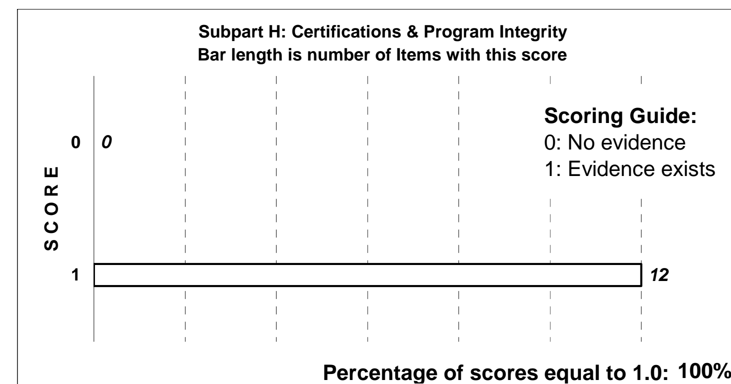
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

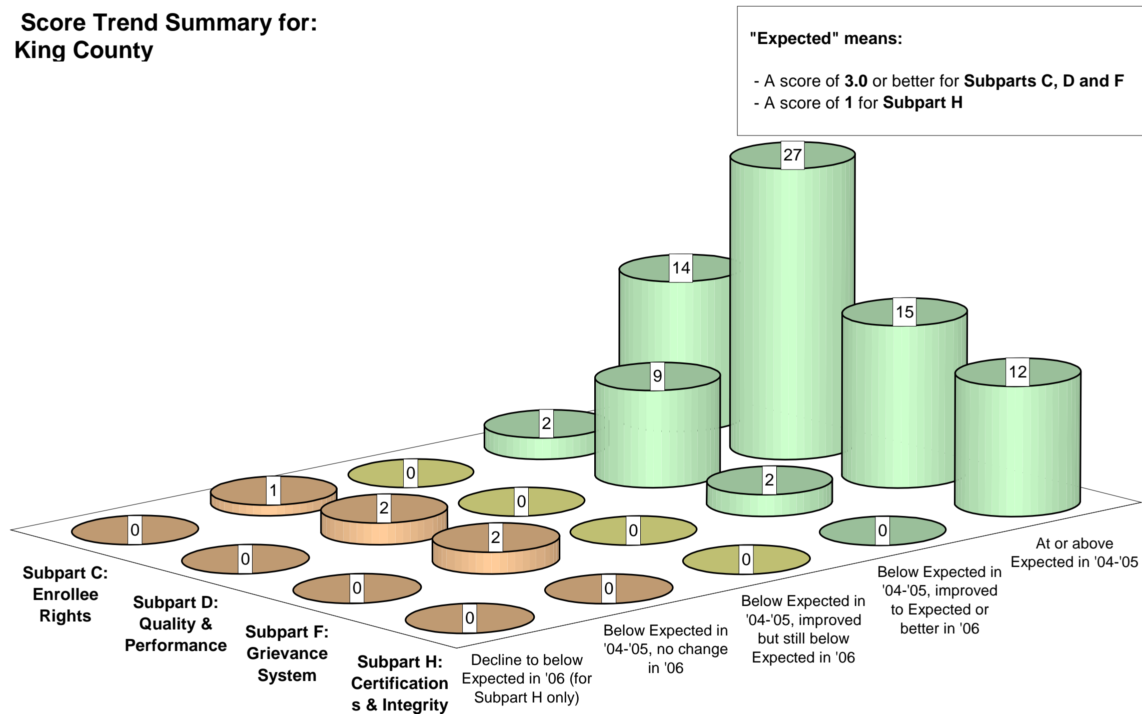
Subpart C: 94%
Subpart D: 95%
Subpart F: 95%
Subpart H: 100%

By prioritizing Certifications and Program Integrity, King County PIHP achieved Expected compliance for Subpart H in 2005, and again in 2006.

The PIHP continues to make progress with respect to Subpart C-Enrollee Rights and Protections, and has achieved Expected compliance for all review elements with one exception: documentation of client choice related to Mental Health Advance Directives.

In addition, King County PIHP has met all but one requirement in Subpart F-Grievance Systems; and has met the majority of requirements in Subpart D-Quality Assessment and Performance Improvement with the exception of two. With regard to the review elements that remain below Expected compliance, relevant policies and procedures are missing key requirements. Specific areas that remain a challenge include, but are not limited to, accurate timeframes for standard authorizations and NOAs. Overall, King County has achieved a high level of Expected compliance within all four Subparts.

Score Trend Summary for:
King County



Score Trend Category	Subpart C: Enrollee Rights		Subpart D: Quality & Performance		Subpart F: Grievance System		Subpart H: Certifications & Integrity	
	Item Count	Percent	Item Count	Percent	Item Count	Percent	Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	1	5.9%	2	5.3%	1	5.3%	0	0.0%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	2	11.8%	9	23.7%	3	15.8%	0	0.0%
At or above Expected in '04-'05	14	82.4%	27	71.1%	15	78.9%	12	100.0%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, King County PIHP performance relative to Subpart C (*Enrollee Rights*) showed 14 out of 17 items (82.4%) already at or above the Expected level of performance. After the 2006 review, 16 items (94.1%) are at the Expected level, reflecting improvement in 2 out of 3 elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), King County PIHP entered the 2006 review with 15 of 19 items (78.9%) already at or above Expected. After the 2006 review, 18 items (94.7%) meet the Expected level of performance, indicating that 3 out of 4 elements improved to Expected or better from 2005 to 2006.

The improvement King County PIHP has made in all four Subparts reflects focused efforts on continuous quality improvement during 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- PIHP staff continue to prioritize the development of creative service options, based on fundamental values of recovery and normalization to meet diverse enrollee needs. In addition, the PIHP has an increased commitment to integrating consumer voice and participation in decision-making.
- The PIHP has developed and started initial implementation of Practice Guideline Review Instruments to ensure that processes of care are consistent with the practice guidelines.
- Annual provider Credentialing and Recredentialing review process ensures that service providers meet the requirements set forth by Federal, State, and local laws, as well as new PIHP service standards that emerge from activities of continuous quality improvement.
- PIHP staff have created effective mechanisms to adopt and approve new and revised policies and procedures, as well as incorporate provider feedback in policy revisions. Additionally, staff have developed effective documentation methods related to tracking policy changes and the distribution to providers of new and revised policies and procedures.

Subpart Challenges

- PIHP policies and procedures lack clearly defined, accurate timeframes related to standard authorizations and NOAs. As a result, provider requests for authorization and NOAs, as well as enrollee Authorization Notifications and NOAs, may be occurring outside the required timeframes as reported.

Subpart Recommendations

1. In provider contracts, stipulate specific client materials to be translated and identify the required languages and alternative formats in which materials are to be made available.

2. Create a mechanism to indicate in the clinical record whether or not a Medicaid enrollee chooses to initiate a Mental Health Advance Directive. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

3. Incorporate into PIHP policies and procedures clear and accurate timeframes and related procedures for Standard Authorization and Extensions, and NOAs. Ensure that appropriate controls are in place for authorization processes, and develop monitoring mechanisms to ensure adherence to required timeframes.

4. Expand outpatient and inpatient NOA tracking logs to monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, and date Notice of Action (NOA) was sent.

5. In order to ensure that all authorizations are conducted by Mental Health Professionals, design a formal qualifications review to ensure that staff who conduct authorizations qualify as MHPs.

6. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the WAEQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited to a technical assistance review and, as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO which, if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The PIHP accepts any valid CPT code, but forwards only those codes accepted by the State. The Provider Network is aware of codes accepted by the State for services provided under the State Plan.

2. Unique member ID
   The PIHP maintains member IDs unique to King County (King County ID). A duplicate, bi-weekly report is created for provider review; a separate report is provided to other systems.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The PIHP can track members, regardless of changes in status, periods of enrollment and disenrollment, or changes across product lines.

4. Calculating member months
   The PIHP creates a monthly report of members served per month ('report card'). The accuracy of this data is tied to monthly provider tracking of eligibility status, which is not always reliable.

5. Member database
   The PIHP uses MHD membership data to test Medicaid eligibility on a monthly basis, but does not maintain a member database.

6. Provider Database
   The PIHP has provider data used internally for a process called 'Vendor Profiling', which primarily serves as a contract management tool. Additional information called a 'Staff Qualification Transaction' is collected, which provides qualifications of individual staff members.

7. Data easily under-reported
   The PIHP does not have a specific policy or procedure with respect to tracking encounters with out-of-network providers. Subcontractor data is rolled into a single submission from the originating contracting agency. The PIHP considers these subcontractors out-of-network providers.

PM Summary

King County PIHP has strong pre-submission screening processes in place for its data and also fared well in the comprehensive encounter validation exercise conducted by the WAEQRO in last year's review cycle. The PIHP's efforts in this year's analysis and encounter validation review (described below) were excellent. The general state of the PIHP's data is evaluated as "good" (using the terms "poor", "fair", and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- The King County PIHP developed an error tracking system that follows submission errors through to successful resubmission. The system assigns suspense dates and tracks resolution dates, thereby significantly increasing accountability for, and confidence in, validity of the data submitted to the State.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs, whenever possible.

APS reviewed one of two submitted PIPs for King County PIHP: Metabolic Syndrome Screening and Intervention, which was identified by the PIHP as clinical. Included in the desk review were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and to evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP. Focus was also directed toward strategies for improving the PIP, or developing new ones based on what was learned in training provided by MHD in September, 2006 (see, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

For validated PIPs, ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Where they might be helpful, comments and suggestions have been included in each Step and in the Summary. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

In conjunction with provider medical directors and PIHP senior staff, the PIHP Medical Director and the QI Specialist developed this PIP in part as a response to a request by the medical primary care providers for assistance related to prescription of atypical anti-psychotic medication. Discussion in medical director meetings led to a further concern related to adverse outcomes of atypicals in general – metabolic syndrome.

The goal of the PIP is to reduce such adverse outcomes through implementation of the ADA/APA screening protocols. These protocols include measuring baseline lab values and patient education, change in prescription, and referral to medical practitioners if values are above safety thresholds.

This PIP has been well-designed, with a clearly stated study question, appropriately designed indicators, a thorough data analysis plan, and thorough intervention planning. Improvement in clinical outcomes as a result of this study will have a significant impact on overall consumer health; successful implementation of the protocols can establish a precedent for addressing other consumer health issues and will enhance the integration of mental health and physical health services, a necessary partnership for treating the whole person and improving consumer health in general.

This PIP was validated through Step 7 as the PIHP will begin the study early in May.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				The PIP Summary cites, "recent estimates show that the life expectancy of a severely mentally ill person is reduced by over 20 years compared to a person without serious mental illness", and "an analysis of King County PIHP management information system data shows that 1,806 individuals have a diagnosis of schizophrenia".
1.2. Is selected following collection and analysis of data (or was selected by the State).	X				The PIHP found 1806 individuals diagnosed with schizophrenia, the majority of whom are on anti-psychotic medications and therefore vulnerable to adverse outcomes related to metabolic syndrome.
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).	X				The spectrum of addressed care includes management of body weight, blood glucose, blood pressure, and blood lipids.
1.4 Includes all eligible populations that meet the study criteria.	X				All (100%) Medicaid-eligible schizophrenic clients taking atypical anti-psychotic

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					medications are included in this study.
1.5. Does not exclude members with special health care needs.	X				The PIP Summary states: “Individuals with special health care conditions are not excluded from the study.”
1.6 Has the potential to affect member health, functional status, or satisfaction.	X				The PIP addresses the potentially devastating constellation of metabolic disorders linked to chronic disease amongst the schizophrenic population.
Totals for Step 1:	**6**				
Number of shaded critical evaluation elements met for Step 1: 1/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study’s framework.	X				The study question asks, “Does implementation of the ADA/APA screening and intervention protocol for metabolic syndrome result in improved symptoms of metabolic syndrome for individuals with schizophrenia receiving Medicaid ongoing outpatient or residential care who use atypical anti-psychotic medications?”
2.2 Is answerable/provable.	X				The PIP Summary anticipates a chi-square analysis to test for significance of change over time in populations with and without metabolic syndrome.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Totals for Step 2:	**2**				
Number of shaded critical evaluation elements met for Step 2: 2/2					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.	**X**				The PIP Summary advances an accomplishment rate indicator. Numerator: Consumers in the denominator who have at least one metabolic syndrome problem at or above threshold levels. Denominator: Medicaid-enrolled consumers authorized for an ongoing outpatient or residential benefit with a diagnosis of schizophrenia, and who are taking at least one atypical anti-psychotic medication at the beginning of the study period.
3.2. Are based on practice guidelines, with sources identified.	**X**				The PIP is built on an APA/ADA consensus statement that recommends intervention strategies to combat metabolic syndrome amongst patients on atypical anti-psychotic medications.
3.3 Allow for the study question/hypothesis to be answered or proven.	**X**				See comments in 2.2 and 3.1 above.
3.4 Measure changes (outcomes) in health or functional status, member	**X**				The study includes health status, outcome, and process of care change measurement:

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
satisfaction, or valid process alternatives.					body weight; measurement/control of blood glucose, blood pressure, and blood lipids.
3.5 Have available data that can be collected on each indicator.	X				Denominator data sources appear to be identified: MAA prescription data and PIHP MIS system. Information from the metabolic syndrome screening and intervention form will be essential, and will be obtained from labs and physicians with whom the PIHP has ongoing relationships.
3.6 Include the basis on which each indicator was adopted, if internally developed.			X		Unknown/unclear.
Totals for Step 3:	**5**		**1**		
Number of shaded critical evaluation elements met for Step 3: 0/0					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					
4.1. Is accurately and completely defined.	X				The PIP Summary clearly specifies the complete sub-population of consumers within the PIHP that are targeted for analysis.
4.2. Includes requirements for the length of a member's enrollment in the MCP.	X				The study establishes enrollment criteria as "consumers (of all ages) who have been Medicaid-enrolled at any time within the last year".
4.3 Captures all members to whom the	X				All consumers meeting the enrollment and diagnostic criteria cited above are included;

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
study question applies.					specifically: “Medicaid-enrolled consumers authorized for an ongoing outpatient or residential benefit with a diagnosis of schizophrenia and who are taking at least one atypical anti-psychotic medication at the beginning of the study period”.
Totals for Step 4:	**3**				
Number of shaded critical evaluation elements met for Step 4: 2/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).	**X**				The PIP Summary estimates the total population of schizophrenics in the PIHP at 1,806; approximately 80% of these are believed to be on atypical anti-psychotics.
5.2. Identify the sample size (or use the entire population).				**X**	All (100%) Medicaid-eligible schizophrenic clients taking atypical anti-psychotic medications were examined in this study.
5.3. Specify the confidence interval to be used (or use the entire population).				**X**	All (100%) Medicaid-eligible schizophrenic clients taking atypical anti-psychotic medications were examined in this study.
5.4 Specify the acceptable margin of error (or use the entire population).				**X**	All (100%) Medicaid-eligible schizophrenic clients taking atypical anti-psychotic medications were examined in this study.
5.5 Ensure a representative sample of the eligible population.				**X**	All (100%) Medicaid-eligible schizophrenic clients taking atypical anti-psychotic

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					medications were examined in this study.
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.				X	All (100%) Medicaid-eligible schizophrenic clients taking atypical anti-psychotic medications were examined in this study.
Totals for Step 5:	**1**			**5**	
Number of shaded critical evaluation elements met for Step 5: 0/0					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.		X			Specific data elements are specified for the metabolic syndrome screening and intervention form. Discrete data elements are not clarified for the remaining data sources: MAA prescription data, PIHP MIS data, and reference laboratory clinical values (although in each of these data sources, the critical data elements are implicit).
6.2. Identification of specified sources of data.	X				Denominator data sources appear to be identified: MAA prescription data and PIHP MIS system. Information from the metabolic syndrome screening and intervention form will be essential, and will be obtained from labs and physicians with whom the PIHP has ongoing relationships.
6.3. A defined and systematic process for collecting baseline and remeasurement		X			While there is a general sense of definition and a systemic nature to the data collection and re-measurement process, greater

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
data.					programmatic detail is desirable. A significant weakness may be the special handling required to accumulate external laboratory clinical values in a cost-effective and replicable way.
6.4. A timeline for collection of baseline and remeasurement data.	X				The baseline data period is defined as May-October 2007. The data collection and re-measurement period extends from May 2007 through October 2008.
6.5. Qualified staff and personnel to abstract manual data.	X				The metabolic syndrome screening and intervention form was designed in a collaborative process involving PIHP staff and prescribers.
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	X				Consistency and accuracy of data collection appears to have been one objective of the collaborative approach described in item 6.5, above.
6.7 A manual data collection tool that supports inter-rater reliability.	X				Reliability was an expressed objective of the collaborative approach described in item 6.5, above.
6.8 Clear and concise written instructions for completing the manual data collection tool.	X				The metabolic syndrome screening and intervention form features succinct but comprehensive design and instructive clarity.
6.9 An overview of the study in written instructions.			X		The instructions for completing the metabolic syndrome screening and intervention form do

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					not include a written overview of the PIP.
6.10 Automated data collection algorithms that show steps in the production of indicators.			X		While conceptually clear, neither step-by-step details nor an algorithmic accounting of the indicator derivation appear in the PIP Summary.
6.11 An estimated degree of automated data completeness.	X				The PIP Summary estimates completeness greater than 95% in the PIHP MIS system in connection with diagnostic and eligibility data critical to establishing denominator cases for the outcome indicator.
Totals for Step 6:	**7**	**2**	**2**		
Number of shaded critical evaluation elements met for Step 6: 1/1					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.	X				The PIP describes a 2-part improvement scheme: 1. Screening – body mass, blood glucose/pressure/lipids; 2. Intervention – education, referral, or medication change depending on screening discovery The improvement scheme is based on ADA/APA protocols.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
7.2 System changes that are likely to induce permanent change.				X	Continued monitoring of events will be required to confirm that measured change is persisting.
7.3 Revised if original interventions are not successful.				X	Continued monitoring of events will be required to confirm that measured change is persisting.
7.4 Standardized and monitored if interventions are successful.				X	Continued monitoring of events will be required to confirm that measured change is persisting.
Totals for Step 7:	**1**			**3**	
Number of shaded critical evaluation elements met for Step 7: 1/1					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					
8.1. Is conducted according to the data analysis plan in the study design.					
8.2. Allows for generalization of the results to the study population if a sample was selected.					
8.3. Identified factors that threaten internal or external validity of findings.					
8.4. Includes an interpretation of findings.					
8.5 Is presented in a way that provides					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
accurate, clear, and easily understood information.					
8.6 Identifies initial measurement and remeasurement of study indicators.					
8.7 Identifies statistical differences between initial measurement and remeasurement.					
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.					
8.9 Includes the interpretation of the extent to which the study was successful.					
Totals for Step 8:					
Number of shaded critical evaluation elements met for Step 8:					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.					
9.2. There is documented improvement in processes or outcomes of care.					
9.3. The improvement appears to be the result of planned intervention(s).					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
9.4. There is statistical evidence that observed improvement is true improvement.					
Totals for Step 9:					
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.					
Totals for Step 10:					
Number of shaded critical evaluation elements met for Step 10:					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS

***Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported**

**** Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported**

***** Not Met = Reported PIHP PIP results or plan/activities not credible**

Summary of Aggregate Validation Findings

* ☒ **Met** * * ☐ **Partially Met** *** ☐ **Not Met**

Summary of PIP validation findings:
The PIP will produce valid and reliable results if carried out as described in the plan. Critical health issues of people diagnosed with schizophrenia are being addressed in a manner that has the potential for improving healthcare coordination for all mental health consumers.

PIP Strengths

- After much discussion, the PIP was developed with input from key stakeholders, thus improving the chances of cooperation from all parties in all phases of the study.
- The data analysis plan is well-developed and will yield valid results.
- The potential impact of the study is wide-ranging and addresses critical issues in treatment of both mental and physical health for Medicaid consumers.

PIP Challenges

- Maintaining focus on this ambitious PIP amidst all of the other planning initiatives underway will require continued strong leadership and commitment.

PIP Recommendations

1. This PIP is ready for implementation.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data, and that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***.
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers with responses that are consistent with each other and the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with all documentation requirements, but, during interviews, staff are unable to consistently articulate processes. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Met	P&P Section XII, including attachments, is an excellent example of gathering the basic requirements for data collection into a single comprehensive policy. However, it should be noted that Attachment C, the HIPAA Trading Partner Agreement (TPA), had dated language. The TPA has language from 2003 which indicates that they either have not revisited this form, or they provided WAEQRO (and include in their policy as an attachment) the wrong version.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The PIHP holds partnership meetings with its providers and uses this forum to coordinate and communicate changes in the data requirements. These changes are ultimately captured in policy and procedure. The KC PIHP uses a tool with a tracking grid to capture all P&P changes in one location. Sharing such changes on a tracking tool like this helps simplify the sometimes complex process by ensuring that changes are communicated effectively.
2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Met	The provider review submitted as evidence relative to the PIHP assessing and documenting provider IT processes, capabilities, and potential vulnerabilities is again excellent. The process used produces the level of detail necessary to guide PIHP actions in correcting any deficiencies.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Met	The processes used by the PIHP achieve most of the results required by this step. The PIHP trends a year's worth of data for accuracy and completeness. This data is collected and reported on a monthly basis as data is submitted. The PIHP tracks errors upon submission and assigns a "correct by date" to the error. Given this practice, the assumption would be that data reported 12 months ago as 90% complete would be more complete by the time the succeeding 11 months had passed. Analyzing and reporting data as a collection of monthly performance measures will not show the above improvements over time, when such improvements obviously take place. If another analysis were to be conducted in the 12th month, using a year's worth of data, the PIHP would know the precise condition of its data at that time, would be able to compare data states between original submission and current report date, and would have a much more powerful tool for understanding data quality and data improvement efforts.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Met	The tools used by the PIHP to evaluate and document their analysis are well developed, easy to read, and clearly show the findings of each report.
Data is evaluated in a frozen state and	Not Met	Data is not frozen for the purpose of analysis.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
archived for future possible use.		
4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Met	The PIHP clearly documented the requirements for the encounter validation. The review is done in concert with a much broader clinical review; however, the PIHP made efforts to ensure that requirements specified in their contract with the MHD are spelled out separately as a distinct part of the larger process. This process exceeds the requirements of their contract with the state.
PIHP includes additional data elements in matching exercise.	Met	The structure of the review is comprehensive, beyond the requirements of the encounter validation. Other data items are clearly checked in the review process. It would be helpful for the PIHP to develop a matrix listing all data elements and methods for their evaluation which includes a tracking system that ensures the periodic review of all data elements. Such a tool would help the PIHP ensure that all data is eventually checked.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Met	The tools used by the PIHP effectively capture review results. The process results can easily be followed from the chart review document, to the collection tool, and in the summaries of both internal and external documents.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Met	The report issued to the state provided general overview information of process purpose, a brief process description, and a summary of findings section. The report is understandable and clear, but a bit brief with respect to process description. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	Ample evidence was provided demonstrating that the PIHP shares the results of this exercise with its provider network.
PIHP regularly reports internally for	Met	Internal reports and meeting minutes that document discussions related to

PIHP Encounter Validation
Process Review

Item	Rating	Comments
quality improvement activities.		the encounter validation results were reviewed; they clearly support the PIHP's communication efforts specific to this review item.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Met	Language in the network provider contracts clearly outlines the policy and procedures used for a corrective action. Additional documentation outlining the corrective action process of one of their providers shows the PIHP maintaining focus through completion of the requirements.
If warranted, evidence of follow-up activity was presented.	Met	Documentation was submitted with respect to evidence of follow-up for the corrective action items generated in the review process; this evidence clearly shows comprehensive follow-up efforts by the KC PIHP.

Summary of Encounter Validation Findings

Score Met _93_%

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☒ **Met** ☐ **Partially Met** ☐ **Not Met**

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP exceeded requirements set forth in its contract with the MHD. Of specific note were efforts the PIHP made in evaluating their provider network environment. Using a data process review tool, they document the processes used by provider agencies for data collection and reporting. This tool evaluates the processes for error report reconciliation, data input, and quality assurance efforts (which address timeliness, accuracy, and completeness). The specific analysis of provider agency data could use enhancement; however, the efforts made were still helpful. The PIHP does not conduct an analysis specific to the encounter validation review data and does not work with a frozen data set. The overall efforts made by the PIHP for this process were excellent.

The overall finding of Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 93% of all items meeting a score of Met, 7% at Not Met, and no items being scored Partially Met.

EV Strengths

- The documentation provided by the King County PIHP that described, defined, and documented the results of these processes was comprehensive, well organized, and generally very useful.
- The evaluation of the PIHP provider network environment does an excellent job of asking critical questions and documenting responses to ensure that the PIHP is able to understand and manage the risks and shortcomings inherent in the processes used within their network.

EV Challenges

- No challenges noted.

EV Recommendations

1. Conduct a data analysis specific to the encounter validation using the exercise timeframe as guidance in defining the minimum dataset to be evaluated.

2. When conducting the data analysis, use a frozen dataset. A frozen dataset protects live data from inadvertent changes and provides means for a third party to verify results of the PIHP's study.

3. Develop a matrix listing all data elements and methodology for assessing accuracy and completeness; design the matrix to track assessment of each element over time in order to ensure that all data is evaluated periodically.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: King County MHCADSD

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		**3**		• The Quality Management Plan (QMP) (including Appendices, Committee and Work Group Charters, Principal Functions Grid, and the QAI Performance Improvement Work Plan), concisely describes the quality management system. • The QMP includes: goals, scope, governance, functional committee structures, quality indicators, monitoring methods, reporting and improvement processes, an annual work plan, and an annual review of the QMP. • The Senior Staff Group (SSG) provides

PIHP: King County MHCADSD

Requirement	Met	PM	Not Met	Findings Comments
				the central oversight of all QAI activities. • Other RSN committees are chartered to perform specific QAI functions and report regularly to SSG. • Staffing assignments are not defined for the following QM functions: o Coordination and integration of quality assurance with quality planning and quality improvement; o Development of the QM Plan; o Approval of QM Plan; and o Oversight and implementation of PIPs. • Appendix B, the QAI Performance Improvement Work Plan and clinical review/corrective action monitoring are not included in the QMP. (Reference to, or incorporation of, the relevant appendices and policies is recommended.) • Plan elements that are missing: mission/vision and performance improvement projects.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		**3**		• The QMP states that the Plan is evaluated annually by SSG. A summary report is prepared that includes: o A summary of QI activities, projects, and products; o An evaluation of the overall

PIHP: King County MHCADSD

Requirement	Met	PM	Not Met	Findings Comments
				effectiveness of these efforts; and o Progress toward improving clinical and administrative practice. • The Plan does not include timing, process, or a plan to incorporate results of the QMP review into the following year's plan.
C. Plan includes annual work plan and process for review of associated activities and progress.		3		• The Quality Assurance/Improvement Work Plan and the Quality Assurance/Improvement Work Plan Initiatives Update September 2005-March 2007 were provided. • In the QMP, responsibility for quality improvement work plan monitoring and update is stated under functions of SSG; however, no timeframes are given in the Plan, Functions Grid, or Work Plan Indicators.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		2		• Routine provider reviews as described generally in the QMP, Appendices, and Functions Grid, include: o Provider administrative reviews, o Routine clinical chart reviews, and o Focused reviews for quality management indicators. • The Functions Grid indicates that clinical chart reviews are annually conducted by the Clinical Services Section for each provider.

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• The matrix of indicators that comprise the Work Plan includes responsibilities, measures, timeframes, and expected outcomes across eight domains. • Indicators lack: o Numerator/denominator, o Thresholds defined for taking action, and o Measurement methodology. • Missing from the QMP are monitoring methods/schedules and reporting activities for: o Clinical Chart Reviews, o Corrective action process, and o Performance improvement projects (PIPs).
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	**4**			• Providers and consumer representatives attend the Partnership Group, Recovery Implementation Group, Plan Management Group, Clinical Directors Committees, and Information Systems Advisory Committee (ISAC). • The Quality Review Team (QRT) has two funded positions within the RSN. Staff report to the SPE Program Manager and are involved with internal (SSG and SPEC) committees and the Quality Council of the KCMHAB. • Consumers are represented in the

PIHP: King County MHCADSD

Requirement	Met	PM	Not Met	Findings Comments
				following ways: o The King County Mental Health Advisory Board (KCMHAB), o Quality Council of KCMHAB, o The Recovery Implementation Group (RIG), and o The Clinical Directors Committee. • The QMP does not indicate whether the Ombuds reports at any meetings.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**3**		• The "Quality Assurance/Improvement Work Plan Initiatives Update September 2005-March 2007" describes on-going quality improvement activities tracked during the year and over time. • Clinical Chart Review and corrective action process documentation provided evidence relative to implementation of the Credentialing and Contract Monitoring Policy. • Many examples of reports were submitted as evidence with respect to implementation of the work plans and review schedules identified in the Plan: o RSN Report Card, 3rd quarter 2006, o 2006 Provider Outpatient Client Profile and Accountability Report, o Service Utilization Report for all providers for 4th quarter 2006,

PIHP: King County MHCADSD

Requirement	Met	PM	Not Met	Findings Comments
				○ Telesage completion rate for each CMHA, ○ Crisis Inpatient Response Time by month and quarter, and ○ Quality Council Annual Report February 2007. • Consumer involvement documented in meeting minutes reflects varied levels of participation: ○ Quality Council meetings were poorly attended with 5 of 8 meetings attended by three or fewer people. ○ Meeting minutes submitted document that QRT attendance is routine at SPECS meetings. ○ While the Charter for SSG states that QRT is a member, QRT was present at only one meeting submitted for review. • No Annual Review of the QM Plan was submitted; however, PIHP management staff indicated that the review was conducted verbally, and that the QMP was approved by SSG. SSG minutes of 3/07 confirm discussion of the QMP. • Neither the QMP for 2007 nor 2006 noted a date of adoption.

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard 1 Count (Target 6 Met):	**1**	**5**	**0**	**Target Points: 24 Actual: 18**
<u>Standard</u> **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			• The Clinical Services Section is responsible for utilization management, contract compliance reviews, and monitoring client services, including complaints and grievances. • Reviews are conducted annually, based on a sample set by King County Sampling Policy (not provided). • Documentation provided to support that reviews are conducted as planned: o System-wide Clinical Findings Report for 2006 reported 710 charts reviewed over the course of the year based on a total population served of 21,451. o Narrative reports and Excel tally of results for all cases reviewed from two provider agencies.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and	**4**			• The Clinical Review Document is a 62-item tool in seven sections. The tool is

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**

required/indicated periodic review.				completed manually with data aggregated in Excel.
				• The tool has an interpretive guide supporting 3 response options and a comments section.
				• Tool attachments include:
				  o Developmental Practice Guidelines,
				  o Attention Deficit Hyperactivity Disorder Diagnosis guidelines for Children, and
				  o Wraparound Practice Guidelines.
				• Several completed examples along with the data tables that explain the scoring process documented an effective tool for measuring performance related to assessment, treatment plans, ongoing care, and required/periodic reviews.

C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**3**		• PIHP management staff interviews confirmed that the inter-rater reliability process includes staff training prior to reviews. • PIHP management staff reported that the tool has been modified over time, with more interpretive guides based on team decisions. • No written documentation is available in policy, procedure, or meeting notes to describe the process.

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• The process would benefit from having multiple people review charts in question, or some other method of comparing scores.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.	**4**			• An effective system for identifying improvements was described in the Functions Grid: o Contract Management Section is responsible for initiating corrective actions; o KCMHAB reviews grievance reports and contract compliance reviews; and, o SSG monitors the UM Plan. • Clear and detailed expectations for compliance were stated in the Credentialing and Contractor Monitoring Policy and contract boilerplate. • Summaries of findings from two providers were submitted, from the beginning of the review process through corrective action completion, in accordance with policies and procedures described. • Provider management staff confirmed frequency of reviews and documentation of the review process as described in policies and procedures, including corrective action.

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard 2 Count (Target 4 Met):	**3**	**1**	**0**	**Target Points: 16 Actual: 15**
<u>Standard</u> **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		**3**		• Minutes of meetings of SSG documented regular review of clinical chart review findings. • QC reviewed 2005 summary report of clinical review findings. • Meeting minutes did not provide detail of discussion or quality improvement activities based on the review of results.
B. PIHP analyzes and trends individual provider performance.	**4**			• Clinical and administrative review findings were provided for two agencies including: o A tally of individual charts with summary of findings and necessary corrective action, and o A summary report for the year, titled, "2006 Mental Health Contract Compliance Site Visits: Agency Specific Clinical Findings". • Trend data was provided in three

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PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				reports: o Comparison of 2005 & 2006 Administrative Review Summary (Non Compliance), o Comparison of 2005 & 2006 Administrative Review Summary (Compliance with Recommendations), and o 2006 Provider Outpatient Client Profile and Accountability Report.
C. PIHP analyzes and trends system-wide performance.	**4**			• System-wide performance was provided in several reports: o 2006 Mental Health Contract Compliance Site Visits: System-Wide Clinical Findings, o BBA Administrative Review Findings (compliance vs. non-compliance comparison,) and o BBA Administrative Review Findings (subset non-compliant or compliant with recommendations). • Trend data was provided in three reports: o 2006 Provider Outpatient Client Profile and Accountability Report, o Comparison of 2005 & 2006 Administrative Review Summary (Non Compliance), and o Comparison of 2005 & 2006

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				Administrative Review Summary (Compliance with Recommendations). • Some analysis was provided in a subset report titled: Clinical Review Findings specific to Recovery.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.	**4**			• Clinical and administrative review findings were discussed routinely in meeting minutes of SSG. • Documentation of distribution to all agencies was provided with respect to the 2006 Provider Outpatient Client Profile and Accountability Report. • RSN Report Cards were often discussed in SSG and QC meeting minutes. • Agendas from SPE indicate that report cards are a routine agenda topic. • Few examples of meeting minutes were provided for stakeholder and provider forums; however, o provider management staff reported information sharing at provider meetings as well as distribution of Report Cards; o Ombuds reported that he attends meetings of the Clinical Directors, KCMHAB, providers/stakeholders, and Partnership.

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PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard 3 Count (Target 4 Met):	**3**	**1**	**0**	**Target Points: 16 Actual: 15**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**2**		• PIHP submitted for review the Grievance Appeal Log with 2006 data provided in Excel format. • Of the two grievances reported in the Log from May and July, 2006, neither appeared resolved. • Of the three appeals provided for review, none were resolved within required timeframes.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.	**4**			• Functions Grid assigns overall responsibility for monitoring grievance reports to SSG with review of findings at KCMHAB. • Evidence provided to support routine incorporation in system improvement: o Reports submitted of PIHP Grievance System Summary (including lack of trends) and Exhibit N. o SSG minutes indicated that

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				recommendations were made following a review of Exhibit N. o PMG minutes referenced review of grievance/appeals procedures and plan for input from clinical directors. • Ombuds Service Semi-Annual Report April-Sept 2006 narrative provided detailed description of services and training received and provided. • New Clinical Directors Charter includes Ombuds.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	**4**			• Evidence of training provided: o Minutes of QC meeting reported grievance system training. o Clinical Directors meeting included training on Complaints and Grievance Process with plan for further training in January 2007. o Provider management staff confirmed that training is done through Clinical Director meetings and that directors, in turn, train agency staff. o Ombuds confirmed that training is provided on HIPAA as described in the PIHP Update. • Provider clinical staff accurately described the grievance process and reported that training occurs in staff

PIHP: King County MHCADSD				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				meetings and in individual supervision. • In his interview, Ombuds expressed a thorough understanding of the grievance process. • Ombuds reported that quarterly phone logs are provided to the PIHP contract monitor. Semi-annual reports are provided to PIHP Client Services, RSN Administrator, and KCMHAB. • Ombuds noted approximately 850 contacts in a 6-month period with 1 grievance, indicating a high resolution at the lowest level of the complaint process.
Standard 4 Count (Target 3 Met):	**2**	**1**	**0**	**Target Points: 12 Actual: 10**
Grand Totals Count (Target 17 Met):	**9**	**8**	**0**	**Target Points: 68 Actual: 58**

Summary Quality Assurance and Improvement Findings
King County Regional Support Network (KCRSN) achieved the highest score possible (Met = 4 points) on 9 out of 17 possible items. Another 8 items were Partially Met and, of these, 6 items were nearly met. No items had scores of Unmet. KCRSN achieved a total score of 58 points (85%) for the first review of Quality Assurance and Improvement Plan and activities. Findings reflect a system that has major strengths in organization and reporting data outcomes. While the “score” reflected in this tool indicates a highly functional QAI system, the WA EQRO encourages the PIHP to continue to find opportunities for improving their process.

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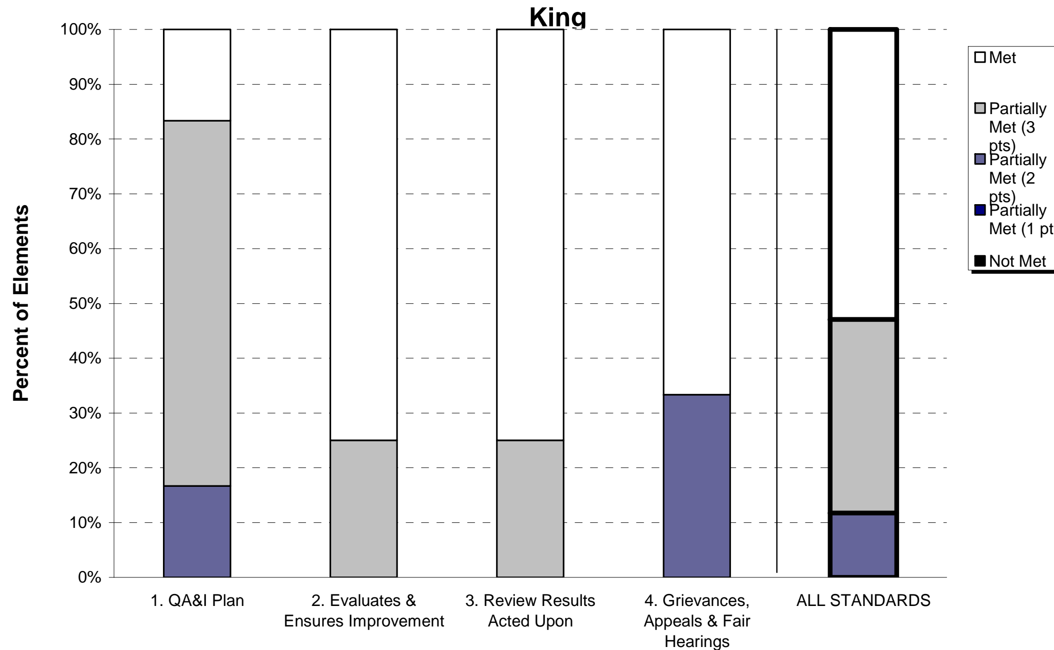

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	1	4	1	0	0
2. Evaluates & Ensures Improvement	4	3	1	0	0	0
3. Review Results Acted Upon	4	3	1	0	0	0
4. Grievances, Appeals & Fair Hearings	3	2	0	1	0	0
ALL STANDARDS	**17**	**9**	**6**	**2**	**0**	**0**

QAI Strengths

- Recent addition of an Ombuds and a consumer representative on the Clinical Directors Committee increases independent consumer involvement in the internal oversight committees of the RSN.
- PIHP reports on service capacity through a client and provider profiling system, which is reported in detail and distributed annually to all providers.
- Key operational committees maintain detailed reporting schedules.

QAI Challenges

- The Quality Council appears to be under-utilized as a forum for activities described in the committee charter.

QAI Recommendations

1. Reference in the Quality Management Plan all appendices and policies/procedures, committee work plans, and reporting schedules involved in the quality management process.

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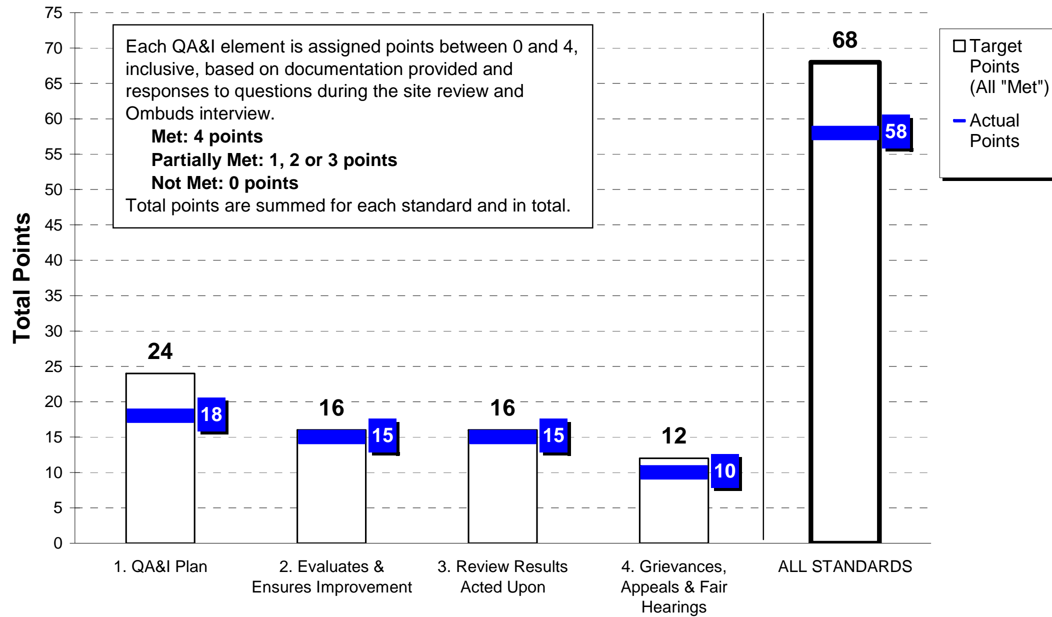

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	18
2. Evaluates & Ensures Improvement	16	15
3. Review Results Acted Upon	16	15
4. Grievances, Appeals & Fair Hearings	12	10
ALL STANDARDS	**68**	**58**

2. Consider formally designating a Quality Manager from senior management staff to assure implementation and monitoring of all aspects of the QM Plan, including annual review and update of the QM Plan and Work Plan, and coordinating quality assurance with quality planning and quality improvement.

3. Create meeting minutes for all committees and workgroups, with the role of individuals attending meetings identified in a signed attendance roster.

4. Include in the matrix of indicators performance thresholds for further action; develop indicators that address quality of care issues such as quality and appropriateness of assessments and treatment plans and grievance/appeals process monitoring.

Recommendations

Subpart Recommendations

1. In provider contracts, stipulate specific client materials to be translated and identify the required languages and alternative formats in which materials are to be made available.

2. Create a mechanism to indicate in the clinical record whether or not a Medicaid enrollee chooses to initiate a Mental Health Advance Directive. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

3. Incorporate into PIHP policies and procedures clear and accurate timeframes and related procedures for Standard Authorization and Extensions, and NOAs. Ensure that appropriate controls are in place for authorization processes, and develop monitoring mechanisms to ensure adherence to required timeframes.

4. Expand outpatient and inpatient NOA tracking logs to monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, and date Notice of Action (NOA) was sent.

5. In order to ensure that all authorizations are conducted by Mental Health Professionals, design a formal qualifications review to ensure that staff who conduct authorizations qualify as MHPs.

6. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. This PIP is ready for implementation.

EV Recommendations

1. Conduct a data analysis specific to the encounter validation using the exercise timeframe as guidance in defining the minimum dataset to be evaluated.

2. When conducting the data analysis, use a frozen dataset. A frozen dataset protects live

data from inadvertent changes and provides means for a third party to verify results of the PIHP's study.

3. Develop a matrix listing all data elements and methodology for assessing accuracy and completeness; design the matrix to track assessment of each element over time in order to ensure that all data is evaluated periodically.

QAI Recommendations

1. Reference in the Quality Management Plan all appendices and policies/procedures, committee work plans, and reporting schedules involved in the quality management process.

2. Consider formally designating a Quality Manager from senior management staff to assure implementation and monitoring of all aspects of the QM Plan, including annual review and update of the QM Plan and Work Plan, and coordinating quality assurance with quality planning and quality improvement.

3. Create meeting minutes for all committees and workgroups, with the role of individuals attending meetings identified in a signed attendance roster.

4. Include in the matrix of indicators performance thresholds for further action; develop indicators that address quality of care issues such as quality and appropriateness of assessments and treatment plans and grievance/appeals process monitoring.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Grays Harbor
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Grays Harbor PIHP is responsible for managing mental health care and services for Medicaid consumers in Grays Harbor County in the state of Washington. The PIHP is located in Aberdeen, Washington and is governed by a board comprised of three Grays Harbor County Commissioners. The PIHP Administrator reports to The Director of the Public Health and Social Services Department of Grays Harbor County. Grays Harbor PIHP contracts with three community mental health centers and specialty providers to serve approximately 1900 adult and child consumers annually. Total annual Medicaid enrollment in the PIHP is 13,072. The PIHP delegates utilization management for inpatient and outpatient services to a private vendor, and in addition, subcontracts for information services and application software.

This report covers the period between September 9, 2005 and September 8, 2006 and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;

5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments numbered 1, 2, 3, and 4; and site visit information is found in Attachments numbered12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective	June-August, 2006	

Activity	Timeline	Documents/Content
Actions		
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	August 9, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	August 25, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	September 5, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	September 26, 2006	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	October 27, 2006	
2. Complete initial scoring and results documentation; construct report	October 25, 26, 2006	
3. Draft report to PIHP	October 27, 2006	
4. Debrief conference call	November 8, 200	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	November 15, 2006	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested

documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Grays Harbor PIHP submitted a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Grays Harbor PIHP, significant events include:

- Grays Harbor began delegating inpatient and outpatient utilization management to a private, for profit vendor in October, 2005. This delegation required compliance with BBA regulations regarding pre-delegation assessment and ongoing oversight.

- The PIHP instituted a significant change in its fee for service reimbursement system, which has had a normalizing impact on utilization

- The PIHP has been working with the jail, the Community Services Office (CSO) and a provider to expedite establishing Medicaid eligibility for inmates returning to the community and enhancing case management prior to release. The result has been fewer people returning to jail.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- Grays Harbor did not submit narrative materials for either PIP, or any recent data related to indicators they had been tracking in 2005. APS was therefore unable to validate a PIP for this PIHP.

- The PIHP submitted very few documents supporting their clinical review activities, including any that addressed follow-through with corrective action requests. While the PIHP and the provider interviewed attested to the occurrence of these activities, the paper trail was unavailable for confirmation.

- The policies and procedures submitted for review contained a place holder for an "Approval" signature; instead of a signature; however, the PIHP Administrator's name was typed in the space. Consequently, the WAEQRO was unable to determine whether all policies and procedures submitted for review had been officially adopted and approved. They were, however, considered in the scoring.

- The PIHP's sample network provider contracts submitted for review were missing title, date, and signature pages. The time period covered under contract was only one month, September 1, 2006 to September 30, 2006. The WAEQRO was unable to determine if the contract references were from an officially executed contract and pertained to the period under review. The sample contract, however, was considered in scoring the Subparts.

- Evidence submitted for the Subpart review was limited with respect to PIHP and provider network staff training as well as implementation of policies and procedures. Therefore, WAEQRO was challenged in determining whether these policies and procedures have been put into practice.

- One network provider (the larger of their two) was unprepared for the scheduled WAEQRO site visit and had no management staff available at the appointed time. As a result, this provider was not interviewed, and scoring is based on information provided by the smaller agency. Fortunately, this smaller agency is well-managed and was able to provide good information for the reviewers.

4. 2006 Review Results

This report provides results and a summary of Grays Harbor PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Grays Harbor PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.206 (b)(3) [Q21]	**Systematic method of accessing a second opinion throughout service delivery system**			
	Policy does not specifically include procedures related to access to a second opinion and does not identify mechanisms to ensure that this is accomplished in a systematic way throughout the PIHP's system of care.	Submit a corrective action plan to the MHD by 4/29/05	Revised CAP requested by MHD on 5/25/05 Submitted by PIHP 6/21/05	Revised Availability and Sufficiency of Services policy and procedures include basic requirements of this provision. PIHP has attained a score of **3-Moderate Compliance**.
438.206 (b)(4) [Q22]	**PIHP has out-of-network policy and procedures, and subcontractors are making referrals as needed**			
	No evidence of a policy or mechanism that ensures the PIHP will purchase medically	Submit a corrective action plan to the MHD by 4/29/05	Revised CAP requested by MHD on 5/25/05 Submitted by PIHP 6/21/05	Revised Availability and Sufficiency of Services policy and procedures contains partial requirements of

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	necessary mental health services outside the provider network if no provider within the network is able to serve the enrollee.			this provision. Policy does not include procedures for out-of-network referrals, or documentation and coordination of care requirements. PIHP has attained a score of **1-Insufficient Compliance**.
438.210(b) [Q40]	**Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise**			
	Evidence indicated the PIHP requires that authorization decisions be made by Mental Health Professionals as defined in WAC 388-0865-0150 as per their newly drafted Utilization Management Decision and Notification Timelines policy and procedure. Network providers had not yet received comprehensive training on these standards at time of review.	Submit a corrective action plan to the MHD by 4/29/05	Revised CAP requested by MHD on 5/25/05 Submitted by PIHP 6/21/05	Revised Access to Outpatient Services and Authorization policy and procedures contains requirements to ensure authorizations are conducted by Mental Health Professionals with appropriate clinical expertise. Unable to verify credentials of individuals authorizing services, and if MHP requirement is practiced. PIHP has attained a score of **2-Partial Compliance**.
438.230(b) [Q52]	**Evaluation of Subcontractor ability to perform delegated functions**			
	No evidence	Submit a	Revised CAP	Revised Delegation

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CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	provided to demonstrate PIHP conducted pre-delegation assessment of prospective subcontractor's ability to perform the activities to be delegated: provision of enrollee information, initial assessment and determination of medical necessity, inpatient and outpatient authorization of services and/or utilization management functions.	corrective action plan to the MHD by 4/29/05	requested by MHD on 5/25/05 Submitted by PIHP 6/21/05	and Sub-contractual Relations policy and procedures includes process for evaluating prospective subcontractor's ability to perform PIHP delegated functions. Unable to determine if policy is implemented for all subcontractors currently performing PIHP delegated functions. PIHP has attained a score of **2-Partial Compliance**.
438.242	**Health Information Systems**			
	No evidence that PIHP and its providers have reports that are used to verify the accuracy of the data submitted.	Submit a corrective action plan to the MHD by 4/29/05	Submitted by PIHP 6/22/05 Accepted by MHD 7/15/05	The PIHP was in the process of implementing a new system at the time of the 2005 review. They now have ample reports and use them to verify the accuracy of their data submitted.
438.242	**Health Information Systems**			
	No evidence that there are ample controls over the screening of the	Submit a corrective action plan to the MHD by		The PIHP now has adequate controls over the screening of their data for

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	data for completeness, logic and consistency.	4/29/05		completeness, logic and consistency in their pre-submission screening process. However, the PIHP does need to develop a plan to analyze their dataset as a whole to screen for completeness, logic and consistency.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks. (See, Attachment #11, Subpart Documentation Request) Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of Expected performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F
- A score of 1 for Subpart H

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Grays Harbor PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

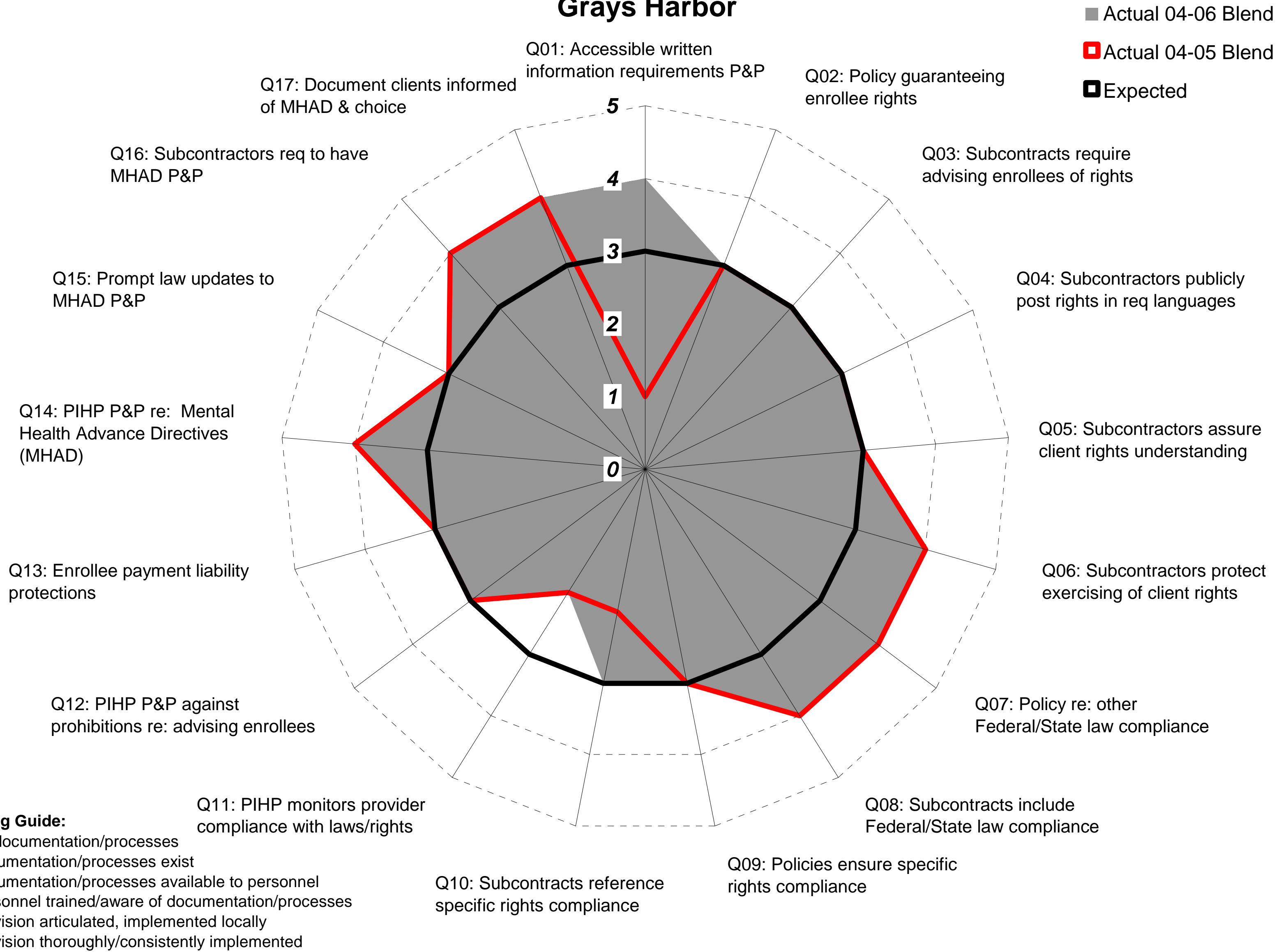
For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.

Subpart C: Enrollee Rights & Protections

Grays Harbor



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Grays Harbor

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
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4: Provision articulated, implemented locally
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Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	1	4	4
Q02: Policy guaranteeing enrollee rights	3		3
Q03: Subcontracts require advising enrollees of rights	3		3
Q04: Subcontractors publicly post rights in req languages	3		3
Q05: Subcontractors assure client rights understanding	3		3
Q06: Subcontractors protect exercising of client rights	4		4
Q07: Policy re: other Federal/State law compliance	4		4
Q08: Subcontracts include Federal/State law compliance	4		4
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	2	3	3
Q11: PIHP monitors provider compliance with laws/rights	2	2	2
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	3		3
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	4		4
Q17: Document clients informed of MHAD & choice	4		4

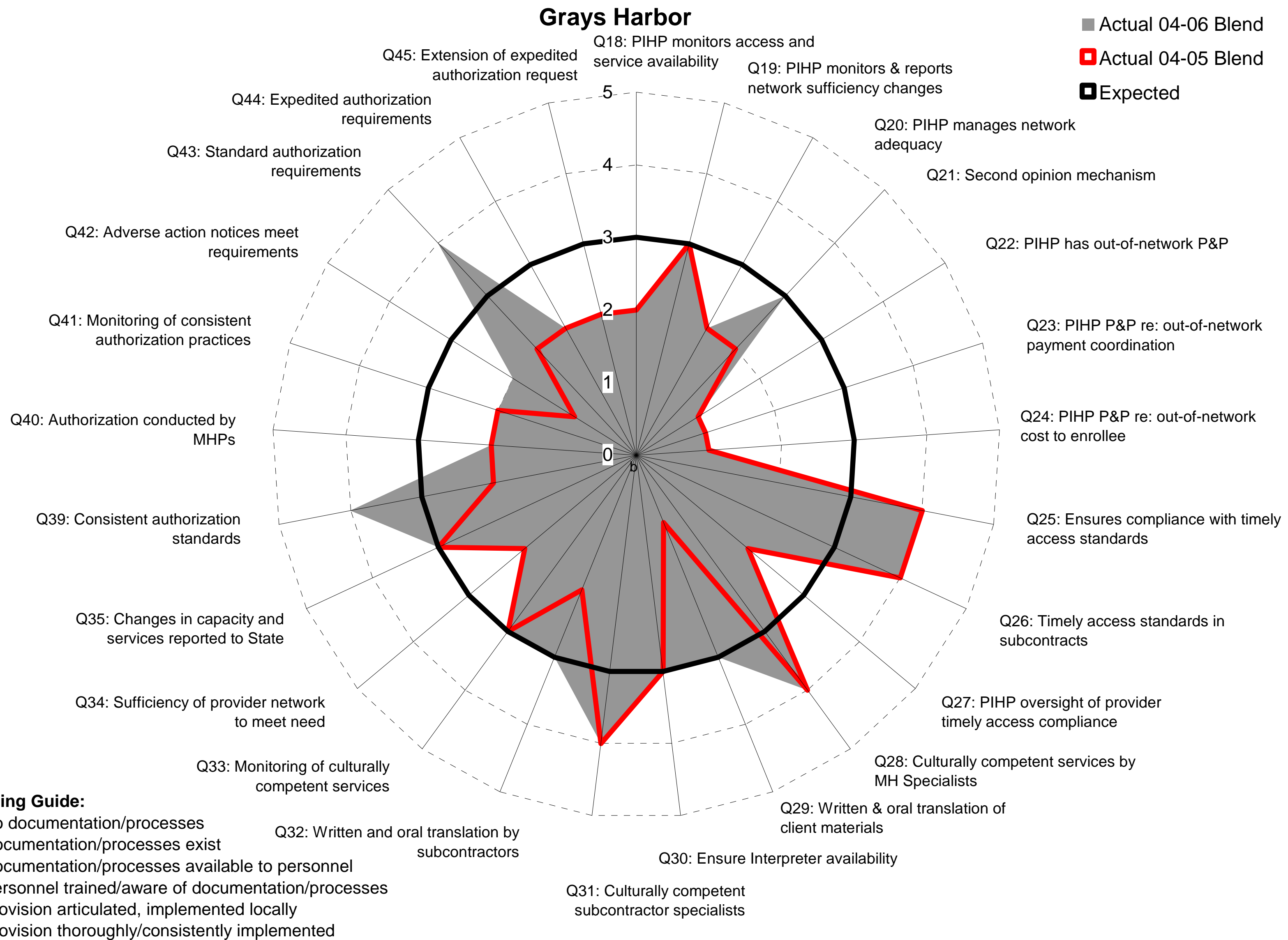
Grays Harbor PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
438.10	**Information Requirements**	
[Q1]	**Written policies and procedures addressing accessible information requirements** Evidence: • Revised Enrollee Information Requirements policy and procedures contain the requirements of this provision. • Policy needs clarification of written translation requirements • DSHS Public Mental Health System Benefits Booklet translated in DSHS required languages • PIHP expects providers to have DSHS benefit booklet available to consumers in all required languages. • Network provider direct service staff able to articulate understanding of the requirements and implementation of this provision. (Substantial Compliance)	4
438.100(d)	**Compliance with Other Federal and State Laws**	
[Q10]	**Subcontracts require compliance with a client's right to a second opinion, involvement in their mental health treatment, and access to clinical records** Evidence: • PIHP Network provider contracts contain requirements to ensure a client's right to a second opinion, involvement in their mental health treatment and access to their clinical record. • Trainings related to access to a second opinion and client participation in treatment (recovery and resiliency trainings) have occurred in formal and informal venues during review period. • No specific training for client access to clinical record or client right to amend record • Direct service staff described treatment and crisis plan documentation, as well as the use of session rating scales to illustrate how consumers participate in treatment planning and decisions. • Provider direct service staff knowledgeable about clients' rights to a second opinion, not clear on implementation steps. • Direct service staff reported they would contact medical records staff if client requested access to their clinical record.	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	• Provider management reported PIHP monitors for client participation in treatment during the onsite clinical chart reviews. • Don't know how the PIHP monitor's for client access to a second opinion and their clinical record. (Moderate Compliance)	3
[Q11]	**PIHP monitors subcontractor compliance with Federal and State laws and client rights** Evidence: • Revised Enrollee Rights-Compliance with Other Federal and State Laws policy and procedure • Policy requires the following monitoring mechanisms for this provision: o licenses and personnel files o ADA self evaluation o complaints and grievances o QRT site review results o any other relevant review or report • Policy does not address PIHP monitoring provider's compliance with the 3 client rights. • Two completed Provider Contract Compliance Checklist-FY 2005, checklists show agencies completed ADA self evaluations • No evidence of monitoring other discrimination laws or 3 client rights listed above in this provision. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2

Subpart D (Part 1): Access Standards



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5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Grays Harbor

Scoring Guide for Subparts C, D and F:
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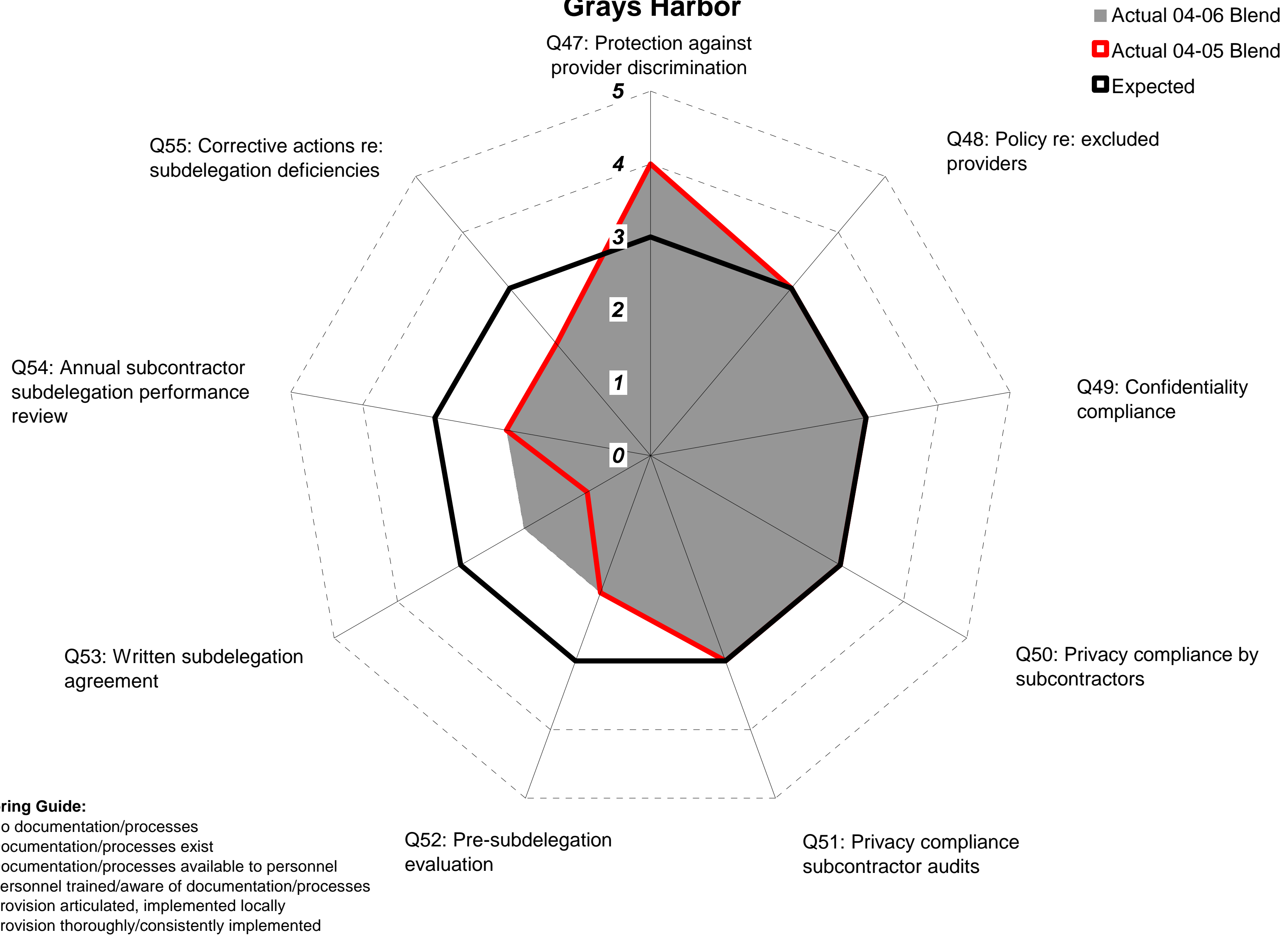
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	2	2	2
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	2	2	2
Q21: Second opinion mechanism	2	3	3
Q22: PIHP has out-of-network P&P	1	1	1
Q23: PIHP P&P re: out-of-network payment coordination	1	1	1
Q24: PIHP P&P re: out-of-network cost to enrollee	1	1	1
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	4		4
Q27: PIHP oversight of provider timely access compliance	2	2	2
Q28: Culturally competent services by MH Specialists	4		4
Q29: Written & oral translation of client materials	1	3	3
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	4		4
Q32: Written and oral translation by subcontractors	2	3	3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	2	2	2
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	2	4	4
Q40: Authorization conducted by MHPs	2	2	2
Q41: Monitoring of consistent authorization practices	2	2	2
Q42: Adverse action notices meet requirements	1	2	2
Q43: Standard authorization requirements	2	4	4
Q44: Expedited authorization requirements	2	2	2
Q45: Extension of expedited authorization request	2	2	2

Subpart D (Part 2): Structure and Operation Standards

Grays Harbor



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3: Personnel trained/aware of documentation/processes
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2004-2006 Subpart Scoring Trend and Detail for
Grays Harbor

Scoring Guide for Subparts C, D and F:
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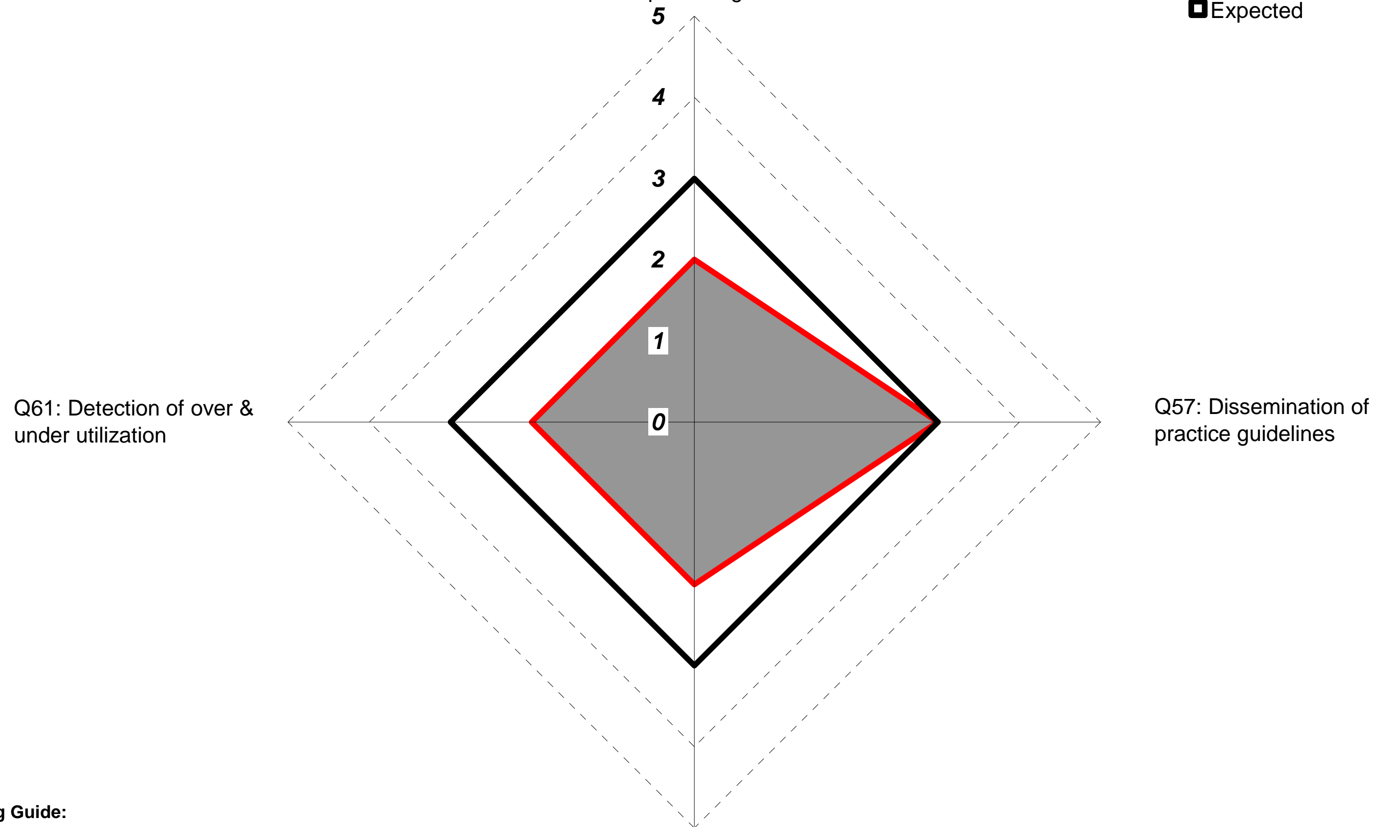
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	4		4
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	3		3
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	3		3
Q52: Pre-subdelegation evaluation	2	2	2
Q53: Written subdelegation agreement	1	2	2
Q54: Annual subcontractor subdelegation performance review	2	2	2
Q55: Corrective actions re: subdelegation deficiencies	2	2	2

Subpart D (Part 3): Measurement and Improvement Standards



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2004-2006 Subpart Scoring Trend and Detail for
Grays Harbor

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3: Personnel trained/aware of documentation/processes
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5: Provision thoroughly/consistently implemented

Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	2	2	2
Q57: Dissemination of practice guidelines	3		3
Q58: Application of practice guidelines	2	2	2
Q61: Detection of over & under utilization	2	2	2

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (b)(1)	**Availability of Services**	
[Q18]	**PIHP monitors access and service availability** Evidence: • Revised Availability and Sufficiency of Services policy and procedures and revised Quality Management Plan include PIHP mechanisms to monitor availability of services and sufficient access. • Geo-Access Report-annually PIHP monitors the geographic location of providers and enrollees through considering distance, travel time, and the means of transportation • PIHP ensures service sites are accessible within a 60 minute commute time • Provider ADA self evaluation report verifying physical access submitted at start of each contract • Network provider monthly caseload reports • Provider management unaware of mechanisms PIHP employs to determine providers are geographically accessible to enrollees. • Provider management unaware if PIHP monitored for sufficient access and capacity in the last year. • No evidence of training related to this review element • PIHP was not able to show documented evidence of Network adequacy guidelines or standards, and were not able to show evidence of a methodical quality improvement process associated with access and availability of services that is currently being implemented. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q20]	**Response to changes in population served, network providers, and gaps in services** Evidence: • Revised Availability and Sufficiency of Services policy and procedures and revised Quality Management Plan include mechanisms PIHP utilizes to monitor availability of services and sufficient access. • Geo-Access Report	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Network provider monthly caseload reports • PIHP was not able to show documented evidence of Network adequacy guidelines or standards and were not able to show evidence of a methodical quality improvement process associated with access and availability of services that is currently being implemented. • PIHP staff and provider management unable to articulate an understanding of the PIHP's strategy for monitoring, and implementing network sufficiency and capacity quality improvements. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.206 (b)(3)	**Delivery Network-Second Opinion**	
[Q21]	**Systematic method of accessing a second opinion throughout service delivery system** Evidence: • Revised <u>Availability and Sufficiency of Services</u> policy and procedures includes basic requirements for clients' rights to access a second opinion. • PIHP provider contracts require providers' adherence to PIHP policies and procedures. • According to provider management, trainings related to access to a second opinion have occurred informally during Provider Collaboration Meetings during. • Provider direct service staff knowledgeable about clients' rights to a second opinion, not clear on implementation steps. • No evidence showing second opinion assessments, tracking logs, related training or monitoring activities submitted for review. (Moderate Compliance)	3
438.206 (b)(4)	**Delivery Network-Out of Network Providers**	
[Q22]	**PIHP have out-of-network policy and procedures, and subcontractors are making referrals as needed** Evidence: • Revised <u>Availability and Sufficiency of Services</u> policy and procedures contains partial requirements related to out of network providers. • Policy does not include procedures for out-of-network referrals, or documentation and coordination of care requirements.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• No evidence of out-of-network service contracts, service reports, invoices, training, or related monitoring activities • Provider management aware they are responsible for accessing out-of network services if unable to provide medically necessary covered services to a Medicaid enrollee. • Direct service staff reported not knowing procedures for making out-of-network referrals; would supervisor for assistance. • No evidence of training related to this review element • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
438.206 (b)(5)	**Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment**	
[Q23]	**Out-of-network policy and procedures include coordination with respect to payment** Evidence: • Revised <u>Availability and Sufficiency of Services</u> policy and procedures contain partial requirements related to coordination of payment with out of network providers. • Policy does not include specific procedures with respect to coordination of payment • Provider management is aware they are responsible to pay for out-of network services if unable to provide medically necessary covered services to a Medicaid enrollee. • Provider management state that out-of-network services are usually coordinated and paid for by PIHP. • Policy and practice appear to be inconsistent • No evidence of training related to this review element • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
[Q24]	**Cost of out-of-network provider is no greater for enrollee than services furnished within network** Evidence: • Revised <u>Availability and Sufficiency of Services</u> policy and procedures require costs for out-of-network services be no greater for the enrollee than services furnished within network. • No monitoring methods outlined in policy and no examples of monitoring mechanisms employed by PIHP to monitor this provision were submitted for review. • PIHP staff knowledgeable of requirement to review providers' financial management to ensure Medicaid enrollees are not charged for within or out-of network services. Have been met	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	with resistance from one provider and have not accomplished this yet. • No evidence of training related to this review element. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
438.206 (c)(1)	**Furnishing of Services**	
[Q27]	**PIHP oversight of subcontractor compliance with timely access standards** Evidence: • Revised Timely Access for Authorizations policy and procedures includes requirements associated with standards for timely access. • No monitoring reports or review activities identified in policy were submitted for review. Unable to determine if policy is being implemented. • Provider management report PIHP conducted a chart audit that included a review of timely access in last 2 weeks. Have not yet received PIHP verbal or written report. Uncertain as to what report will include, no guidelines or expectations discussed prior to review. • No evidence of training related to this review element. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.206 (c)(2)	**Furnishing of Services - Continued**	
[Q29]	**Written and oral translation of client materials** Evidence: • Revised Enrollee Information Requirements policy and procedures contain requirements for written and oral translation of client materials. • Policy unclear about written translation requirements; policy states client materials are to be translated in Spanish only and also states client materials must be translated in the DSHS required languages. • Relevant PIHP provider contract language provides some clarification to expectations in policy. • DSHS Public Mental Health System Benefits Booklet translated in DSHS required languages • Provider management report client rights, grievance	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	procedures, HIPAA privacy practices and DSHS benefits booklet must be available to clients in required DSHS languages. • Direct service staff able to articulate languages that must be available in oral translation and how to access interpreters including American Sign Language interpreters. • PIHP reported one provider has required client materials in all required DSHS languages, the other has English and Spanish only. PIHP states that due to inconsistency in WAC it is difficult to hold providers accountable to all DSHS required languages. (Moderate Compliance)	3
[Q32]	**Client materials translated according to WAC 388-865-0330 requirements related to language thresholds** Evidence: • Revised Enrollee Information Requirements policy and procedures contain requirements for written and oral translation of client materials. • Policy unclear about written translation requirements; policy states client materials are to be translated in Spanish only and also states client materials must be translated in the DSHS required languages. • Relevant PIHP provider contract language provides some clarification to expectations in policy. • DSHS Public Mental Health System Benefits Booklet translated in DSHS required languages • Provider management report client rights, grievance procedures, HIPAA privacy practices and DSHS benefits booklet must be available to clients in required DSHS languages. • Direct service staff able to articulate languages that must be available in oral translation and how to access interpreters including American Sign Language interpreters. • PIHP reported one provider has required client materials in all required DSHS languages; the other has English and Spanish only. PIHP states that due to inconsistency in WAC it is difficult to hold providers accountable to all DSHS required languages. (Moderate Compliance)	3
438.207	**Assurances of Adequate Capacity and Services**	
[Q34]	**Sufficient number, mix and geographic distribution of Network Providers to meet anticipated need** Evidence: • Revised Availability and Sufficiency of Services policy and procedures and revised Quality Management Plan include	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	PIHP mechanisms to monitor availability of services and sufficient access. • <u>Geo-Access Report</u>-annually PIHP monitors the geographic location of providers and enrollees through considering distance, travel time, and the means of transportation • PIHP ensures service sites are accessible within a 60 minute commute time • Provider ADA self evaluation report verifying physical access submitted at start of each contract • Network provider monthly caseload reports • Provider management unaware of mechanisms PIHP employs to determine providers are geographically accessible to enrollees. • Provider management unaware if PIHP monitored for sufficient access and capacity in the last year. • No evidence of training related to this review element • PIHP was not able to show documented evidence of Network adequacy guidelines or standards, and were not able to show evidence of a methodical quality improvement process associated with access and availability of services that is currently being implemented. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.210(b)	**Authorization of Services**	
[Q39]	**Authorization is consistent with Access to Care Standards and takes place in consultation with requesting provider** Evidence: • In combination, revised <u>Access to Outpatient Services and Authorization</u> policy and procedures and <u>GHRSN PIHP SMHC Access to Care Standards</u>, contain requirements to ensure authorization is consistent with Access to Care Standards. • On-going training conducted by provider management in conjunction with electronic record (Avatar) development and upgrades. • Network provider staff have knowledge of the Access to Care Standards and how they are employed with regard to authorization of services. • PIHP sub-delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. • PIHP has not reviewed BHO for inter-rater reliability of UM decisions. (Substantial Compliance)	4

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
[Q40]	**Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise** Evidence: • Revised Access to Outpatient Services and Authorization policy and procedures contains requirements to ensure authorizations are conducted by Mental Health Professionals with appropriate clinical expertise. • As per PIHP provider contract, PIHP requires intake assessments to be conducted by Mental Health Professionals. • PIHP sub-delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. • PIHP has not reviewed BHO for inter-rater reliability of UM decisions. • No copies of authorizations, or credentials of professionals performing authorizations submitted for review; unable to verify credentials of individuals authorizing services, and if MHP requirement is practiced. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q41]	**PIHP audits subcontractors for consistent authorization practices and evidence of policy** Evidence: • Revised Access to Outpatient Services and Authorization policy and procedures requires a monthly 10% clinical record review to monitor for consistent application of Access to Care Standards and authorization practices. • PIHP sub-delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. • PIHP has not reviewed BHO for inter-rater reliability of UM decisions. • No copies of authorizations or clinical record review reports submitted for review of this element. • No evidence of training for PIHP, BHO or provider network staff. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • Revised Notice of Action (NOA) policy and procedures include all requirements of this provision.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Sample NOA form letter stipulates enrollee's right to appeal, and includes all other required information • No copies of actual NOA letters submitted for review; unable to determine if PIHP is complying with required timeframes • PIHP reports BHO (Utilization Management Subcontractor) tracks denials and NOAs; no tracking logs submitted for review. • Majority of provider direct service staff unfamiliar with NOAs and related timeframes. • No related QA&I activities submitted for review. (Partial Compliance)	2
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • Revised Access to Outpatient Services & Authorization policy and procedures contains procedures for standard authorization decisions. • No evidence of training for PIHP, BHO or provider network staff. • Network provider management and direct service staff able to articulate requirements of this provision and standard authorization practices of this PIHP. • No copies of authorizations or authorization Request/Response tracking data (Substantial Compliance)	4
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Revised Access to Outpatient Services & Authorization policy and procedures contains procedures for expedited authorization decisions • No evidence of training for PIHP, BHO or provider network staff. • Provider direct service staff unable to articulate understanding of expedited authorizations and how they may be practiced in this PIHP. • No copies of expedited authorizations or expedited authorization Request/Response tracking data. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q45]	**Extension of expedited authorization request** Evidence: • Revised Access to Outpatient Services & Authorization policy	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	and procedures contains procedures for extension of expedited authorization decisions • No evidence of training for PIHP, BHO or provider network staff. • Provider direct service staff unfamiliar with extensions of expedited authorizations and how they may be practiced in this PIHP. • No copies of expedited authorizations, extensions or expedited authorization Request/Response tracking data. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.210(e)	**Compensation for Utilization Management Activities**	
[Q46]	**Protections against financial incentives for authorization decisions** Evidence: • Revised Access to Outpatient Services & Authorization and Performance Improvement-Clinically Appropriate Care and Utilization Management policies and procedures include language to protect against financial incentives for authorization decisions. • As reported by the PIHP in the 2006 WAEQRO Information Request Update, payment to BHO (UM sub-delegate) is based on 14,000 members at $.35 per member per month. This payment methodology minimizes the risks of financial incentives related to authorizing or denying an individual enrollee's care and services. • No QA&I activities or reports related to this review element submitted for review. (Moderate Compliance)	3
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • Revised Delegation and Sub-contractual Relations policy and procedures includes process for evaluating prospective subcontractor's ability to perform PIHP delegated functions. • Pre-Delegate Audit, dated10/01/05; audit findings and recommendations contain only the word "yes" for each audit element. No description is included as to who was audited (based on questions, appears to be BHO-UM subcontractor),	

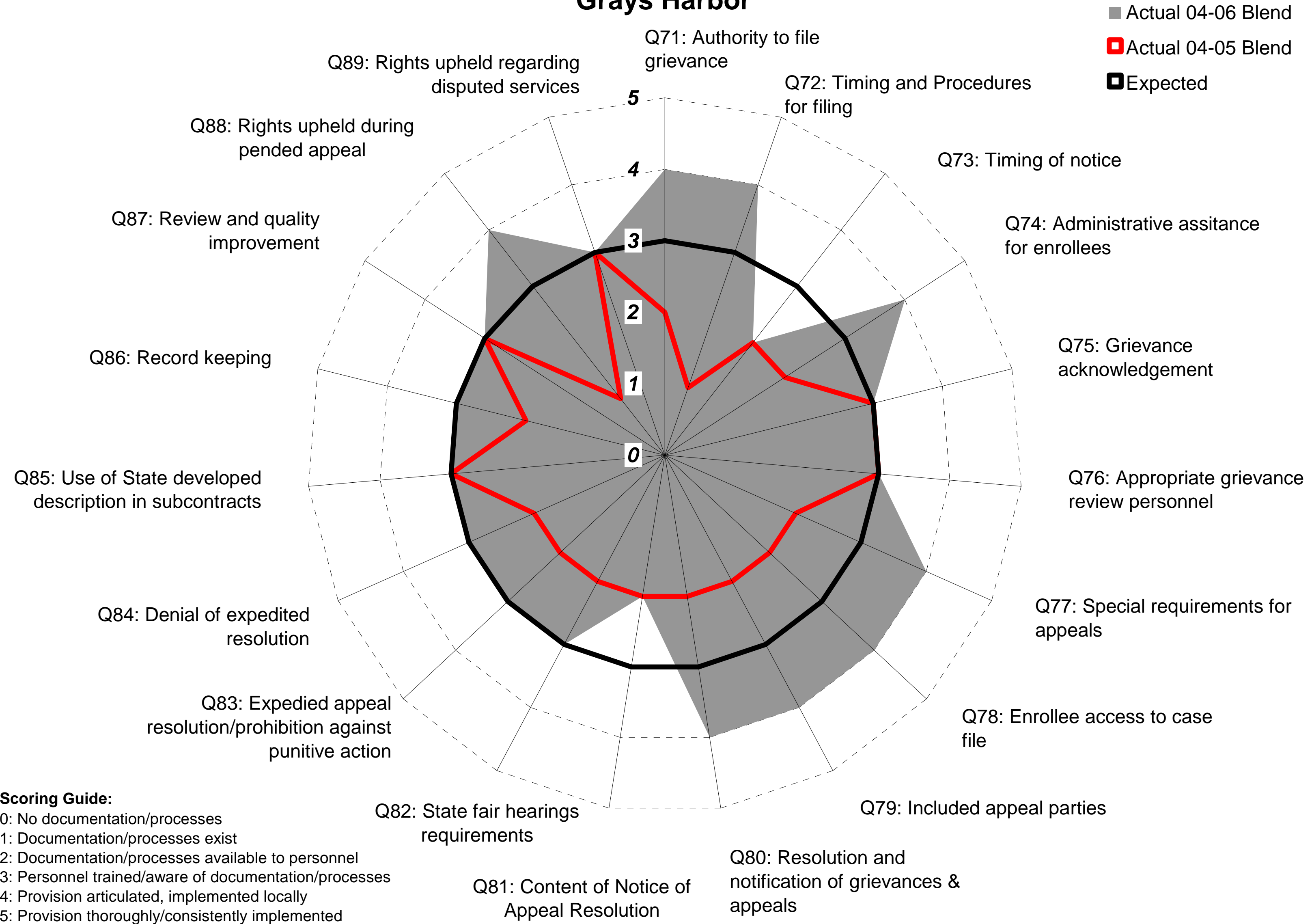
CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	who participated or conducted the audit, how it was conducted, evidence supporting each score, or recommendations for quality improvements. • No other pre-delegate audits for additional sub-delegates were submitted for review. • Unable to determine if Delegation and Sub-contractual Relations policy is implemented with PIHP's Netsmart Technologies (PIHP's MIS vendor), who houses PIHP's data and submits it to MHD. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • Revised Delegation and Sub-contractual Relations policy and procedures contains requirements for written delegation agreements • BHO Contract & Delegation Agreement and separate Attachment-attachment has no name, date or identifier, unable to determine when it went into effect. This is significant in that the requirements of this provision are contained in the attachment. • No written agreement between the PIHP and Netsmart Technology was submitted for review, therefore unable to determine if agreement meets requirements of this provision. (Partial Compliance)	2
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • Revised Delegation and Sub-contractual Relations policy and procedures specifies monitoring activities related to subcontractor performance of delegated functions. • BHO Contract Attachment outlines specific PIHP monitoring activities; unable to determine if attachment was in effect during review period. • No annual performance review or monitoring activities of BHO, other than the Pre-Delegate Audit, were submitted for review. • No annual performance review or other monitoring activities of Netsmart Technologies was submitted for review; unable to determine if PIHP is monitoring the performance of Netsmart on a regular basis. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	(Partial Compliance)	2
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • Revised Delegation and Sub-contractual Relations policy and procedures specifies the PIHP will identify subcontractor deficiencies associated with delegated functions and institute corrective actions if warranted. • BHO Contract Attachment includes language addressing potential corrective actions; unable to determine if attachment was in effect during review period. • No annual performance review or other monitoring activities of Northwest Technologies or BHO were submitted for review; unable to determine if PIHP is monitoring the performance of these subcontractors on a regular basis. Also unable to determine if the PIHP has imposed any quality improvements or corrective actions. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.236	**Practice Guidelines**	
[Q56]	**Adoption of practice guidelines meets established requirements** Evidence: • Practice Guidelines policy and procedures include the basic requirements of this provision. • Practice Guideline Implementation and Auditing Plan-lists timelines, responsible parties and duties, unable to determine if plan is in effect. • Provider Collaboration Meeting minutes at which Disruptive Behavior and OCD Practice Guidelines developed by local network providers were adopted. • Disruptive Behavior and OCD Practice Guidelines need clinical detail at critical decision junctures, currently are graphic flow chart diagrams, are difficult to follow, lack clinical guidance and detail, and appear incomplete. • No evidence of related training • Provider direct service staff able to name the adopted guidelines; have no adults with OCD and have not been trained on guidelines; report Disruptive Behavior guideline still under development. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	(Partial Compliance)	2
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • Practice Guidelines policy and procedures include the basic requirements of this provision. • PIHP staff not sure if provider direct service staff have been trained on the adopted practice guidelines; not sure the guidelines are being practiced at providers. • PIHP has not begun clinical monitoring of adopted practice guidelines. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.240	**Quality Assessment and Performance Improvement Program**	
[Q61]	**Effective mechanisms to detect under and over utilization** Evidence: • Performance Improvement Program outlines mechanisms in utilized to detect under and over utilization. Includes: o Clinical record review of 10% clients served annually o Inpatient, outpatient, crisis and stabilization services, hospital diversion, high service utilizers, consumers who have filed grievances, consumers identified in "critical incidents", sampling of minority and ethnic consumers, and sampling of age groups, as well as other enrollees and programs either on a random or targeted basis • Revised Quality Management Plan lists mechanisms and reports used to detect under and over utilization: o Hospitalization and crisis utilization reviews (twice monthly), authorizations, renewals, exceptions and extension requests for services, MIS/CIS reports, provider quarterly reports, fiscal reports, complaints, grievances, critical incidents and Ombuds reports, QRT activities and reports. o QM Plan indicates specific cases of over or under utilization will be addressed as they occur. If provider specific patterns are noted, they will be addressed in written feedback to the provider, along with appropriate corrective actions if required. • Submitted reports included: BHO UM 2006 Report, Crisis Clinic Statistics-July 2006, Children Services Report-June2006, Adult Services Report-July 2006 and a sample Pending	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	Outpatient Authorization. • PIHP gathers a wide range of utilization data on a variety of populations, there was no analysis of the data describing trends of utilization; no information on related QA&I activities. Unable to determine how PIHP is using utilization data to monitor and manage appropriate levels of care. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2

Subpart F: Grievance System
Grays Harbor



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Grays Harbor

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	2	4	4
Q72: Timing and Procedures for filing	1	4	4
Q73: Timing of notice	2	2	2
Q74: Administrative assitance for enrollees	2	4	4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	2	4	4
Q78: Enrollee access to case file	2	4	4
Q79: Included appeal parties	2	4	4
Q80: Resolution and notification of grievances & appeals	2	4	4
Q81: Content of Notice of Appeal Resolution	2	2	2
Q82: State fair hearings requirements	2	3	3
Q83: Expedied appeal resolution/prohibition against punitive action	2	3	3
Q84: Denial of expedited resolution	2	3	3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	2	3	3
Q87: Review and quality improvement	3		3
Q88: Rights upheld during pended appeal	1	4	4
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.402	**Grievance System and Filing Requirements**	
[Q71]	**Authority to file a grievance, appeal, or State fair hearing** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures indicate the PIHP has an enrollee grievance and appeal process, and access to the State's fair hearing system, with accurate filing, timing, authority, and procedural requirements of this provision. • Recommend clarifying policy language related to the CMHA filing an appeal on behalf of an enrollee, with the enrollee's written consent • List of PIHP trainings include Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Direct service staff able to articulate basic understanding of who can file a grievance and appeal. • Limited related QA&I activities submitted for review. (Substantial Compliance)	4
[Q72]	**Timing and Procedures for filing a grievance, appeal, or State fair hearing** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures and Grievance System Timelines attachment indicate the PIHP has an enrollee grievance and appeal process, and access to the State's fair hearing system, with accurate filing, timing, authority, and procedural requirements of this provision. • Recommend adding clarifying language to policy regarding who may submit a written signed request for a grievance or appeal. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Provider direct service staff able to articulate basic understanding of how to file a grievance and appeal and associated timeframes. • No related QA&I activities submitted for review. (Substantial Compliance)	4

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.404	**Notice of Adverse Action**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • Revised Notice of Action (NOA) policy and procedures include all requirements of this provision. • Sample NOA form letter stipulates enrollee's right to appeal, and includes all other required information • No copies of actual NOA letters submitted for review; unable to determine if PIHP is complying with required timeframes • PIHP reports BHO (Utilization Management Subcontractor) tracks denials and NOAs; no tracking logs submitted for review. • Majority of provider direct service staff unfamiliar with NOAs and related timeframes. • No related QA&I activities submitted for review. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.406	**Handling of Grievances and Appeals**	
[Q74]	**PIHP ensures enrollees are provided assistance in completing forms and taking procedural steps** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures incorporates language that ensures enrollees are provided reasonable assistance in completing forms and taking other procedural steps related to grievances and appeals. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Provider direct service staff able to articulate basic understanding assistance available to enrollees • Limited related QA&I activities submitted for review. (Substantial Compliance)	4
[Q77]	**Oral appeal inquiries treated as appeals; opportunity to present evidence and allegations of fact or law in person and in writing** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures incorporates requirements of oral appeals and enrollee's right to present evidence and allegations of fact or law in person and in writing.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	• Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Provider direct service staff able to articulate basic understanding of enrollee's right to present evidence during an appeal. • No related QA&I activities submitted for review. (Substantial Compliance)	4
[Q78]	**Enrollee and representative opportunity to examine case file, medical records, other documents related to appeal process** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures incorporates majority of requirements of this provision. • Recommend adding clarifying language policy reflecting that an enrollee's representative shall also have opportunity to review the enrollee's medical record and other relevant documentation. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Provider direct service staff able to articulate basic understanding of enrollee's right to examine their medical record and other appeal related documents. • No related QA&I activities submitted for review. (Substantial Compliance)	4
[Q79]	**Included parties to the appeal** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures stipulate parties to the appeal may include the enrollee and his/her representative; or the legal representative of a deceased enrollee's estate. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Provider direct service staff able to articulate parties that can be included in an appeal. • No related QA&I activities submitted for review. (Substantial Compliance)	4
438.408	**Resolution and Notification of Grievances and Appeals**	

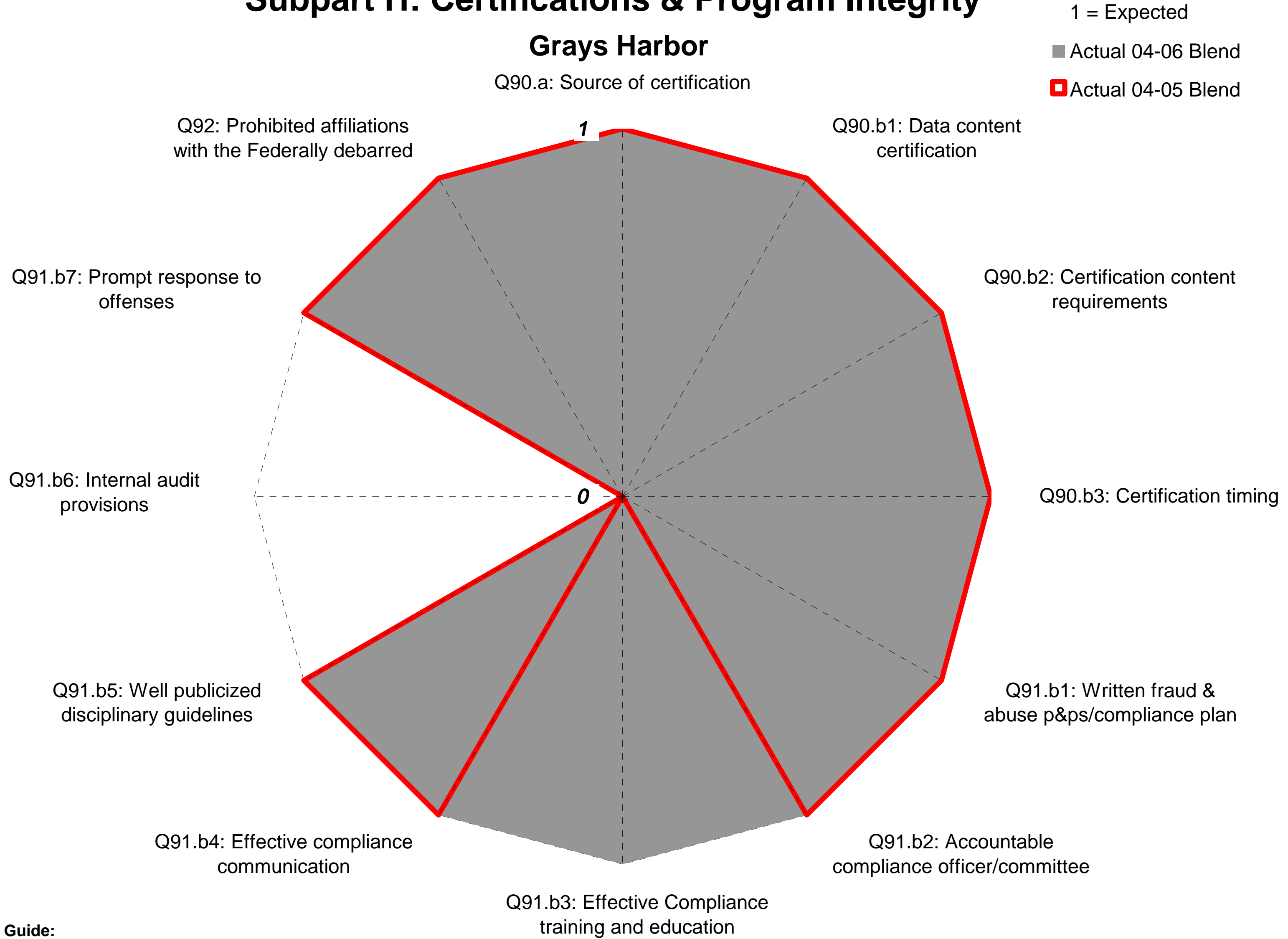
CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
[Q80]	**Resolution and notification for grievance and appeals** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures include PIHP mechanisms established to meet all requirements to dispose of grievances and resolve each appeal, provide notice with format requirements, expeditiously as the enrollee's health condition requires, within State established timeframes including extension of timeframes and associated requirements. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Provider direct service staff able to articulate basic understanding of resolution and notification process for grievances and appeals. • Limited related QA&I activities submitted for review. (Substantial Compliance)	4
[Q81]	**Content of Notice of Appeal Resolution** Evidence: • Only document submitted for review of this element, BHO NOA Template, has no relevance to the requirements of this provision. • Revised Grievance Systems: Structure and Operations policy and procedures do not incorporate the requirements of this provision. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q82]	**State fair hearings requirements** Evidence: • Only document submitted for review of this element, BHO NOA Template, has no relevance to the requirements of this provision. • Relevant language discovered in the revised Grievance Systems: Structure and Operations policies and procedures accurately stipulating the State Fair Hearings requirements. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Majority of provider direct service staff indicated they did not have a clear understanding of State Fair Hearings and their purpose.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	• No related QA&I activities submitted for review. (Moderate Compliance)	3
438.410	**Expedited Resolution of Appeals**	
[Q83]	**Expedited resolution of appeals and assurance of no punitive action** Evidence: • Revised Grievance Systems: Structure and Operations and Notice of Action policies and procedures, and BHO NOA Template collectively contain language that adequately incorporates the requirements of this provision. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Direct service staff unable to articulate basic requirement of this provision. • No related QA&I activities submitted for review. (Moderate Compliance)	3
[Q84]	**Denial of expedited resolution** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures specify actions to be implemented following a denial of a request for expedited resolution, including prompt oral notice of the denial to the enrollee with a written notice to follow within two (2) calendar days and transfer of the appeal to the timeframe for standard resolution. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Direct service staff unable to articulate basic requirement of this provision. • No related QA&I activities submitted for review. (Moderate Compliance)	3
438.416	**Record Keeping and Reporting Requirements**	
[Q86]	**Mechanism to maintain records of grievances and appeals** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures indicate the PIHP and the network providers maintain records of all grievances, appeals and fair hearings in a separate confidential file from the enrollees' clinical record.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	• Complaint and Grievance Resolution Log • Multiple examples of communications between PIHP, network providers and allied service organizations demonstrating complaint resolution process. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Majority of direct service staff did not know where grievance, appeal and fair hearing records are filed and stored. (Moderate Compliance)	3
438.420	**Continuation of Benefits while the PIHP Appeal and the State Fair Hearing are Pending**	
[Q88]	**Continuation of benefits while the appeal and State fair hearing are pending** Evidence: • Revised Grievance Systems: Structure and Operations policy and procedures contains language to ensure the continuation of benefits during the time an appeal or State fair hearing is pending. • Grievance System training on 10-11-05, no attendance rosters, agenda, PowerPoint, or curriculum submitted for review • Network provider direct service staff reported participating in grievance system training during the review period. • Provider direct service staff able to articulate basic understanding that enrollees' benefits continue pending the resolution of an appeal or State fair hearing. • No related QA&I activities submitted for review. (Substantial Compliance)	4

Subpart H: Certifications & Program Integrity

Grays Harbor



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for
Grays Harbor

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	0	1	1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	0	0	0
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source Content and Timing Certifications**	
[Q90.a]	a) Evidence of certifications. (Compliance)	1
[Q90.b1]	(b) Content Certification (1) To the accuracy, completeness and truthfulness of the data. (Compliance)	1
[Q90.b2]	(2) To the accuracy, completeness and truthfulness of the documents specified by the State. (Compliance)	1
[Q90.b3]	(3) Timing of the certification. (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b3]	**Effective training for Compliance Officer and employees** Evidence: • Requirement for effective training and education for the compliance officer, and PIHP and provider network employees is present in the PIHP's revised Medicaid Fraud and Abuse policy and procedures. • 3 Power Point Compliance Program Trainings produced and conducted by MHD, PIHP and providers during review period. • Training attendance rosters (Compliance)	1
[Q91.b6]	**Provisions for internal monitoring** Evidence: • New draft of RSN Medicaid Fraud and Medicaid Abuse Internal Audit Plan • Emails from approval agents, approving draft of plan • Internal Audit Plan refers to an attached Risk Assessment; unable to locate • Internal Audit Plan includes PIHP review of network providers and does not include the review and monitoring of the internal processes at the PIHP to detect and prevent potential fraud and abuse. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.	

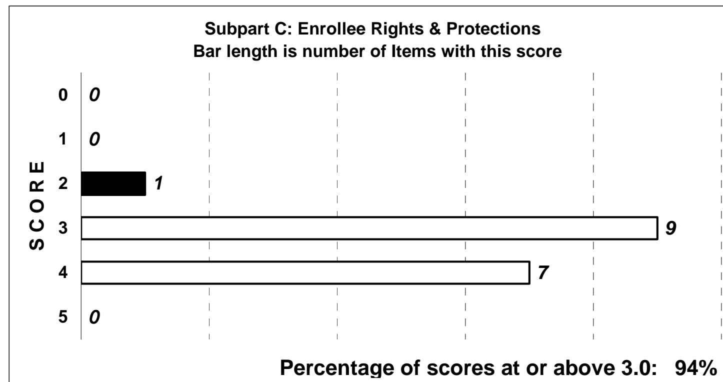
(No Compliance)	0

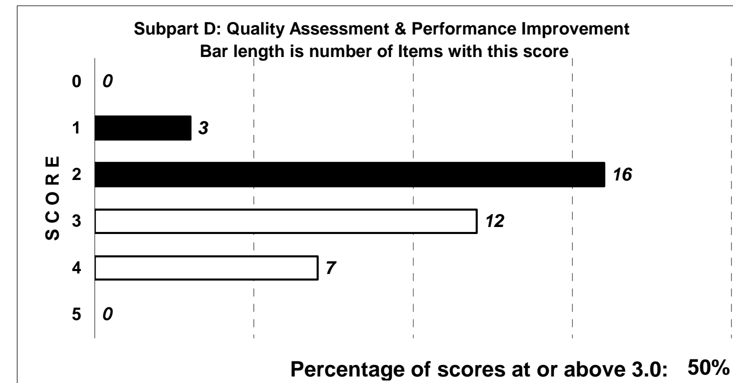
Scoring Frequency Overview

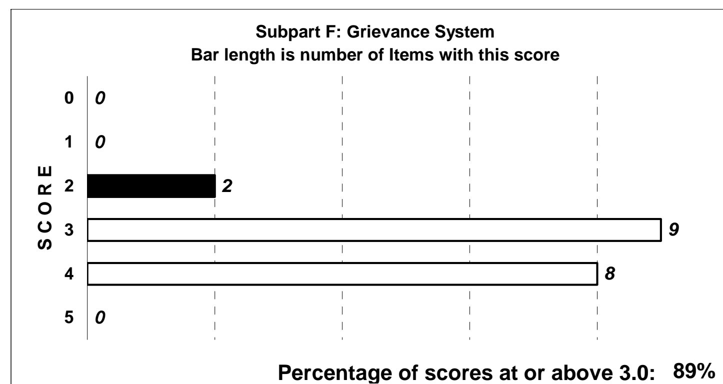
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Grays Harbor

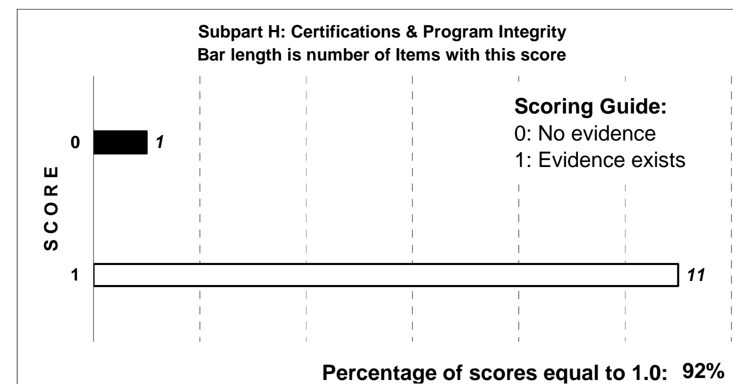
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 94%
Subpart D: 49%
Subpart F: 89%
Subpart H: 92%

Grays Harbor PIHP meets the minimum standard for a great majority of the specific requirements in Subparts C and H. The PIHP has prioritized Subpart C by ensuring that direct service staff are knowledgeable about rights and protections and provide this information to consumers. With respect to Subpart H, PIHP staff have also met nearly all of the minimum standards by ensuring that all data certifications meet source, content, and timing requirements, and that all but one of the required elements for program integrity are in place.

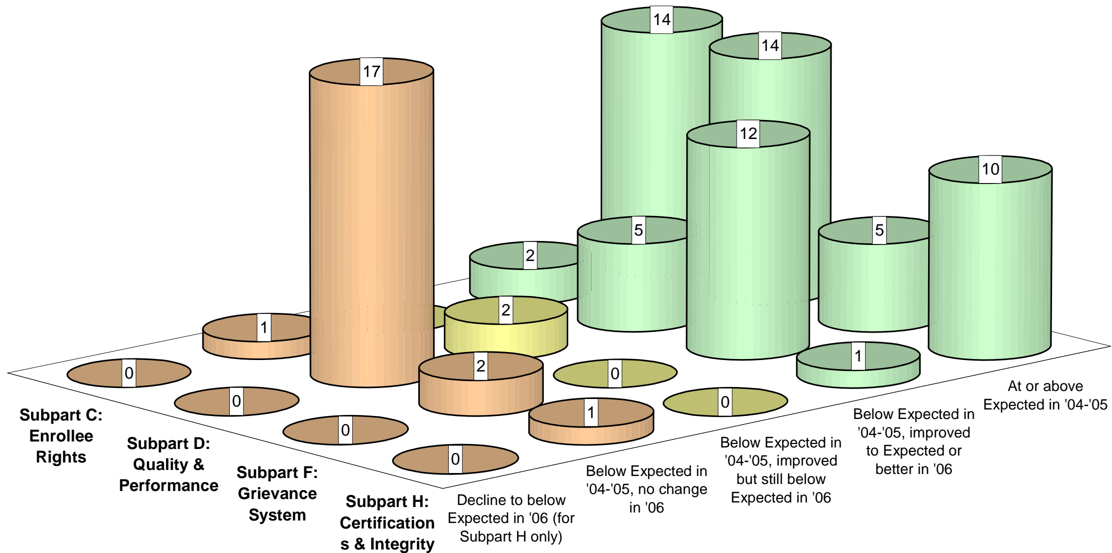
This year, Grays Harbor PIHP made the greatest improvement in Subpart F. PIHP staff have prioritized continual grievance system training with their network providers. Direct service staff know where to access policies and procedures and are able to articulate many of the expected requirements and standards.

The PIHP continues to make progress with respect to Subpart D-Quality Assessment and Performance Improvement. However, relevant policies and procedures remain underdeveloped and are missing key requirements. Moreover, WAEQRO was unable to find evidence of their implementation. In addition, the Grays Harbor PIHP needs to increase the knowledge and application of Subpart D requirements at the level of network providers and their staff.

Score Trend Summary for:
Grays Harbor

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Subpart C: Enrollee Rights Percent	Subpart D: Quality & Performance Item Count	Subpart D: Quality & Performance Percent	Subpart F: Grievance System Item Count	Subpart F: Grievance System Percent	Subpart H: Certifications & Integrity Item Count	Subpart H: Certifications & Integrity Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	1	5.9%	17	44.7%	2	10.5%	1	8.3%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	2	5.3%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	2	11.8%	5	13.2%	12	63.2%	1	8.3%
At or above Expected in '04-'05	14	82.4%	14	36.8%	5	26.3%	10	83.3%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, Grays Harbor PIHP performance relative to Subpart C (*Enrollee Rights*) showed 14 out of 17 items (82.4%) already at or above the Expected level of performance. After the 2006 review, 16 items (94.2%) are at the Expected level, reflecting improvement in 2 out of 3 elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), Grays Harbor PIHP entered the 2006 review with 5 out of 19 items (26.3%) already at or above Expected. After the 2006 review, 17 items (89.5%) meet the Expected level of performance, indicating Subpart F was the PIHP's greatest area of improvement. 12 out of 14 elements improved to Expected or better from 2005 to 2006.

The significant improvement Grays Harbor PIHP made in Subpart F indicates where their efforts for quality improvement were focused in 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- Direct service staff who were interviewed during the provider site visit are well informed and aware of PIHP grievance system policies and procedures.
- After PIHP requests for MHD technical assistance regarding practice guidelines and evidence-based practices (EBPs) were turned down, staff conducted their own research and continued efforts to develop clinical pathways and explore potential EBPs in collaboration with network providers.
- Grays Harbor PIHP is strongly committed to developing new services based in a foundation of recovery and resiliency. For the first time, a new clubhouse will be opening its doors in October/November.

Subpart Challenges

- Insufficient number of staff available to perform all required PIHP functions and additional state requirements; resource management continues to pose challenges.
- Increased oversight of providers intensifies the communication and relationship challenges. Maintaining effective and productive communication with network providers, in conjunction with holding the agencies accountable, is critical to the success of the local public mental health system providing quality care and services.
- Grays Harbor PIHP lacks quality assurance and improvement activities related to a majority of Subpart review elements.
- Various recommendations from the 2005 WAEQRO review remain relevant.

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Develop an effective process for monitoring provider network compliance with timely access.

3. Create a procedure to officially adopt and approve new and revised policies and procedures. Include dated **signatures** of PIHP officials or designees.

4. Clarify delegated PIHP functions and develop processes related to sub-delegation:
    - Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    - Review their related performance on an annual basis.

5. Determine network adequacy guidelines/standards and manage using the existing provider database. Develop a quality improvement process for evaluating capacity and network sufficiency through the use of reports and effective management practices that make use of information contained in the

reports.

6. Develop and train PIHP and provider network staff on specific procedures related to out-of-network provider referrals, and coordination of care and payment.

7. Establish well-defined procedures for collecting and analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

8. Further develop practice guidelines with respect to clinical guidance at critical decision junctures. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant.

9. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which, if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The PIHP's information system does not allow the use of non-standard codes and maintains a crosswalk to change local Provider codes to the State standard. Submissions that have not been previously mapped to the standard are returned to the Provider. The PIHP stipulates that there is a procedure for providers to have their changes incorporated into the crosswalk.

2. Unique member ID
   The PIHP uses the State's data dictionary definition, which specifies requirements for one unduplicated member ID. The PIHP also described procedures to ensure that only one member ID is used for each individual. Duplicates are identified and merged by the PIHP's IT contractor. Missing are policies and procedures to ensure that a timely and consistent process is maintained.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The PIHP's information system tracks individuals across product lines and through enrollment, disenrollment, and re-enrollment. Medicaid and non-Medicaid are considered different product lines.

4. Calculating member months
   In the 2005 review, the PIHP reported they were working with other PIHPs in the state to define methods for calculating member months. The PIHP reports no new progress on this item.

5. Member database
   Grays Harbor PIHP now maintains a member database. Data made available to the PIHPs by MHD for creating and maintaining a member database is imported

into an SQL database as a first stop toward defining Medicaid financial eligibility. The PIHP expressed concerns about the accuracy and timeliness of data offered by MHD for this purpose.

6. Provider Database
   Grays Harbor PIHP maintains provider data on a server; data is specific down to the individual practitioners.

7. Data easily under-reported
   This item remains unchanged from 2005. PIHP staff expect to develop a policy and procedure to cover out-of-network data in the coming year.

PM Summary

Grays Harbor PIHP has strong pre-submission screening processes on its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. Unfortunately, the PIHP's efforts fell short in this year's analysis and encounter validation review (described below). The overall score of Partially Met in the 2006 encounter validation review has a depressing impact on the general state of the PIHP's performance measure accuracy. Therefore, the general state of the PIHP's data is evaluated as "fair", despite being aided by the 2005 performance. Unfortunately, no steps are being taken to help bring their data quality up to "good" (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- This PIHP has very strong pre-submission processes to identify errors before data is entered into their system. These processes are largely responsible for the fairly positive results in last year's encounter validation.

PM Challenges

- All areas discussed in the encounter validation review later in this report are relevant here.
- The PIHP has done little to reconcile data already in their system, data which could provide much useful information in a variety of QA/QI arenas.
- Of the topical items listed above, the PIHP has made little, if any, progress since the last review cycle.

PM Recommendations

1. In 2005, the PIHP reported that they were currently working on defining methods to calculate member months. No progress has been made on this item. The level of granularity offered by calculating the member month facilitates comparisons between PIHPs and between the State and other entities. Per Member per Month (PMPM) measures are commonly used within the Managed Healthcare industry to calculate utilization and penetration rates, and as a basis for outcomes analysis.

2. Develop a policy and procedure outlining the requirement for data submission when

out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS conducted a review of one of two submitted PIPs for each PIHP. Included in the desk review were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006. (See, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

Grays Harbor PIHP submitted minimal information regarding two PIPs for the 2006 EQR. For each PIP the PIHP provided a self evaluation, a policy and procedure indicating their intent to engage in performance improvement activities per BBA requirements, and minutes of the August 8, 2006 Mental Health Advisory Board Meeting (their QAI Committee) which indicated that the PIHP was waiting for further clarification before proceeding on any PIPs. In the summary of their self-evaluations they stated that "GHRSN is awaiting formal training on the operation of PIPs from the MHD before engaging in substantial activity related to PIP program development." They gave themselves an overall score of "not met" for both PIPs. Due to the lack of activity and information, APS could not review either PIP.

PIP Challenges

- PIHP appears to lack the resources necessary to initiate BBA-required Performance Improvement Projects based on their own interpretation of BBA protocols.

PIP Recommendations

- Develop or bring in (or collaborate with other PIHPs) the skills and necessary staffing capacity to accomplish the required PIP activities.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Met	Data requirements are well defined by the State's data dictionary; through policy, the RSN requires its provider network to follow requirements documented in that data dictionary. Policies and procedures submitted contain contradictory timeline information. For example, one policy states that data is submitted within 60 days of the current calendar month, but also specifies that data will be reported….within 50 days of the encounter. The contract between RSN and the providers states that data is due within 7 days of the close of each calendar month.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The RSN provides the policies and data dictionary requirements to its provider network.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	There was no evidence to support that the RSN has made efforts to document its provider network IT capabilities and vulnerabilities. Such evidence would include documentation of processes used by provider staff to enter data, as well as maintain and transmit it accurately and in a timely manner.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Not Met	Provider data is not uploaded into the GHRSN system until it is accurate and screened for internal consistency, logic, and completeness, although the documentation does not describe how this process takes place. The GHRSN has policies which specify requirements for the provider agencies. Reports are used to review accuracy, timeliness, and completeness issues at the providers, a process which helps assess the capabilities and vulnerabilities of their respective systems. The RSN documents, through policy, the error handling procedure; however, the definition provided does not give a clear picture of how data in the reports is used toward this end. Interviews with PIHP IT staff indicated that data is compared between different sources for consistency. They also are comparing what the provider system indicates it sent against what their system received. The PIHP does not conduct a specific data analysis to validate completeness and accuracy. Efforts to verify such data prior to transmission are excellent, but it do not provide the views needed to calculate completeness values needed in this analysis.
Tools are defined by the PIHP to evaluate and document their data	Not Met	Reports were submitted that are used to check the validity and consistency of data, but tools and processes describing their use were not submitted.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
analysis findings.		
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data analysis specific to an encounter validation is not done.

4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Partially Met	Documentation reviewed reiterates contract requirements. A sampling requirement was stated, but sampling methodology was not. The number of encounters reviewed exceeded the requirement. The review used randomly-selected data records that were compared to the clinical records. The reviewer examined the type of service, date of service, and service provider to determine agreement between the two sources. No evidence was presented to indicate that a check was made on the validity of the encounter documented.
PIHP includes additional data elements in matching exercise.	Not Met	No evidence that any additional elements were checked.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Not Met	No tools were submitted into evidence.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report to the State reiterates contract requirements. A sampling requirement was stated; sampling methodology was not. The number of encounters reviewed did exceed the requirement. The review used randomly-selected data records that were compared to the clinical records. The reviewers examined the type of service, date of service, and service provider for agreement between the two sources. MHPs were used as reviewers as a means to ensure that clinical judgment was used in reconciling type of service between the clinical record and the data. No evidence was presented to indicate that a check was made on the validity of the encounter documented. Ideally, the report should contain the information requested by this tool. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		• Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Not Met	No evidence submitted.
PIHP regularly reports internally for quality improvement activities.	Not Met	A more detailed version of the State Report was submitted internally (specific to provider agency). No information was provided with respect to follow-up activities by either the RSN or the provider agencies.
6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Not Met	No relevant policy was submitted.
If warranted, evidence of follow-up activity was presented.	Not Met	No evidence was submitted.

Summary of Encounter Validation Findings

Score Met _14_%

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

Met **Partially Met** **Not Met**

Summary of encounter validation findings:

The encounter validation efforts undertaken by this PIHP met most of the requirements set forth in the contract between the MHD and the PIHP. However, the encounter validation review did not include all items specified in the contract. Specifically, there was no evidence of efforts to validate other data elements nor were additional steps made to ensure that encounters checked actually took place.

Using the tool outline provided by CMS, other deficiencies were noted. An analysis of the network's capacity to produce accurate and complete encounters was not done, nor was an analysis of the PIHP's data for the purpose of an encounter validation. The communication process between the PIHP and its provider agencies was not evident in documents submitted; nor were communications indicating quality improvement activities. The submission from the Grays Harbor PIHP lacked follow-up activity documentation addressing their encounter validation findings.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. Had the entire tool been used in computing the score, the PIHP would not have fared as well, with 14% of all items meeting a score of Met, 72% at Not Met, and the remaining 14% at Partially Met.

EV Strengths

- The PIHP has developed a strong infrastructure to check data prior to entry into its IT system. This check for accuracy and completeness is comprehensive and understood by both PIHP and provider IT staff.
- This PIHP fared better than most in last year's comprehensive encounter validation exercise, and this infrastructure contributed greatly to those results.

EV Challenges

- The PIHP relies on pre-submission processing to catch errors before submission, but does not extrapolate to the general condition of their data from those findings. Items caught and corrected in the pre-submission process are only opportunities to correct what was specifically found. Such correction does nothing with respect to analyzing the types of errors occurring and developing a method to minimize their occurrence and manifestation elsewhere in the data.
- The PIHP did not conduct its own data analysis; therefore, its overall accuracy and completeness could not be determined.

EV Recommendations

1. Data submission standards need to be consistent throughout the various policies and procedures maintained by the PIHP. Having one published standard that other policies reference would be a way to ensure that any changes to the standard are located in only one place.

2. Document network capability studies covering provider capability to produce accurate and complete encounter data. These studies should address everything from systems to processes and forms employed. Such studies should draw conclusions as to the capabilities and potential vulnerabilities associated with the systems evaluated.

3. Conduct analyses on the PIHP's data. Preferably, this would be accomplished on a frozen dataset (a copy of the "live" data held in some other database other than that being used by the RSN and providers). Such analysis needs to be conducted for two reasons: (1) there is no chance for errors being introduced to the data through the analysis process, and (2) the data can be revisited for further analysis or research.

4. The PIHP's encounter validation reports to the State should be stand-alone documents that explain its entire encounter validation program. The comments in number 5 in the Encounter Validation tool indicate more specifically what should be included.

5. Employ a more system-wide approach to conducting an encounter validation. The errors found were corrected, and potential errors may have been avoided using the current process. Nonetheless, an increased emphasis placed on systemic issues may yield critical information about wider problems in the PIHP's dataset.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan; organizational charts; Annual Work Plan; minutes of relevant meetings; data and reports submitted to committees involved in QAI activities; the chart review tool (including scoring methods) used in clinical audits and completed review tools; letters, review reports to the providers, and corrective action requests sent to providers; and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a reporting process that is data-driven. The completed tool, with detailed comments can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results are included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. Each standard was then scored separately and the number of Met/Partial/Not Met summed for each. Total percentages are calculated by dividing the number in each category of Met/Partial/Not Met by the total number of items scored. Scores greater than 80% are considered an overall Met score; 65% to 79% is Partially Met, and those below 65% are considered overall as Not Met.

APS HEALTHCARE
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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Grays Harbor

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.			**0**	• Quality Management (QM) Plan is confusing to read and lacks specificity regarding indicators, reporting process and schedule; • Missing discussion of PIPs • Lacks clarity re: QI recommendation and approval process
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.	**4**			• Plan includes annual review; MHAB reviews at retreat; minutes of that meeting in 2005 provided
C. Plan includes annual work plan and process for review of associated activities and progress.			**0**	• Work Plan not attached to QM Plan; • RSN states they have one but not using it

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PIHP: Grays Harbor

Requirement	Met	PM	Not Met	Findings Comments
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		2		• Much of what is required in the plan is there; however, information is not written in a way that can be easily read and interpreted
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	4			• Opportunities for provider and consumers/families to participate at all levels according to plan
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		3		Evidence provided: • Emails from RSN to providers stating that reports are on shared drive • P&P on Coordination of Care – more policy than procedure • MHAB, Provider Collaboration, Children's Policy Team met regularly throughout review period – minutes provided • Attendance at above meetings reflects participation of a broad range of stakeholders. • Inpatient, crisis, and outpatient utilization reports are provided to MHAB monthly, with some discussion of problematic situations and plans to address such matters
Standard 1 Count (Target 6 Met):	**2**	**2**	**2**	**Target Points: 24 Actual: 13**

PIHP: Grays Harbor

Requirement	Met	PM	Not Met	Findings Comments
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.		**1**		Evidence includes: • Email from IS Administrator scheduling Evergreen and BHR onsite review – appears to be encounter review • Email from provider clinical director acknowledging onsite activities • PIHP and 1 provider state that reviews are conducted by contractors on a monthly basis • 1 report for 1 provider submitted to EQRO • No documented evidence of monthly chart reviews per QM Plan

B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**2**		• Use ORR – comprehensive per current WAC; contains interpretive guide for scoring yes/no
				  o ORR is long and exhaustive; unrealistic for monthly reviews
				  o Not clear how individual record performance tallied, nor aggregate of all reviewed

PIHP: Grays Harbor

Requirement	Met	PM	Not Met	Findings Comments
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		1		• RSN states that RSN Administrator and Program Specialist have been conducting reviews; use contract staff for some as well • Use ORR interpretive guide – don't do IRR
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		1		• Provider contract contains details of CA plan requirements, including time frames, responsibilities, etc. • Provider states PIHP provides immediate feedback on chart reviews, verbally and in writing • Provider states has not seen PIHP follow-up explicitly on CAs –may do it as conducting chart reviews • CA for 1 provider - letter to agency stating problem, required solution, time frame and follow-up by RSN. • Documentation required from provider to verify activities had been conducted not specified. • No evidence submitted for follow-up on suggested improvements or CAs • Re: tracking Corrective Actions - PIHP states they have file for each agency – put due dates on calendar now
Standard 2 Count (Target 4 Met):	**0**	**4**	**0**	**Target Points: 16 Actual: 5**

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PIHP: Grays Harbor

Requirement	Met	PM	Not Met	Findings Comments
Standard **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.			0	• QM Plan contains information reviewed – very general, with timeframes • No evidence in MHAB minutes that clinical chart reviews are discussed
B. PIHP analyzes and trends individual provider performance.			0	• No evidence of reports regarding clinical quality • No evidence of analysis/trend reports
C. PIHP analyzes and trends system-wide performance.			0	• No evidence this occurs
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.			0	• No evidence this occurs
Standard 3 Count (Target 4 Met):	**0**	**0**	**4**	**Target Points: 16 Actual: 0**

PIHP: Grays Harbor

Requirement	Met	PM	Not Met	Findings Comments
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		2		Evidence provided: • 2005 Appeals report documents include number, timeliness, and resolution; source of data unknown • Exhibit N dated 10/1/05 re: grievances and fair hearings; source of data unknown • Process described by PIHP: they track incoming information from all sources on a weekly basis; immediately intervene in any problems; review with MHAB quarterly; trend regarding crisis clinic not responding appropriately • They don't have written plan or formal method for tracking – it's "in the Program Specialist's head" • Staff state that they maintain a log to track time frames related to required activities
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.			0	• Unable to ascertain – no evidence submitted to indicate this occurs

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PIHP: Grays Harbor

Requirement	Met	PM	Not Met	Findings Comments
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.		2		• Training provided October, 2005; no documentation provided • Staff at one agency visited able to articulate requirements and their roles • The current Ombuds started in September and has little experience thus far in working with consumers. Having held a senior position in a PIHP in the recent past, he is familiar with the role and the requirements for assisting consumers with appeals/grievances and fair hearings. • The Ombuds stated that he has not had any formal training since starting this position; however, he has had several phone consultations with the staff responsible for conducting the quarterly statewide Ombuds training. He plans to attend the next formal training, which may now be scheduled semi-annually rather than quarterly. In addition, he has met with other Ombuds in the state and is working closely with staff at the PIHP to familiarize himself with their procedures and requirements.
Standard 4 **Count (Target 3 Met):**	**0**	**2**	**1**	**Target Points: 12 Actual: 4**

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PIHP: Grays Harbor					
Requirement		Met	PM	Not Met	Findings Comments
Grand Totals	**Count (Target 17 Met): 2**	**2**	**8**	**7**	**Target Points: 68 Actual: 22**

Summary Quality Assurance and Improvement Findings

The PIHP's QM Plan contains most of the elements essential for a functional QAI system; as written, however, the plan is difficult to follow and lacks clarity and direction for the PIHP and/or the entities involved in its implementation. The PIHP did not provide evidence of trending or analysis of their indicators, although a key set of utilization indicators was reported at each monthly MHAB meeting (note: the MHAB functions as the PIHP's Quality Assurance and Improvement Committee). Because their largest provider was unavailable for the site visit, it was also difficult to ascertain the level of participation and knowledge of the majority of the network staff in the QAI, appeal/grievance, and fair hearing processes. Clinical oversight, again, is reported by the RSN and one provider to occur monthly via chart reviews; however, only one report was submitted, and there was no evidence of review results discussed at the MHAB.

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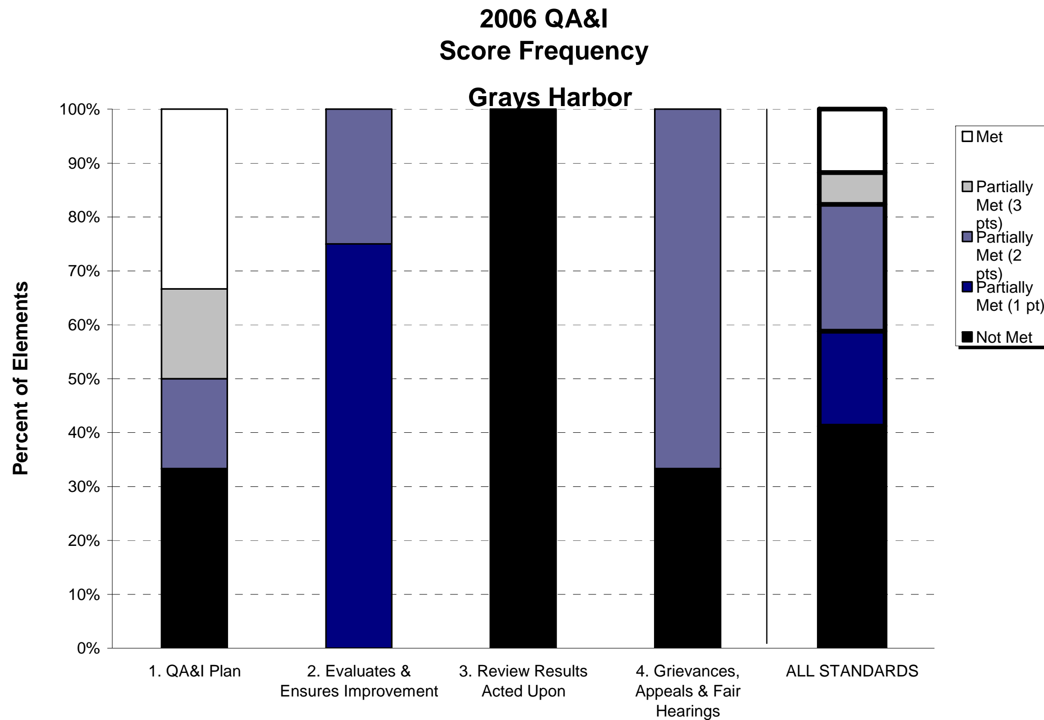

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	2	1	1	0	2
2. Evaluates & Ensures Improvement	4	0	0	1	3	0
3. Review Results Acted Upon	4	0	0	0	0	4
4. Grievances, Appeals & Fair Hearings	3	0	0	2	0	1
ALL STANDARDS	**17**	**2**	**1**	**4**	**3**	**7**

QAI Strengths

- Based on discussion with the PIHP at the site visit, the staff appears to understand the improvements required to ensure that their QAI plan and process is thorough, consistent, and meaningful.
- At least one of their network providers is well-informed with respect to requirements concerning clinical documentation and participation in the grievance/appeal/fair hearing processes.

QAI Challenges

- The QM Plan is confusing to follow and should be re-written.
- PHIP staff currently lack adequate data analysis skills and do not appear to understand how to use the data they generate for true quality improvement.
- The PIHP appears to be understaffed relative to the activities required to ensure consistent application of its QM plan. This understaffing impacts MIS as well as clinical oversight functions.

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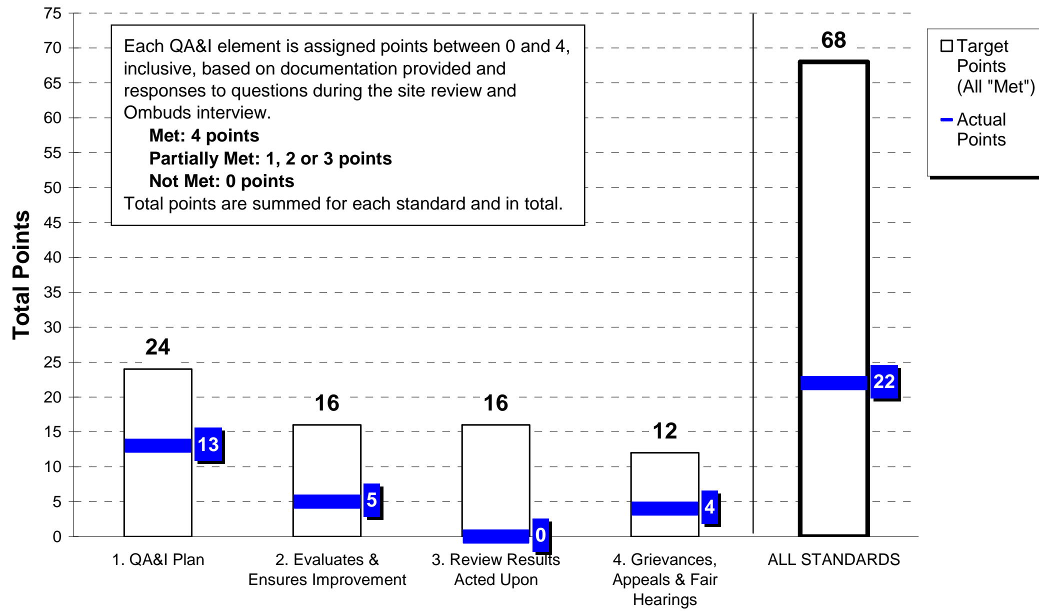

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	13
2. Evaluates & Ensures Improvement	16	5
3. Review Results Acted Upon	16	0
4. Grievances, Appeals & Fair Hearings	12	4
ALL STANDARDS	**68**	**22**

- The PIHP failed to provide documentation or evidence to support the activities that they most likely undertake, indicating a need for expertise in responding to compliance monitoring.
- The PIHP's largest network provider was unavailable for a site visit on the specified day, and provided notice of this unavailability at the last minute.

QAI Recommendations

1. Revise QM Plan to eliminate redundancy and to add clarity with respect to process, reporting, indicators, and other relevant factors.

2. Consider revision of the QAI structure; specifically, consider creating a QAI Committee comprised of PIHP and network provider staff that takes input from the MHAB, but has authority to make decisions (retaining Governing Board oversight and decision-making on certain issues) and ensure implementation.

3. Incorporate into the QM Plan a matrix of indicators that defines the measurement method,

thresholds for action, reporting frequency, and responsibility for each.

4. Develop an Annual Work Plan that includes 2-4 focused projects based on the previous year's indicators; incorporate this Annual Work Plan into the overall QAI Plan.

5. Include a description of the annual process used to identify PIPs, and consider making those PIPs part of the Annual Work Plan.

6. Improve ability to thoroughly respond to EQR and other reviews.

Recommendations

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Develop an effective process for monitoring provider network compliance with timely access.

3. Create a procedure to officially adopt and approve new and revised policies and procedures. Include dated **signatures** of PIHP officials or designees.

4. Clarify delegated PIHP functions and develop processes related to sub-delegation:
   - Conduct a formal evaluation of subcontractor ability to perform PIHP- delegated functions prior to their delegation;
   - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
   - Review their related performance on an annual basis.
   -

5. Determine network adequacy guidelines/standards and manage using the existing provider database. Develop a quality improvement process for evaluating capacity and network sufficiency through the use of reports and effective management practices that make use of information contained in the reports.

6. Develop and train PIHP and provider network staff on specific procedures related to out-of-network provider referrals, and coordination of care and payment.

7. Establish well-defined procedures for collecting and analyzing aggregate data to identify trends and related quality improvements to better manage over and under utilization.

8. Further develop practice guidelines with respect to clinical guidance at critical decision junctures. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant.

9. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

PM Recommendations

1. In 2005, the PIHP reported that they were currently working on defining methods to

calculate member months. No progress has been made on this item. The level of granularity offered by calculating the member month facilitates comparisons between PIHPs and between the State and other entities. Per Member per Month (PMPM) measures are commonly used within the Managed Healthcare industry to calculate utilization and penetration rates, and as a basis for outcomes analysis.

2. Develop a policy and procedure outlining the requirement for data submission when out-of-network activities take place. This is needed to ensure that each encounter provided on behalf of the PIHP is correctly submitted in a timely fashion.

PIP Recommendations

1. Develop or bring in (or collaborate with other PIHPs) the skills and necessary staffing capacity to accomplish the required PIP activities

EV Recommendations

1. Data submission standards need to be consistent throughout the various policies and procedures maintained by the PIHP. Having one published standard that other policies reference would be a way to ensure that any changes to the standard are located in only one place.

2. Document network capability studies covering provider capability to produce accurate and complete encounter data. These studies should address everything from systems to processes and forms employed. Such studies should draw conclusions as to the capabilities and potential vulnerabilities associated with the systems evaluated.

3. Conduct analyses on the PIHP's data. Preferably, this would be accomplished on a frozen dataset (a copy of the "live" data held in some other database other than that being used by the RSN and providers). Such analysis needs to be conducted for two reasons: (1) there is no chance for errors being introduced to the data through the analysis process, and (2) the data can be revisited for further analysis or research.

4. The PIHP's encounter validation reports to the State need to be stand-alone documents that explain its entire encounter validation program. The comments in number 5 in the Encounter Validation tool indicate more specifically what should be included.

5. Employ a more system-wide approach to conducting an encounter validation. The errors found were corrected, and potential errors may have been avoided using the current process. Nonetheless, an increased emphasis placed on systemic issues may yield critical information about wider problems in the PIHP's dataset.

QAI Recommendations

1. Revise QM Plan to eliminate redundancy and to add clarity with respect to process, reporting, indicators, and other relevant factors.

2. Consider revision of the QAI structure; specifically, consider creating a QAI Committee comprised of PIHP and network provider staff that takes input from the MHAB, but has authority to make decisions (retaining Governing Board oversight and decision-making on certain issues) and ensure implementation.

3. Incorporate into the QM Plan a matrix of indicators that defines the measurement method, thresholds for action, reporting frequency, and responsibility for each.

4. Develop an Annual Work Plan that includes 2-4 focused projects based on the previous year's indicators; incorporate this Annual Work Plan into the overall QAI Plan.

5. Include a description of the annual process used to identify PIPs, and consider making those PIPs part of the Annual Work Plan.

6. Improve ability to thoroughly respond to EQR and other reviews.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

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Washington External Quality Review Organization

Greater Columbia Behavioral Health Prepaid Inpatient Health Plan

External Quality Review
2006

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2006 External Quality Review

Technical Report for Greater Columbia Behavioral Health

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Greater Columbia Behavioral Health (GCBH) is responsible for managing mental health care and services for Medicaid consumers in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman, and Yakima counties, as well as the Yakama Nation. The PIHP is located in Kennewick, Washington and is governed by a board comprised of a commissioner from each of the member counties, the Director of Yakima County Community Services, and the Deputy Director of the Yakama Nation Department of Human Services. The PIHP Administrator reports to the Board of Directors. GCBH contracts with fourteen (14) community mental health centers and specialty providers to serve approximately 13,000 adult and child consumers annually. Average monthly enrollment in the PIHP is approximately 129,000 Medicaid-eligible individuals. In addition, the PIHP delegates utilization management to a private administrative services organization based in Nevada.

This report covers the period between January 20, 2006 and January 19, 2007 and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);

3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement	June-August, 2006	

Activity	Timeline	Documents/Content
• PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions		
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	December 19, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	January 5, 2007	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	January 16, 2007	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	February 6 and 7, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	February 12, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	March 2, 2007	
4. Debrief conference call	March 19, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	March 26,	

Activity	Timeline	Documents/Content
	2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Greater Columbia Behavioral Health submitted a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For GCBH, significant events include:

- The PIHP has greatly expanded its staffing over the last year (although some positions remain unfilled), affording the organization an opportunity to implement significant process improvements.

- The PIHP has started implementing a culture of "transparency", bringing "all news to everyone all the time". This new culture and operational strategy has improved collaboration among the providers and fostered more positive working relationships between the providers and the PIHP.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- PIHP submitted three "PIPs", none of which meet the CMS definition of a Performance Improvement Project. Documentation provided for each was lacking in one or more significant/required elements, including project summary, data reports, and evidence of process for definition and implementation of the project. The WAEQRO was therefore unable to formally validate any of the projects.

- The PIHP's sample network provider and Behavioral Health Options (BHO) contracts did not contain dated signatures of contracting parties. Thus, the WAEQRO was unable to determine if the contract references were from officially executed contracts. The sample contracts, however, were considered in scoring the Subparts.

- The policies and procedures submitted for review are approved by the Board of Directors; however, they do not contain a place holder for an official approval signature. In addition, approval dates indicate that revised policies have not been approved by the Board of Directors. Consequently, the WAEQRO was unable to determine if all the policies and procedures submitted for review had been officially adopted. They were, however, considered in scoring the subparts.

- PIHP staff did not submit a 2004 Corrective Action Plan update per the WAEQRO Document Submission Request. Therefore, the WAEQRO had limited information regarding the PIHP's accomplishments related to the implementation of their 2004 Corrective Actions Plan.

4. 2006 Review Results

This report provides results and a summary of GCBH's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of GCBH's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.100(b) [Q4]	**Subcontract requires providers to post client rights in public places in all prevalent languages**			
	No evidence was discovered in the policy or the PIHP Provider contract requiring enrollee rights be posted "in all prevalent languages" as per 438.100(b)	Submit a corrective action plan to the MHD by 5/10/05.	Submitted by PIHP 5/09/05.	Relevant policies and procedures include all requirements of this provision. PIHP has attained a score of **4-Substantial Compliance.**
438.207 [Q34]	**Assurances of Adequate Capacity and Services**			
	No documented evidence of Network adequacy and capacity guidelines or standards, and were not able to show evidence of a methodical quality improvement process associated	Submit a corrective action plan to the MHD by 5/10/05.	Submitted by PIHP 5/09/05.	PIHP staff acknowledged they have not established network adequacy guidelines or standards. In addition, staff recognized they have not developed systematic

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	with access and adequate capacity that is currently being implemented.			strategies and methods of analysis for planning and identification of quality improvements associated with access, capacity, and availability of services on an ongoing basis. PIHP staff have submitted a Sufficiency Strategy Project Proposal to their Governing Board and are awaiting approval. PIHP has attained a score of **2-Partial Compliance**.
438.230(b) [Q52]	**Evaluation of Subcontractor ability to perform delegated functions**			
	PIHP's Delegation Standard (Subcontracting) applies primarily to the PIHP subcontracting the provision of mental health services rather than the subcontracting functions of the PIHP such as eligibility checks, determination of medical necessity and resource and utilization	Submit a corrective action plan to the MHD by 5/10/05.	Submitted by PIHP 5/09/05.	Revised Delegation Policy does not include the requirements related to the evaluation of Subcontractor ability to perform delegated functions. Policy includes list of PIHP-delegated activities. PIHP has attained a score of 1-**Insufficient Compliance**.

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	management functions. In addition, the standard does not include how it evaluates the subcontractor's ability to perform the activities delegated.			

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Greater Columbia Behavioral Health. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

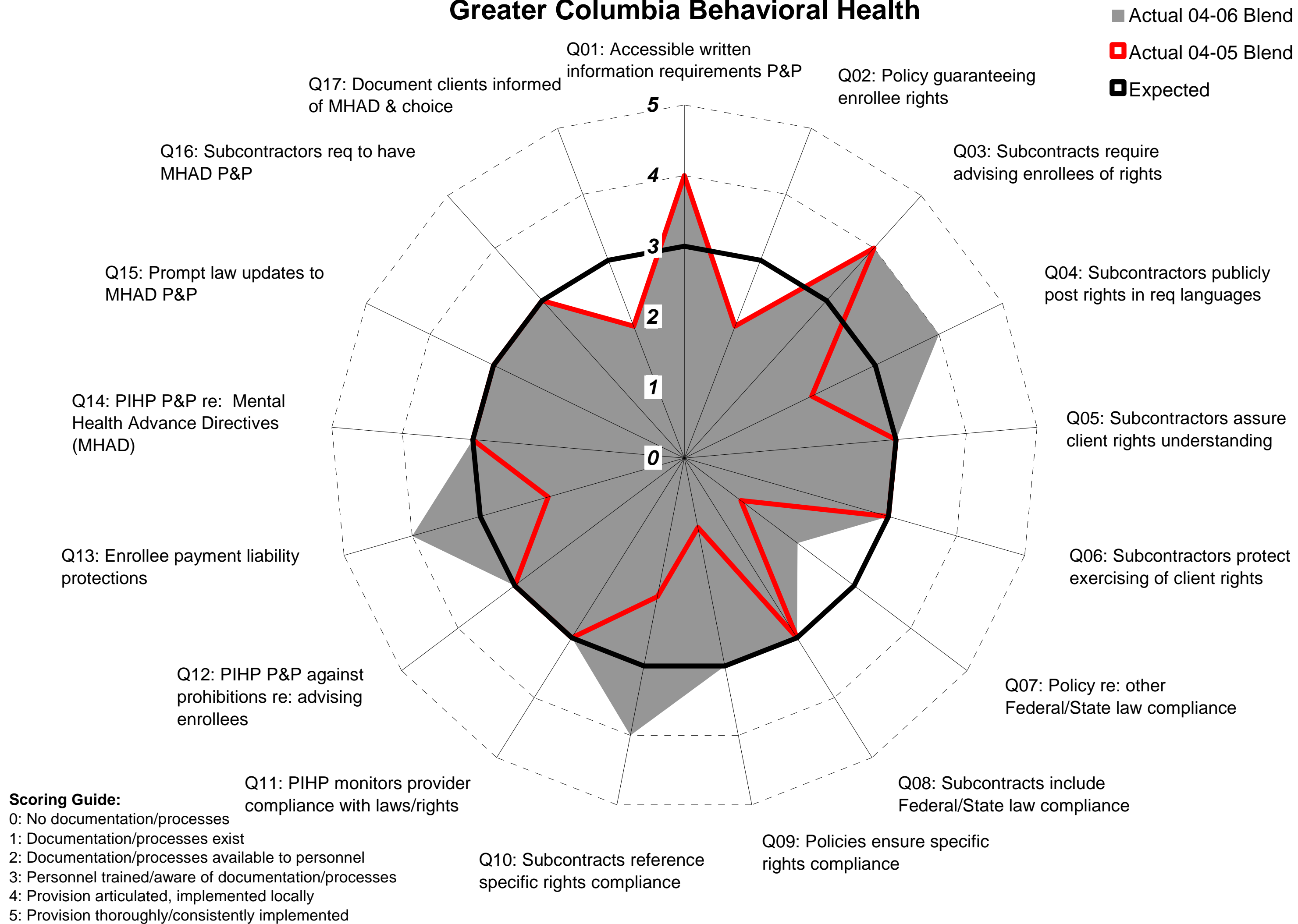
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



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2004-2006 Subpart Scoring Trend and Detail for
Greater Columbia Behavioral Health

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Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	4		4
Q02: Policy guaranteeing enrollee rights	2	2	2
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	2	4	4
Q05: Subcontractors assure client rights understanding	3		3
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	1	2	2
Q08: Subcontracts include Federal/State law compliance	3		3
Q09: Policies ensure specific rights compliance	1	3	3
Q10: Subcontracts reference specific rights compliance	2	4	4
Q11: PIHP monitors provider compliance with laws/rights	3		3
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	2	4	4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	3		3
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	2	2	2

Greater Columbia Behavioral Health
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
438.100(b)	**Specific Enrollee Rights**	
[Q2]	**Policy guaranteeing the rights of enrollees** Evidence: • Enrollee Rights Policy contains all rights listed in this provision with the exception of the enrollee's right to request and receive a copy of their medical record. Policy only stipulates that an enrollee can review and amend their medical record. In addition, it states that an enrollee has the right to confidentiality and to have their privacy protected; however, only Washington State law is referenced. There is no reference to the privacy rule as set forth in 45 CFR parts 160 and 164. No additional policies related to HIPAA or Personal Health Information were submitted for this review element. • No completed Clinician Attestations were submitted as referenced in the PIHP Enrollee Rights Policy. Clinician signature acknowledges that consumer has received an explanation and written copies of their rights, and understands their rights, grievance procedures, Advance Directives, and second opinions. Provider management reported that they were not required to use the PIHP Clinician Attestations. Recommend that the PIHP clarify this requirement or modify Enrollee Rights Policy to reflect desired practice and procedures. • Provider Enrollee Notice of Rights—do not explicitly state whether the enrollee has a right to request and receive a copy of their medical record. • Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—includes all rights related to this provision. • Clinical Review Rating Tool and Results (January-June 2006—shows "evidence consumer has received either a copy of or an explanation of rights and received this information in a language/format this person understands." • 05-06 Administrative Audit Results (Scoring by Provider)—reviews provider policies and procedures to ensure that provider staff take enrollee rights into account when furnishing services. • Score remains the same as 2005 EQR due to insufficient	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q4]	**Subcontract requires providers to post client rights in public places in all prevalent languages** Evidence: • 05-06 PIHP Subcontract and Enrollee Rights Policy include the requirement to post enrollee rights in all prevalent languages, in noticeable public locations and conspicuously marked. • Enrollee rights in required eight (8) languages were observed to be posted in the lobby at both providers. • Consumer Rights Training Schedule and Attendance Rosters—indicate training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—includes "Consumer rights must be posted in the prevalent DSHS languages (lists all 8 languages) in a public location within each CMHA." • Provider direct service staff identified the languages in which the rights were translated, and where the rights are posted in their agencies. • Direct service staff did not consistently know if rights were available in Braille, large print, or on audio tape for visually impaired individuals. • 05-06 Administrative Audit Results (Scoring by Provider)—reviews policies and procedures to ensure that enrollee rights are available in prevalent languages and alternate formats for "individuals with visual impairments or limited reading proficiency." (Substantial Compliance)	4
438.100(d)	**Compliance with Other Federal and State law**	
[Q7]	**Compliance with other Federal and State laws is reflected in policies** Evidence: • Service Provision Policy—references the nondiscrimination laws related to this provision. • Enrollee Rights Policy and Second Opinion Policy do not include reference to other Federal and State laws, or the non-discrimination laws. • 05-06 PIHP Subcontract and 06-07 PIHP Subcontract reference compliance with other Federal and State law; specifically, the non-discrimination laws. • Consumer Rights Training PowerPoint—does not include reference relevant non-discrimination law.	

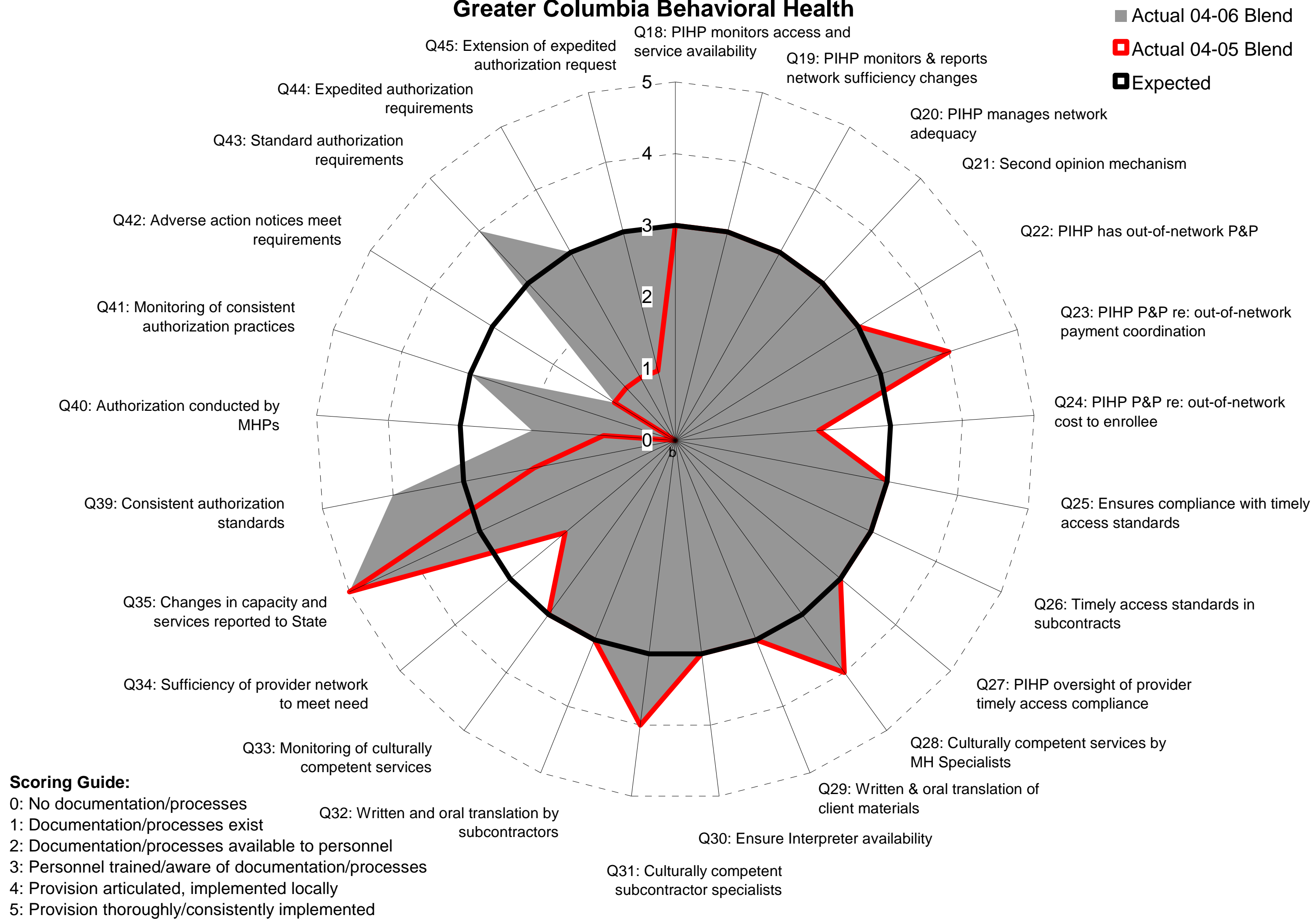
<table>
<tr><th>CFR Reference</th><th>Compliance Determination Report
Subpart C</th><th>Score 0-5</th></tr>
<tr><td></td><td>• <u>Clinical Review Rating Tool and Results (January-June 2006</u>—does show evidence of monitoring for implementation of relevant non-discrimination laws.
• PIHP staff and provider management reported that provider compliance with non-discrimination and other Federal and State laws is monitored during the PIHP annual provider administrative audits. No documentation of monitoring and results was submitted.
(Partial Compliance)</td><td>2</td></tr>
<tr><td>[Q9]</td><td>PIHP policies assure compliance with right to a 2nd opinion, client participation in treatment, and access to clinical records
Evidence:
• <u>Enrollee Rights Policy</u> lists client rights to a second opinion, access to clinical records, and participation in decisions about their treatment. Did not include procedures related to providers' response and execution of these rights.
• <u>Second Opinions Policy</u> includes procedures related to required timeframes, access within and outside of provider network, description of second opinion assessment and how it should be used, review with consumer, and monitoring of second opinions.
• <u>05-06 PIHP Subcontract</u> and <u>06-07 PIHP Subcontract</u> contain references to the 3 client rights listed in this provision.
• <u>Consumer Rights Training Schedule and Attendance Rosters</u>—indicate training occurred for the majority of network providers between 1/06 and 12/06.
• <u>Consumer Rights Training PowerPoint</u>—includes all rights related to this provision. Training did not appear to include detailed procedures related to the 3 rights.
• <u>Clinical Review Rating Tool and Results (January-June 2006</u>—shows "evidence consumer has received either a copy of or an explanation of rights and received this information in a language/format this person understands." However, neither this statement, nor the tool reviews for provider compliance with the 3 rights.
• <u>05-06 Administrative Audit Results (Scoring by Provider)</u>—reviews provider policies and procedures related to client rights to a second opinion, access to their clinical record, and participation in decisions about their treatment.
• Network provider management reported that the PIHP reviews client access to a second opinion and participation in treatment decisions via regular chart reviews and by ensuring that the provider has relevant policies and procedures.
• Inconsistent reports from provider management related to whether the PIHP has specifically monitored for compliance with</td><td></td></tr>
</table>

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	client access to their clinical record and relevant provider processes. • Direct service staff are able to articulate basic understanding of procedures related to access to a second opinion, and client involvement in treatment decisions. Reported they would contact staff responsible for medical records if client requested access to their clinical record. • Recommend that the PIHP develop, and incorporate into policy, procedures related to execution of client access to clinical record, and client participation in treatment decisions. (Moderate Compliance)	3
[Q10]	**Subcontracts require compliance with a client's right to a second opinion, involvement in their mental health treatment, and access to clinical records** Evidence: • 05-06 PIHP Subcontract and 06-07 PIHP Subcontract contain references to ensure provider compliance with a client's right to a second opinion, involvement in their mental health treatment, and access to clinical records. • Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—includes all rights related to this provision. Training did not appear to include detailed procedures related to the 3 rights. • Clinical Review Rating Tool and Results (January-June 2006—shows "evidence consumer has received either a copy of or an explanation of rights and received this information in a language/format this person understands." However, neither this statement, nor the tool reviews for provider compliance with the 3 rights. • 05-06 Administrative Audit Results (Scoring by Provider)—reviews provider policies and procedures related to client rights to a second opinion, access to their clinical record, and participation in decisions about their treatment. • Network provider management reported that the PIHP reviews client access to a second opinion and participation in treatment decisions via regular chart reviews and by ensuring that the provider has relevant policies and procedures. • Inconsistent reports from provider management related to whether the PIHP has specifically monitored for compliance with client access to their clinical record and relevant provider processes. • Direct service staff are able to articulate basic understanding of	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	procedures related to access to a second opinion, and client involvement in treatment decisions. Reported that they would contact staff responsible for medical records if client requested access to the clinical record. (Substantial Compliance)	4
438.106	**Liability for Payment**	
[Q13]	**Subcontracts ensure enrollee payment liability protections** Evidence: • 05-06 PIHP Subcontract and 06-07 PIHP Subcontract includes relevant language meeting the requirements of this provision. • Revised Addressing Enrollee Needs in the Event of Community Hospital Insolvency Policy protects Medicaid enrollees from liability for payment in all required circumstances outlined in this provision. • Inpatient Balance Billing Resolution—demonstrates efforts made by the PIHP to ensure that a parent is not wrongly charged for inpatient and physician services. • 05-06 Administrative Audit Results (Scoring by Provider)—reviews provider policies and procedures to ensure that requirements of this provision are included. • Provider management reported that the PIHP monitors to ensure Medicaid enrollees are not held liable for payment during their annual administrative audit. No documentation was submitted showing evidence of this monitoring mechanism. (Substantial Compliance)	4
438.10(g) 438.6(l)	**Advance Directives**	
[Q17]	**Client informed in writing of Mental Health Advance Directives, and choice is documented** Evidence: • Revised Advance Directive Standard policy and procedures contain requirements. • Blank sample copy of Consumer Advance Directive Attestation acknowledges client receipt of WA State Advance Directive information, understanding of information provided, opportunity to ask questions, and choice of whether to initiate Advance Directive. • Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—Includes training	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	related to the purpose and benefits of an Advance Directive. The training did not appear to address specific requirements related to this provision. • Network provider management reported that the Consumer Advance Directive Attestation forms are not used. One provider was not familiar with the form; the other stated that the form was optional. • Each provider agency has their own unique method of documentation. Forms used at intake indicate Advance Directive information is provided to consumers; however, the forms do not reflect consumer choice related to pursuing an Advance Directive or not. • Provider direct service staff reported that they are required to document their provision of Advance Directive information to the client and whether the client already has an Advance Directive. In addition, staff stated that the client's crisis plan should mimic what is in the Advance Directive. Direct service staff did not consistently confirm that they are required to document consumer choice as to whether client wants to execute an Advance Directive. • Clinical Review Rating Tool and Results (January-June 2006—shows "The chart contains documentary evidence that the person received an explanation of, and opportunity to establish, an Advance Directive." • 05-06 Administrative Audit Results (Scoring by Provider)—reviews to ensure all Advance Directive requirements are included in provider policies and procedures. • Recommend that the PIHP standardize the method for documenting the provision of Advance Directive information and enrollee choice for the provider network. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2

Subpart D (Part 1): Access Standards



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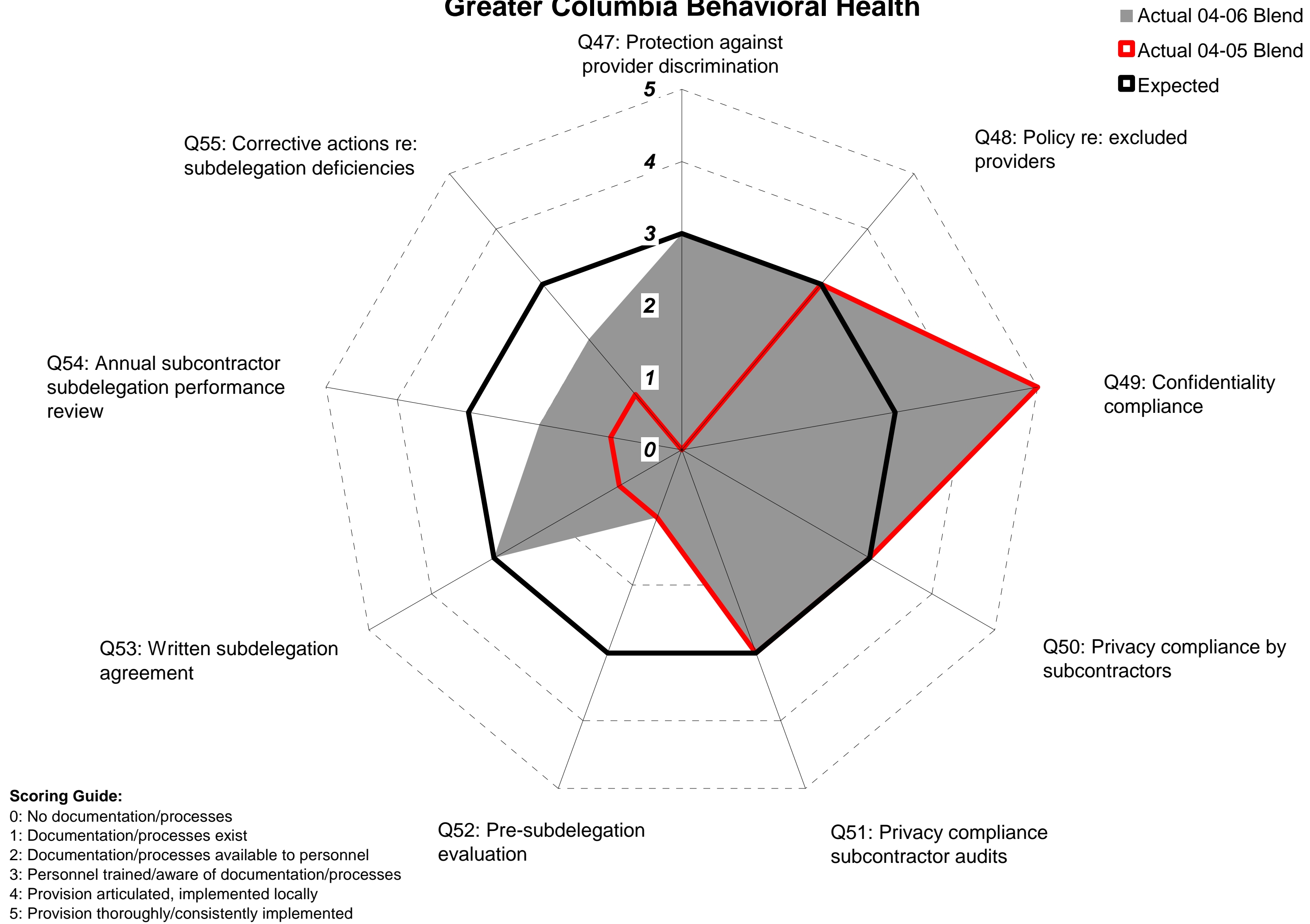
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	4		4
Q24: PIHP P&P re: out-of-network cost to enrollee	2	2	2
Q25: Ensures compliance with timely access standards	3		3
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	3		3
Q28: Culturally competent services by MH Specialists	4		4
Q29: Written & oral translation of client materials	3		3
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	4		4
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	2	2	2
Q35: Changes in capacity and services reported to State	5		5
Q39: Consistent authorization standards	2	4	4
Q40: Authorization conducted by MHPs	1	2	2
Q41: Monitoring of consistent authorization practices	0	3	3
Q42: Adverse action notices meet requirements	1	1	1
Q43: Standard authorization requirements	1	4	4
Q44: Expedited authorization requirements	1	3	3
Q45: Extension of expedited authorization request	1	3	3



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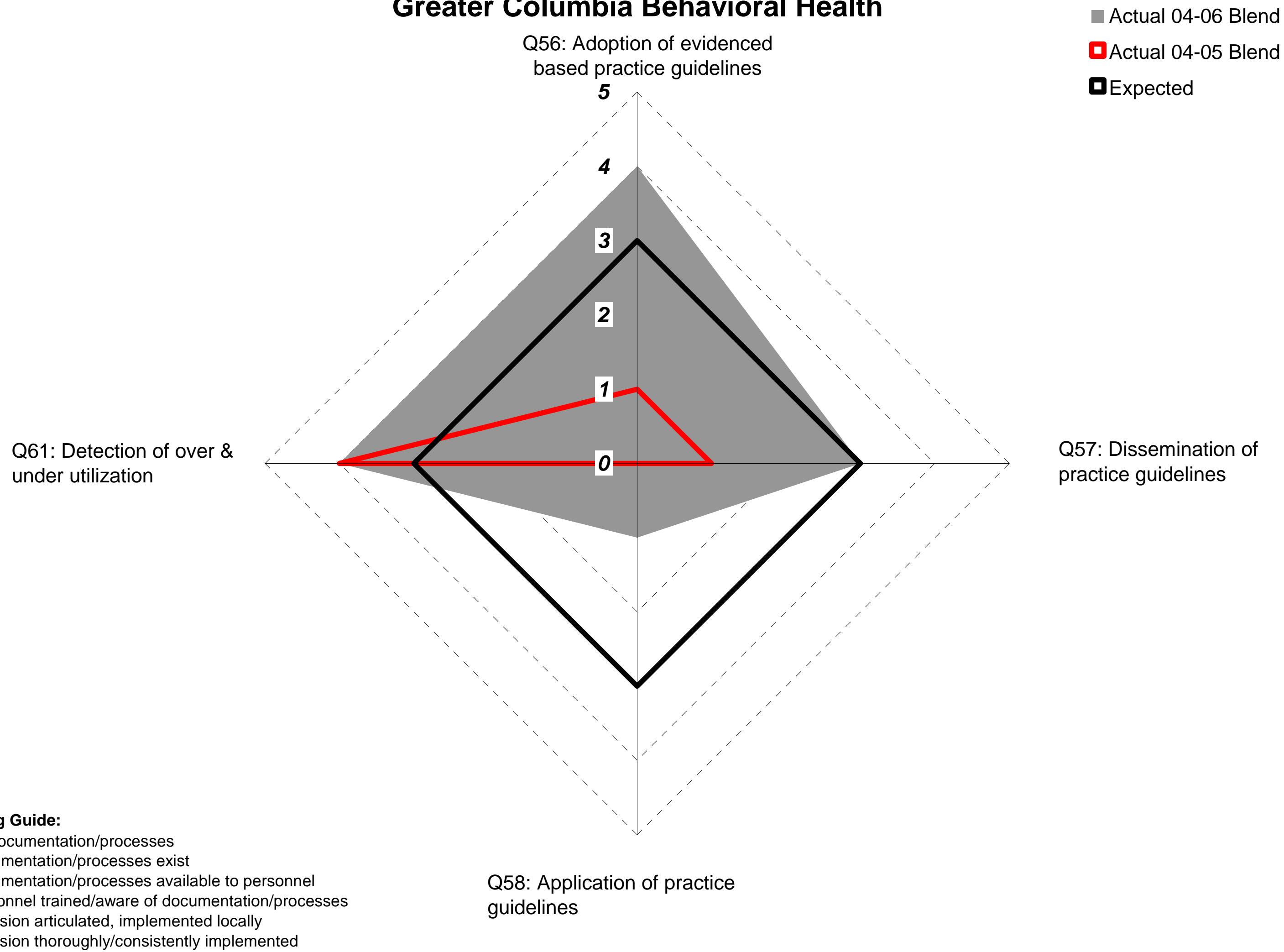
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	0	3	3
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	3		3
Q52: Pre-subdelegation evaluation	1	1	1
Q53: Written subdelegation agreement	1	3	3
Q54: Annual subcontractor subdelegation performance review	1	2	2
Q55: Corrective actions re: subdelegation deficiencies	1	2	2

Subpart D (Part 3): Measurement and Improvement Standards

Greater Columbia Behavioral Health



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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	1	4	4
Q57: Dissemination of practice guidelines	1	3	3
Q58: Application of practice guidelines	0	1	1
Q61: Detection of over & under utilization	4		4

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
438.206 (b)(5)	**Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment**	
[Q24]	**Cost of out-of-network provider is no greater for enrollee than services furnished within network** Evidence: • Out of Network Referrals Policy includes the provision requirements with respect to payment and coordination of care. • Counseling Services Agreement and related invoices with Carol Conrad, MS, LMHC (Out-of-Network Provider). • Inpatient Balance Billing Resolution—demonstrates efforts made by the PIHP to ensure a parent is not wrongly charged for in-network and out-of-network inpatient and physician services. • Inpatient Hospital Billings Spreadsheet showing 12% or $510,000 was spent on inpatient services at hospitals outside the PIHP during FY05. Evidence of payments to additional out-of-network providers such as Columbia River Mental Health and Clark County included. • PIHP staff and provider management reported that it is the responsibility of the network providers to coordinate care and payment for out-of-network services. Reviewer noted this as a discrepancy, in that the Out of Network Referrals Policy, Counseling Services Agreement, and payment documentation show evidence of the PIHP coordinating care and paying for out-of-network services. • Reporting and tracking mechanisms outlined in the Out of Network Referrals Policy are limited, and are inconsistently employed. • No evidence was submitted with respect to training related to this review element. • Recommend that the PIHP clarify coordination of care and payment responsibilities in policy and trainings. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.207	**Assurances of Adequate Capacity and Services**	
[Q34]	**Sufficient number, mix and geographic distribution of Network Providers to meet anticipated need**	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5

Evidence:

- Network Sufficiency and Accessibility Standard Policy, Quality Management Policy, and Utilization Management Policy collectively contain the requirements that meet this provision.
- Sufficiency Strategy Project Proposal (Clegg & Associates-February 2007-June 2007—"To develop a Sufficiency Strategy that will guide Greater Columbia Behavioral Health's efforts to serve a broader range of adults with serious mental illness in community-based settings and thereby reduce the utilization of Eastern State Hospital. By achieving inpatient utilization reductions at a prescribed level, the Network can increase the level of state resources it receives for community-based services and continue to build the sufficiency of these services across the system." 2006 PIHP Board Meeting Minutes provide evidence of several months of related discussions relative to this project proposal with no resolution as of this review.
- PIHP Services Analysis Table and December 2006 Agency Services Grid—lists PIHP services by network provider, and differentiates Eastern, Central, and Western provider networks.
- Inpatient Savings Reallocation Plan and related correspondence—purpose is to use funding to improve overall care and coordination of mental health services in Benton-Franklin Counties. Inpatient savings to be used for Crisis Stabilization Beds, Flexible Funding, Detox Diversion Project, and Improve Systems for Diversion Capacity.
- Access to Intake Timeline Analysis—indicates percentages per network provider of intakes offered and provided within 14 days of request for service.
- Additional Documents Submitted:
    - August and November 2006 Clinical Directors Meeting Minutes—nothing relevant to Network Sufficiency noted.
    - Executive Committee Meeting Minutes for 2006—References to the Sufficiency Strategy Project Proposal and need for the PIHP to develop a process to establish and monitor network sufficiency.
    - November and December 2006 and January 2007 Utilization Management Committee Meeting Minutes for 2006—nothing relevant to Network Sufficiency noted.
    - Out-of Network Referrals Policy
    - PACT Adhoc Memo of November 17,2006 and PACT Adhoc Recommendation Memo of January 2, 2007
    - November 2005 Geo Mapping—completed prior to 2005 EQRO.
    - BHO Annual Executive Summary

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	o Inpatient Fiscal Report. • No evidence of training related to this review element. • PIHP staff acknowledged that they have not established network adequacy guidelines or standards. In addition, staff recognized that they have not developed systematic strategies and methods of analysis for planning and identification of quality improvements associated with access, capacity, and availability of services on an ongoing basis. • Recommend that the PIHP move forward with the Sufficiency Strategy Project Proposal. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.210(b)	**Authorization of Services**	
[Q39]	**Authorization is consistent with Access to Care Standards and takes place in consultation with requesting provider** Evidence: • Level of Care and Authorization Criteria Policy contains requirements to ensure that authorization is consistent with Access to Care Standards. • PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. Undated Sample of BHO Subcontract Amendment 01 states, “The Delegate shall ensure authorization is consistent with GCBH’s Access to Care Standards and takes place in consultation with requesting provider.” • BHO Inter-Rater Reliability Report—a sample of 3 clinical vignettes was presented to 3 UM Specialists performing pre-service and concurrent reviews. A threshold of 90% compliance was established as evidence of consistent decision-making. Individual scores were 87%, 93%, 93%. One UM Specialist failed to meet the 90% compliance threshold. Results indicated opportunities for improvement in applying continued-stay criteria. “The one (1) UM Specialist who failed to meet the threshold received individualized training, and follow-up auditing will be implemented to measure ongoing compliance of criteria use.” • No training documentation related to this review element was submitted; however, network provider management reported that relevant training has been provided periodically by the PIHP and BHO. In addition, relevant agency training occurs internally through a variety of venues. • Network provider staff have knowledge of the Access to Care Standards and how they are employed with regard to	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	authorization of services. (Substantial Compliance)	4
[Q40]	**Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise** Evidence: • PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. BHO Subcontract states, "Delegate shall provide RSN with documentation to confirm use of staff (that will accomplish the U/CM activities) that are properly qualified, trained and supervised. Health professionals will maintain necessary current and valid licenses and certificates." Undated Sample of BHO Subcontract Amendment 01 states, "The Delegate shall ensure that authorization decisions are made by Mental Health Professionals with appropriate clinical expertise." • Clinical Review Rating Tool and Results (January-June 2006—reviews for evidence that "There is a complete assessment in the clinical record, conducted by a Mental Health Professional." • No relevant policy and procedures were submitted for review. • No copies of authorizations, job descriptions, or credentials of professionals performing authorizations were submitted for review; unable to verify credentials of individuals authorizing services, and whether MHP requirement is practiced. • Recommend update of policies and procedures to consistently and accurately reflect positions responsible for conducting authorizations and denials of service, and their required qualifications. (Partial Compliance)	2

[Q41]	**PIHP audits subcontractors for consistent authorization practices and evidence of policy**
	Evidence:
	• Undated Completed BHO Audit Tool (no names of reviewers or participants) monitors BHO UM Plan and policies and procedures for:
	    o "Delegate will manage, as authorized by the RSN, prior authorization related to case management activities, including that for Extended Care Benefits (ECBs).
	    o Delegate will manage, as authorized by the RSN, Case Management: assessment and re-assessment, care planning and implementation, collaboration with the company in authorizations required for discharge and transfer needs.
	    o Delegate shall perform its obligations under the terms and provisions of this Agreement in accordance with the	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	following timeframes based upon presence of membership admitted to the Delegate's facility. The RSN timeframes for UM/Case management decisions are: 1) Approval/Denial of non-urgent pre-service decisions - 72 hours; 2) Approval/Denial of urgent pre-service decisions - 72 hours from date of request; 3) Approval/Denial of urgent concurrent pre-service decisions inpatient, intensive, outpatient, residential, behavioral health care, ongoing ambulatory care - certification serves as authorization and is completed in 12 hours, authorization number provided next business day; 4) Physician reviews of denials - within 24 hours; and 5) Notices of action - sent at time of decision." • Undated Completed BHO Audit Tool does not show evidence of PIHP monitoring BHO's **performance** related to the standards listed above. Purpose of audit appeared to be to ensure standards were incorporated into BHO's UM Plan and related policies and procedures. Recommend that future reviews focus on BHO's performance relevant to the PIHP's requirements, standards, and expected outcomes. • BHO Inter-Rater Reliability Report—a sample of 3 clinical vignettes were presented to 3 UM Specialists performing pre-service and concurrent reviews. A threshold of 90% compliance was established as evidence of consistent decision-making. Individual scores were 87%, 93%, 93%. One UM Specialist failed to meet the 90% compliance threshold. Results indicated opportunities for improvement in applying continued-stay criteria. "The one (1) UM Specialist who failed to meet the threshold received individualized training, and follow-up auditing will be implemented to measure ongoing compliance of criteria use." • No copies of authorizations or relevant clinical record review reports were submitted for review of this element. (Moderate Compliance)	3
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • Notice Requirements (Notice of Action) Policy incorporates the Notice of Action (NOA) requirements with the exception of the following timeframe related to the mailing of the NOA: 438.404(c)(2) for denial of payment, at the time of any action affecting the claim. • BHO Subcontract—PIHP delegates authorization and utilization management (UM) and responsibility for sending	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	Notice of Actions to Behavioral Health Options (BHO) of Nevada. Subcontract specifies that BHO will make "adverse determinations and will deliver notice of adverse determinations." • Undated Sample of BHO Subcontract Amendment 01 states: o "The Delegate shall ensure that Notice of Adverse Actions (NOA) meets all State requirements. o Any changes to the NOA shall be made upon GCBH's approval. o The Delegate must establish a procedure to track denials of medical necessity and institute NOA's to protect enrollee rights and allow them an opportunity to exercise their right to appeal." • The BHO Utilization Management Plan incorporates the required NOA content and indicates that notices are provided in writing to enrollees, and orally to providers. • Upon review of two copies of NOAs, reviewer unable to determine if the required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs detailing timeframes from request of service forward were submitted for review. • Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—includes Timing of Notice requirements as specified in 438.404. • Providers receive notification of denials, reductions, suspensions, or terminations as part of the authorization/denial notification process. Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Provider staff had differing reports as to whether the provider receives copy of NOA or are verbally informed. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • Revised Service Authorizations, Expedited Service Authorizations and Extension of Authorizations for Ongoing Outpatient Services Policy contain procedures for standard authorization decisions. • Undated Sample of BHO Subcontract Amendment 01 states:	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	"The Delegate shall maintain policies and/or procedures for standard authorization decisions, expedited authorization decisions and extensions of expedited authorization requests." • Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—includes requirements related to standard authorizations and extensions. • Provider management and direct service staff reported that ongoing training for authorization practices occurs in team meetings. All interviewed staff were knowledgeable and able to articulate the standard authorization practices and procedures. (Substantial Compliance)	4
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Revised Service Authorizations, Expedited Service Authorizations and Extension of Authorizations for Ongoing Outpatient Services Policy contain procedures for expedited authorization requests. • Undated Sample of BHO Subcontract Amendment 01 states: "The Delegate shall maintain policies and/or procedures for standard authorization decisions, expedited authorization decisions and extensions of expedited authorization requests." • Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—includes requirements related to expedited authorizations and extensions. • Provider direct service staff were inconsistent in accurately articulating the general purpose of an expedited authorization. (Moderate Compliance)	3
[Q45]	**Extension of expedited authorization request** Evidence: • Revised Service Authorizations, Expedited Service Authorizations and Extension of Authorizations for Ongoing Outpatient Services Policy contain procedures for extensions of expedited authorization requests. • Undated Sample of BHO Subcontract Amendment 01 states: "The Delegate shall maintain policies and/or procedures for standard authorization decisions, expedited authorization decisions and extensions of expedited authorization requests." • Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Consumer Rights Training PowerPoint—includes requirements related to expedited authorizations and extensions. • Provider direct service staff were unable to consistently articulate the purpose of expedited authorization extensions. (Moderate Compliance)	3
438.214(c)	**Nondiscrimination**	
[Q47]	**Protection against provider discrimination** Evidence: • New Policy Provider Network Selection and Retention Policy contains requirements related to protections against provider discrimination. • 05-06 PIHP Subcontract and 06-07 PIHP Subcontract incorporate includes requirements of this provision. • 05-06 Administrative Audit Results (Scoring by Provider)—reviews to ensure that "Nondiscrimination. Contractor provider selection policies & procedures must not discriminate for the participation, reimbursement or indemnification of any provider who is acting within scope of his/her license or certification under applicable State Law, solely on the basis of that license or certification. If Contractor declines to include groups of providers in its network, it must give the affected providers written notice of the reason for its decision. All contracts with CMHAs must comply with 42 CFR 438.214." • Provider network management reported that they have not experienced discrimination by PIHP.	
	(Moderate Compliance)	3
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • Revised Delegation Policy does not include the requirements related to the evaluation of Subcontractor ability to perform delegated functions. Policy includes list of PIHP-delegated activities. • BHO Pre-Delegation Audit conducted by G. Lippman, MD 7/04/05-7/05/05. **Conclusion:** "This audit was performed by Greater Columbia RSN in preparation to delegation of UM activities to Behavioral Health Options. Behavioral Health Options was found to be in significant compliance with the UM standards. Needs to include formalization of time frames, reliability processes."	

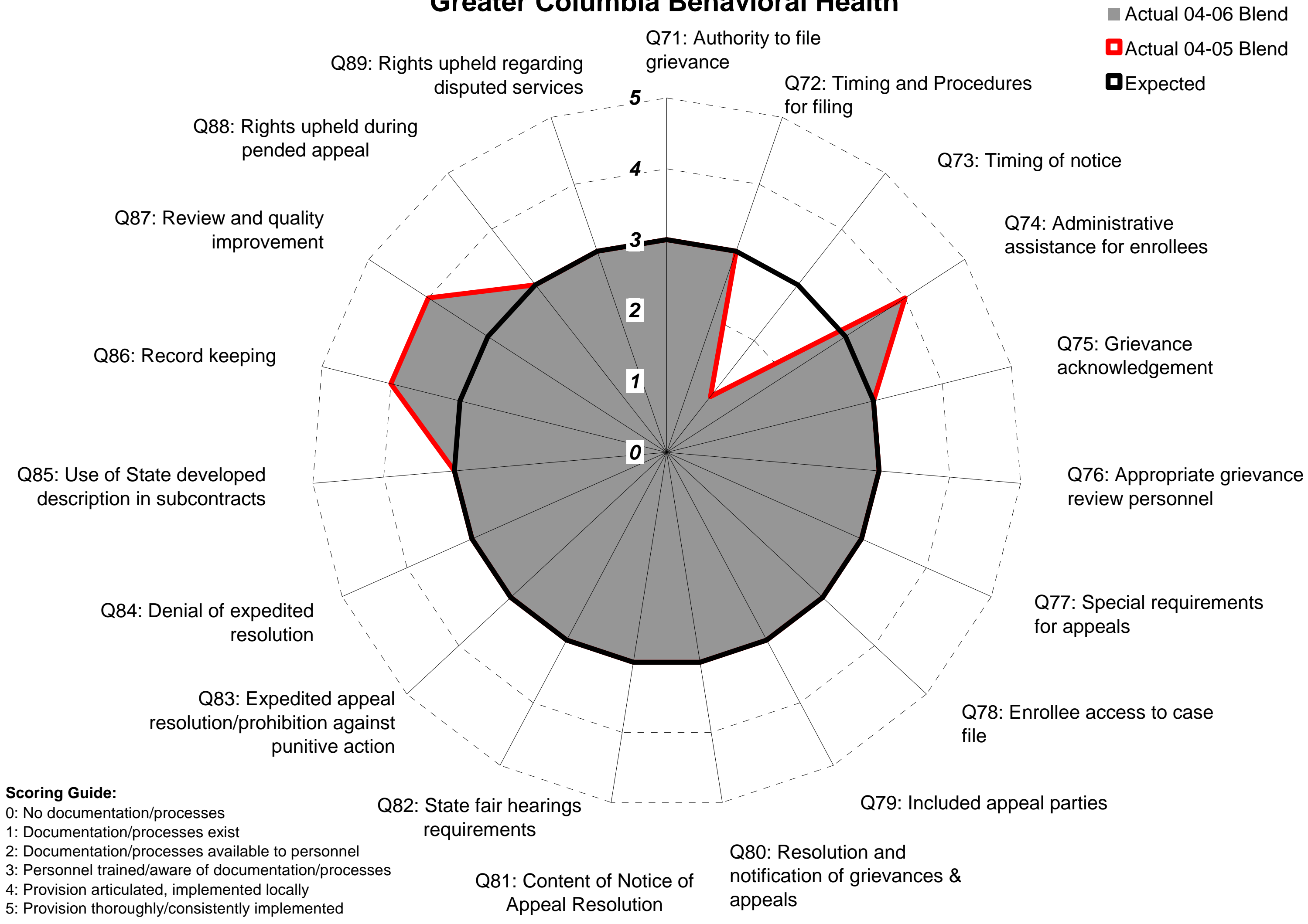
CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Ombuds RFQ, Benton-Franklin Dispute Resolution Center's Response, and Comparison of Responses to RFP. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • Revised Delegation Policy does not include the requirements related to the evaluation of Subcontractor ability to perform delegated functions. Policy includes list of PIHP-delegated activities. • BHO Subcontract—PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. Subcontract specifies the activities and responsibilities delegated to BHO and provides for revoking delegation. Subcontract does not specify other sanctions if the subcontractor's performance is inadequate. • 05-06 Ombuds Contract and 06-07 Ombuds Contract—Contract stipulates Ombuds activities and responsibilities, and provides for revoking delegation. Contract does not specify other sanctions if the subcontractor's performance is inadequate. • Recommend that PIHP delegation subcontracts explicitly outline potential sanctions related to sub-standard performance (in addition to termination). (Moderate Compliance)	3
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • GCBH Contract Audits Policy states, "This policy applies to GCBH Member Governments and subcontractors for monitoring of delegated responsibilities from Greater Columbia Behavioral Health… Audits will be performed according to a GCBH Board approved annual audit plan. Audits will be performed to assess compliance with contractual requirements." Policy includes an effective audit process tree/flowchart. • Undated Completed BHO Audit Tool (no names of reviewers or participants)—desk review of BHO QI and UM Plan, contract, and policies and procedures. Purpose of audit appeared to be to ensure that standards were incorporated into BHO's UM Plan and related policies and procedures. Reviewer unable to determine if performance of BHO was reviewed and whether	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	quality improvements and/or corrective actions were issued. Recommend that future reviews focus on BHO's performance relevant to the PIHP's requirements, standards, and expected outcomes. • BHO Final Administrative Audit Report—Indicates that an audit was conducted onsite at BHO in Las Vegas, Nevada, April 17, 2007, by Mary Todd-PIHP Contracts Manager, with participation from the BHO Utilization Management Manager. Report Summary identifies opportunities for improvement/recommendation related to BHO's QI and UM Plan. As indicated earlier, report does not include opportunities for improvement related to BHO's performance. • No review of Ombuds performance was submitted. • Recommend that the PIHP delineate review standards for each of the delegated functions. Stipulate in each delegation subcontract the frequency and manner by which delegates will be reviewed. (Moderate Compliance)	3
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • GCBH Contract Audits Policy states, "Findings would include statements of compliance, recommendations which may be permissive, or statements of noncompliance that require coming into compliance with corrective actions within agreed upon timelines. Subcontractor shall have 10 business days to respond to the preliminary audit report. This may include face-to-face meetings between subcontractor and GCBH to discuss their rebuttal input, and as appropriate, agree on acceptable changes." • Undated Completed BHO Audit Tool (no names of reviewers or participants)—desk review of BHO QI and UM Plan, contract, and policies and procedures. Purpose of audit appeared to be to ensure that standards were incorporated into BHO's UM Plan and related policies and procedures. Reviewer unable to determine if performance of BHO was reviewed and whether quality improvements and/or corrective actions were issued. Recommend that future reviews focus on BHO's performance relevant to the PIHP's requirements, standards and expected outcomes. • No review of Ombuds performance submitted. • BHO Final Administrative Audit Report—Indicates that an audit was conducted onsite at BHO in Las Vegas, Nevada, April 17, 2007, by Mary Todd-PIHP Contracts Manager, with participation from the BHO Utilization Management Manager.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	Report Summary identifies opportunities for improvement/recommendation related to BHO's QI and UM Plan. As indicated earlier, the report does not include opportunities for improvement related to BHO's performance. • BHO Corrective Action Plan—from BHO-Executive Director of Operations, dated 7/7/06. No PIHP final approval of BHO corrective action plan was submitted for review. (Moderate Compliance)	3
438.236	**Practice Guidelines**	
[Q56]	**Adoption of practice guidelines meets established requirements** Evidence: • Utilization Management Policy and the Quality Management Plan collectively include the basic requirements of this provision. • Quality Management Plan states, "Practice Guidelines currently adopted for system-wide implementation include: APA Practice Guideline: Psychiatric Evaluation of Adults, Second Edition, APA Practice Guideline: Treatment of Patients with Major Depressive Disorder, Second Edition." • Board of Director's Meeting Minutes dated 08-24-06—provide evidence that the practice guidelines were officially adopted. • Network provider management reported that the PIHP originally distributed the proposed practice guidelines (Adult Major Depression and ADHD) during the August 2006 Clinical Directors meeting. Upon reviewing the ADHD practice guideline, providers determined that it was not a good fit. Therefore, the PIHP proposed an alternative and, ultimately, the PIHP and provider network selected the practice guidelines identified above. • No evidence of related training for PIHP or network provider staff. In addition, provider management and direct service staff reported that no practice guideline training has been provided by the PIHP. At one provider, supervisors have reviewed the guidelines with their direct service staff. (Substantial Compliance)	4
[Q57]	**Dissemination of practice guidelines to providers and enrollees upon request** Evidence: • Utilization Management Policy and the Quality Management Plan collectively include the basic requirements of this provision. • Quality Management Plan states, "Practice Guidelines currently	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	adopted for system-wide implementation include: APA Practice Guideline: Psychiatric Evaluation of Adults, Second Edition, APA Practice Guideline: Treatment of Patients with Major Depressive Disorder, Second Edition." • Board of Director's Meeting Minutes dated 08-24-06—provide evidence that the practice guidelines were officially adopted. • Network provider management reported that the PIHP originally distributed the proposed practice guidelines (Adult Major Depression and ADHD) during the August 2006 Clinical Directors meeting. Upon reviewing the ADHD practice guideline, providers determined that it was not a good fit. Therefore, the PIHP proposed an alternative and, ultimately, the PIHP and provider network selected the practice guidelines identified above. • Clinical Director's Meeting Minutes dated 11-28-06—brief discussion of practice guidelines and need to have documented evidence that staff have been exposed to the practice guidelines. • Provider management and direct service staff are able to identify the adopted practice guidelines. • No evidence of related training for PIHP or network provider staff. In addition, provider management and direct service staff reported that no practice guideline training has been provided by the PIHP. At one provider, supervisors have reviewed the guidelines with their direct service staff. (Moderate Compliance)	3
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • Utilization Management Policy and the Quality Management Plan collectively include the basic requirements of this provision. • Quality Management Plan states, "Practice Guidelines currently adopted for system-wide implementation include: APA Practice Guideline: Psychiatric Evaluation of Adults, Second Edition, APA Practice Guideline: Treatment of Patients with Major Depressive Disorder, Second Edition." • Board of Director's Meeting Minutes dated 08-24-06—provide evidence that the practice guidelines were officially adopted. • Clinical Director's Meeting Minutes dated 11-28-06—brief discussion of practice guidelines and need to have documented evidence that staff have been exposed to the practice guidelines. • No tools or methods of monitoring the practice guidelines were submitted for review. • PIHP and provider staff reported that the PIHP has not begun	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	clinical monitoring of the adopted practice guidelines. PIHP staff reported that they are just beginning the process of creating tools and methods to monitor fidelity to ensure full utilization of the practice guidelines in clinical services. (Partial Compliance)	2



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Greater Columbia Behavioral Health

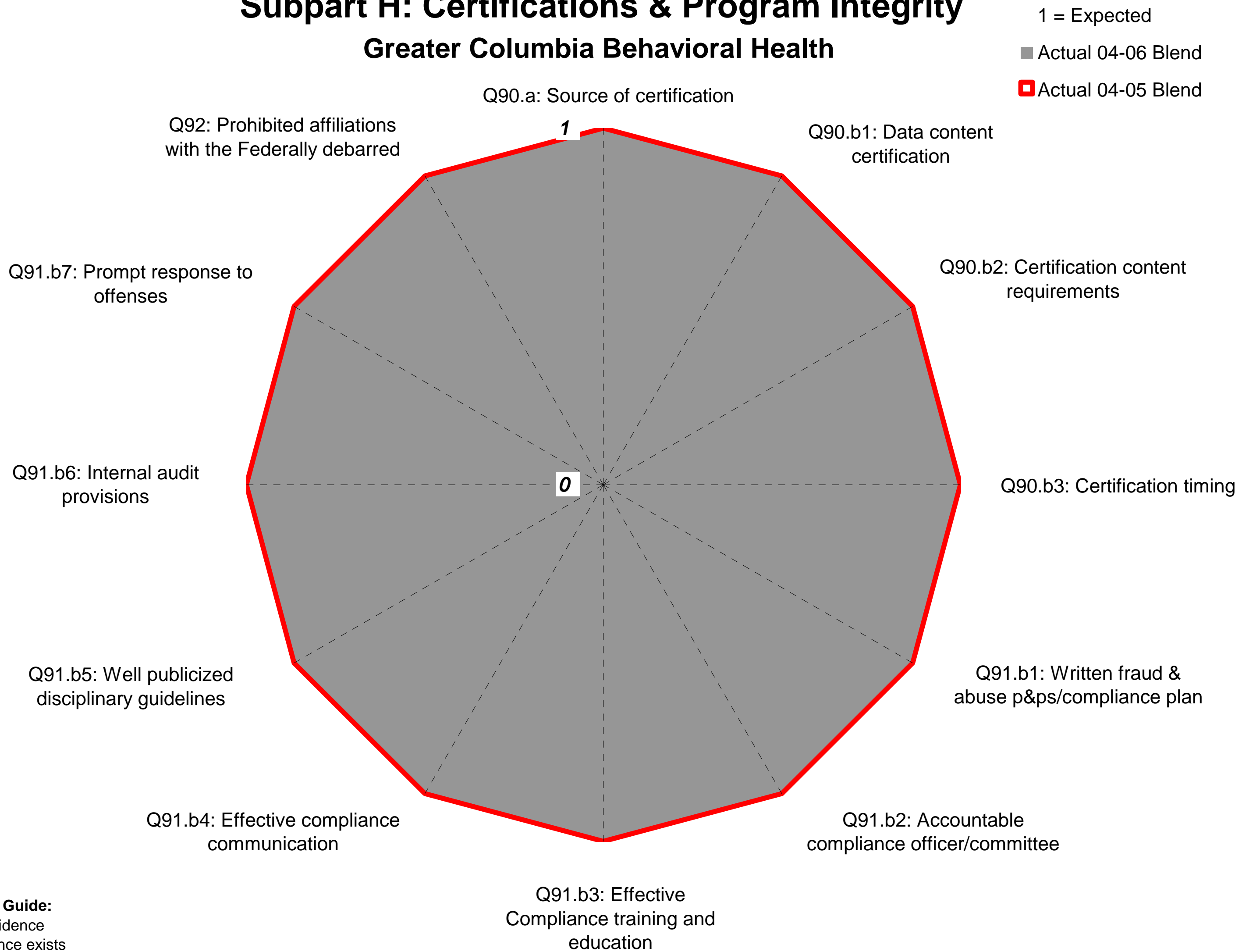
Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	3		3
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	1	1	1
Q74: Administrative assistance for enrollees	4		4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	4		4
Q87: Review and quality improvement	4		4
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
438.404	**Notice of Action-Timing of Notice**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • Notice Requirements (Notice of Action) Policy incorporates the Notice of Action (NOA) requirements, with the exception of the following timeframe related to the mailing of the NOA: 438.404(c)(2)-For denial of payment, at the time of any action affecting the claim. • BHO Subcontract—PIHP delegates authorization and utilization management (UM), and responsibility for sending Notice of Actions to Behavioral Health Options (BHO) of Nevada. Subcontract specifies that BHO will make "adverse determinations and will deliver notice of adverse determinations." • Undated Sample of BHO Subcontract Amendment 01 states: o "The Delegate shall ensure that Notice of Adverse Actions (NOA) meets all State requirements. o Any changes to the NOA shall be made upon GCBH's approval. o The Delegate must establish a procedure to track denials of medical necessity and institute NOA's to protect enrollee rights and allow them an opportunity to exercise their right to appeal." • The BHO Utilization Management Plan incorporates the required NOA content, and indicates that notices are provided in writing to enrollees and orally to providers. • Upon review of 2 NOAs, reviewer unable to determine if required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs were submitted for review (detailing timeframes from request of service forward). • Consumer Rights Training Schedule and Attendance Rosters—indicate training occurred for the majority of network providers between 1/06 and 12/06. • Consumer Rights Training PowerPoint—includes timing of notice requirements as specified in 438.404. • Providers receive notification of denials, reductions, suspensions, or terminations as part of the authorization/denial notification process. Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Provider staff had differing reports as to whether the provider receives copy of NOA or are verbally informed.	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	• Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for
Greater Columbia Behavioral Health

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	1		1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

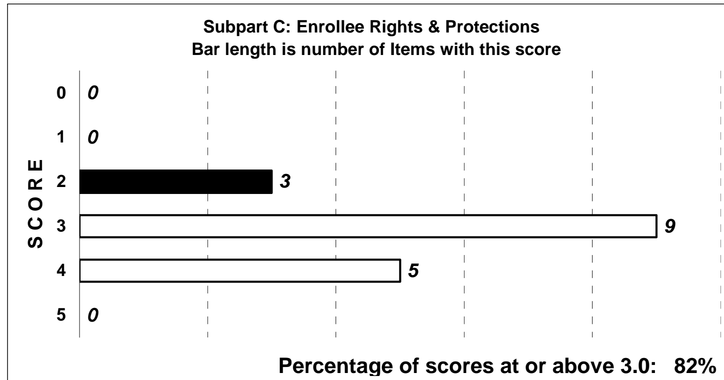
CFR Reference	Compliance Determination Report *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness, and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness, and truthfulness of the data (Compliance)	1
[Q90.b2]	**Accuracy, completeness, and truthfulness of documents specified by State** (2) To the accuracy, completeness, and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (Compliance)	1

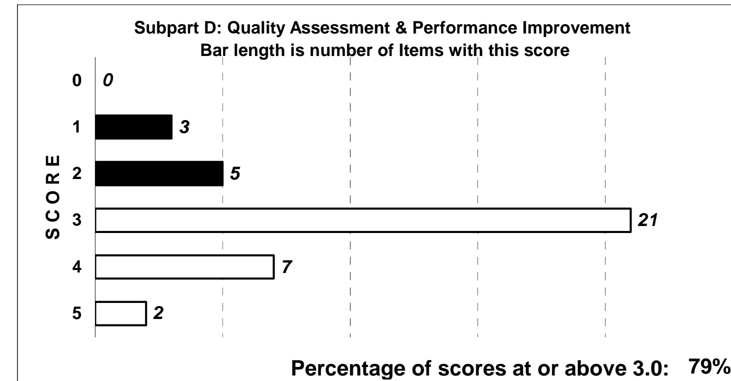
Scoring Frequency Overview

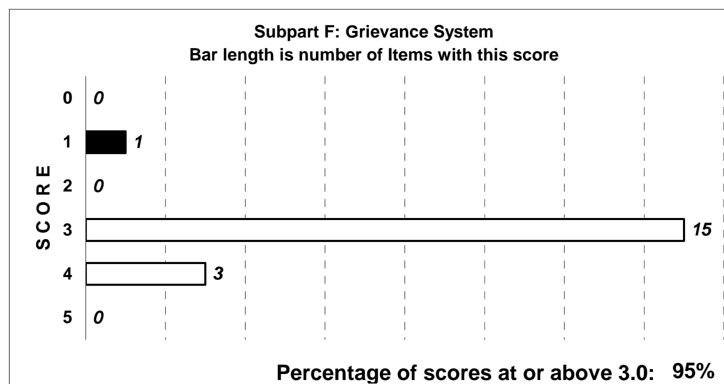
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Greater Columbia Behavioral Health

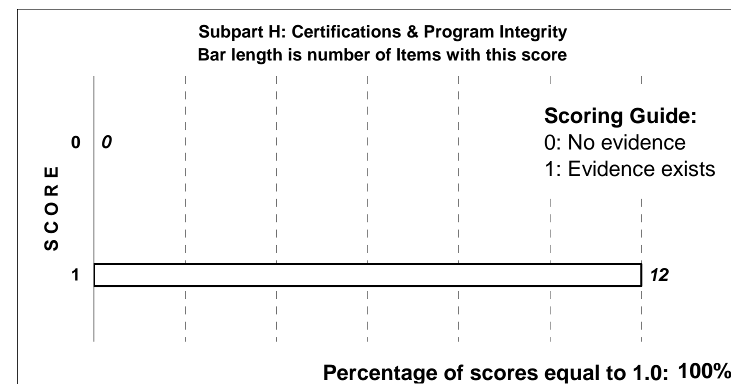
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the “blended” 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 82%
Subpart D: 84%
Subpart F: 95%
Subpart H: 100%

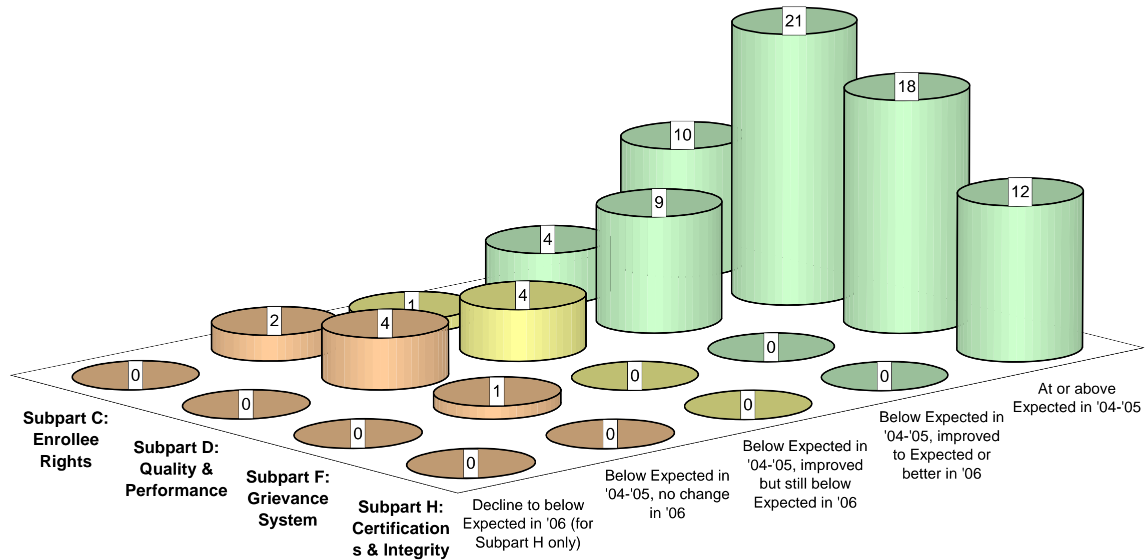
By prioritizing Certifications and Program Integrity, Greater Columbia Behavioral Health achieved Expected compliance for Subpart H in 2005, and again in 2006. GCBH has also achieved Expected compliance for all but one review element in Subpart F-Grievance Systems.

The PIHP continues to make progress with respect to Subpart C-Enrollee Rights and Protections, and Subpart D-Quality Assessment and Performance Improvement. However, relevant policies and procedures remain underdeveloped and are missing key requirements. Specific areas that remain a challenge include, but are not limited to, elements related to sufficiency of provider network, evaluation of subcontractor ability to perform delegated functions, requirements related to Notice of Actions, and implementation of practice guidelines. In addition, the GCBH needs to increase the knowledge and application of Subparts C and D requirements at the level of network providers and their staff.

Score Trend Summary for:
Greater Columbia Behavioral

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights		Subpart D: Quality & Performance		Subpart F: Grievance System		Subpart H: Certifications & Integrity	
	Item Count	Percent	Item Count	Percent	Item Count	Percent	Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	2	11.8%	4	10.5%	1	5.3%	0	0.0%
Below Expected in '04-'05, improved but still below Expected in '06	1	5.9%	4	10.5%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	4	23.5%	9	23.7%	0	0.0%	0	0.0%
At or above Expected in '04-'05	10	58.8%	21	55.3%	18	94.7%	12	100.0%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, GCBH performance relative to Subpart C (*Enrollee Rights*) showed 10 out of 17 items (58.8%) already at or above the Expected level of performance. After the 2006 review, 14 items (82.3%) are at the Expected level, reflecting improvement in 4 out of 7 elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), GCBH entered the 2006 review with 18 of 19 items (94.7%) already at or above Expected. After the 2006 review, GCBH had no score changes in Subpart F; therefore, 18 items (94.7%) remain at the Expected level of performance

Although Greater Columbia Behavioral Health did not show improvement in Subpart F, improvement in other required Subparts reflects focused efforts on continuous quality improvement during 2006.

Subpart Strengths

- The PIHP has maintained a steady level of continuous quality improvement while recruiting for a PIHP Administrator and other positions during the review period.
- PIHP prioritized and conducted a comprehensive Consumer Rights training for their entire provider network in 2006.
- Automation of Administrative and Clinical Review Tools to electronic formats with immediate data entry, resulting in accessible, aggregated data providing the capability to identify strengths and opportunities for improvement across the PIHP provider network.

Subpart Challenges

- Delays and barriers in obtaining Governing Board approval to move forward with the Sufficiency Strategy Project Proposal.
- Revised policies and procedures were not re-approved once revisions were finalized.
- PHIP staff are challenged in effectively using the data they generate for aggregate data analysis and formulating quality improvements.
- Increased oversight of providers intensifies the communication and relationship challenges. Maintaining effective and productive communication with network providers, in conjunction with holding the agencies accountable, is critical to the success of the local public mental health system providing quality care and services.

Subpart Recommendations

1. Revise Enrollee Rights Policy to ensure the inclusion of the enrollee's right to request and receive a copy of their medical record, and enrollee's protection of privacy as set forth in 45 CFR parts 160 and 164.

2. Determine network adequacy guidelines/standards, and manage using the existing provider database. Develop a quality improvement process for evaluating capacity and network sufficiency through the use of reports and effective management practices that makes use of report information.

3. Clarify and train PIHP and provider network staff on specific procedures related to out-of-network provider referrals, and coordination of care and payment.

4. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

5. Revise policies and procedures to consistently and accurately reflect staff positions responsible for conducting authorizations and denials of service. Include the required qualifications of relevant staff.

6. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

7. Incorporate all required BBA requirements for Notice of Actions in policy and procedures. In addition, establish a procedure to accurately track and monitor all critical timeframes related to service access, denials, reductions, suspensions of service, and Notice of Actions (NOAs).

8. Clarify delegated PIHP functions and develop processes related to **<u>all</u>** subcontractor delegation:
    a. Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    b. Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    c. Review their related **<u>performance</u>** on an annual basis.

9. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).

10. Prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms. To provide a reliable record of activities, create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the WAEQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited to a technical assistance review, and, as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO which, if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The PIHP has a policy and procedure which requires all providers to submit their crosswalk on an annual basis, or whenever it changes.

2. Unique member ID
   Each provider has a unique system for assigning Client IDs, and the RSN manages unique IDs for all clients within its jurisdiction. They review their client IDs for duplicates and eliminate them as needed.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The PIHP can track members, regardless of changes in status, periods of enrollment and disenrollment, or changes across product lines.

4. Calculating member months
   The PIHP is using member month calculations in some management reports. The accuracy of the methodology used to generate their member months and its applicability is still being studied. Authorizing services for six (6) month periods could undermine member month calculations if breaks in eligibility during these periods are not accurately tracked.

5. Member database
   The PIHP is using the data provided by MHD in a member database. They update their data monthly and use this data as a step in determining Medicaid eligibility.

6. Provider Database
   PIHP staff stated that they maintain provider data in their database. They collect

more than the State requires and use this data for coordinating surveys within their provider network.

7. Data easily under-reported
The PIHP reports that the only services they use out-of-network are inpatient services. The PIHP has a policy for out-of-network services.

PM Summary

GCBH has strong pre-submission screening processes on its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. The PIHP's efforts in this year's analysis and encounter validation review (described below) show that the PIHP made good efforts to validate its data. The overall score of Partially Met in the 2006 encounter validation review has a depressing impact on the general state of the PIHP's performance measure accuracy. The general state of the PIHP's data is evaluated as "fair". Steps are being taken to help bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- The PIHP's system to ensure that its data is timely, accurate, and complete is well-documented, helping the PIHP consistently apply the tools developed.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback whenever possible on previously developed (or new) PIPs.

APS reviewed all three submitted PIPs for GCBH: two were identified by the PIHP as non-clinical and one as clinical. Included in the desk review were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post-measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and to evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006 (see, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

For validated PIPs ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

Non-clinical PIPs submitted for review are titled, "Community Inpatient Savings Project" and "Study and Implementation Plan to Improve Data Storage and Retrieval"; the clinical PIP is "Implementation of Family Assessment and Stabilization Team (FAST) in Benton-Franklin County". None of the submitted PIPs are developed or formulated well enough to be validated using the CMS protocol. All are descriptions of ongoing improvement activities, one reaching back five years, that have not been consistently conducted in a structured QI manner. The data storage and retrieval project is resulting in a conversion from Fox Pro to SQL, a much-needed enhancement but not related to clinical outcomes or processes of care. The other two projects relate to development of community-based alternatives to inpatient care; again, much-needed improvements. The inpatient savings project is organized around financial considerations, and the PIHP did not submit a project summary for the FAST program. Minimal documentation was provided of the structure and plan for this project.

Discussion with the PIHP at the site visit focused on their experience of the MHD PIP training in September: GCBH staff demonstrated an enhanced understanding of the protocol and requirements for conducting PIPs. The WAEQRO clarified some concepts and expectations, emphasizing that the PIHP is required to develop two of their own PIPs and recommending that they review their performance data related to clinical

outcomes and processes to identify potential study topics.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Validation was not performed for this PIHP

Activity 2: Evaluate Overall Validity and Reliability of Study Results

Validation was not performed for this PIHP

PIP Strengths

- The PIHP appears to have a more accurate understanding of the PIP protocol and the process by which study topics are most effectively considered and selected.

PIP Challenges

- The PIHP, in waiting for the MHD training and final word on the possibility of a state-wide PIP, will be starting anew in year 4 of the EQR process.

PIP Recommendations

1. Ground study topic in available data that has been analyzed and prioritized for improvement of client outcomes or processes of care.

2. Design specific and provable study questions (i.e., data is available for study indicators).

3. Design a data analysis plan that provides strong support for results of study, including assessment of reliability of data and potential bias in results.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements (see, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff and, in some cases, a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding), and identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers with responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	The Greater Columbia Behavioral Health PIHP uses the State Data Dictionary and the MHD Service Encounter Reporting Instructions as a basis for its own data dictionary. The PIHP has items in addition to the state requirements that their provider agencies are required to submit. The PIHP's data dictionary and their trading partner agreements (TPAs) with network providers further define how and in what format providers submit data to the PIHP's database. The PIHP has a policy and procedure for making changes in their data dictionary. There was no evidence of a completeness standard for their data.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The State and PIHP's Data Dictionaries, MHD Service Encounter Reporting Instructions, and TPAs are communicated to the PIHP's providers when they become available. Changes are coordinated in an open forum where the providers are given opportunity to participate.

Item	Rating	Comments
2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	There was no evidence to support that the PIHP has made efforts to document its provider network IT capabilities and vulnerabilities. However, their pre-submission screening process helps resolve issues that may cause errors, and they have standards in their contracts stating minimum functionality levels for software used. The PIHP has not documented and

PIHP Encounter Validation
Process Review

Item	*Rating*	*Comments*
		evaluated its entire network to identify potential vulnerabilities in the provider agencies' IT systems.
3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Partially Met	The PIHP employs an array of processes to ensure that data is accurate and complete prior to submission. The various processes used are well documented. Data is screened automatically when the provider submits batches of encounters to the PIHP's database. Alerts, errors, and warnings are generated and reviewed by GCBH staff and communicated to the provider via reports and e-mails specific to that batch. Additional reports for analysis of the providers' data are generated after the provider batch is accepted and before the data is submitted to MHD. When the data is transmitted to the state, further screening generates feedback that PIHP staff address with their provider network. Although the PIHP creates reports of its data to validate its completeness and accuracy, it does so in monthly or smaller increments. The reports that were submitted do not provide trends, thresholds, or comments indicating what actions may have been taken based on quality of the data. Efforts to verify data prior to transmission are excellent. Although completeness values are generated, these values mean little without defined completeness standards, trends, and feedback indicating action is

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		being taken based on the results.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Partially Met	Tools are defined to accomplish the screening and reporting described above. Including trends and feedback from analysis of the data needs to be incorporated.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data is not frozen for the purpose of analysis.
4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Met	The encounter validation conducted by GCBH met the requirements outlined in the contract between the state and the PIHP. The process is comprehensive and well-documented.
PIHP includes additional data elements in matching exercise.	Partially Met	The EV process is combined with a clinical chart review; therefore, other data elements are present. If the PIHP had a method to identify data that is seldom (if ever) verified, such data could be added to reviews on a rotating basis to ensure its eventual scrutiny.

PIHP Encounter Validation Process Review

Item	Rating	Comments
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Partially Met	The tool used by GCBH is the primary tool for clinical chart reviews. A tool mapping data elements to processes that checks accuracy and completeness of those elements needs to be developed, as does a data completeness standard.
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	It is unclear whether the report provided summarizing the audits conducted by GCBH is the same report provided to the state; the WAEQRO will make that assumption for the purpose of this report. The report discussed the number of records required and the time period for that requirement but does not reiterate other requirements. The overarching method of review (strength-based and partnering with provider staff) is discussed, as are summaries of accuracy found. Areas of particular note are summarized and process issues are documented. The report ends with a list of recommended areas where further emphasis may be needed. Since the process combined both data verification and clinical chart review, the report also combines elements of both. The link between the contract requirements and the report results is not obvious. It would be helpful to break out the elements more specific to data validation from those more clinical in nature. Ideally, the report covering the encounter validation activities should contain the information requested by this tool.

PIHP Encounter Validation Process Review

Item	Rating	Comments
		At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	These reviews are conducted with provider staff. PIHP staff provided evidence demonstrating the practice of sharing review results with their providers.
PIHP regularly reports internally for quality improvement activities.	Met	Policy and procedures require the reporting and internal discussion of the results of these activities. The recommendations at the end of the report pertain to these activities.
6. Follow-up activities		
PIHP has policy and procedure for	Met	The PIHP has a policy and procedure that outlines documentation and

PIHP Encounter Validation
Process Review

Item	Rating	Comments
documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.		oversight activities for findings generated from review activities. Evidence was submitted documenting a PIHP request for a corrective action plan to address deficiencies found in an agency review. Evidence of the PIHP working with the provider agency on these issues was also submitted.
If warranted, evidence of follow-up activity was presented.	Met	Evidence was submitted related to PIHP follow-up on a request for corrective action that, a year later, had not produced measurable improvement.

Summary of Encounter Validation Findings

Score Met _43_%

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

Met	Partially Met	Not Met

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP met the requirements set forth in the contract between the MHD and the PIHP. The encounter validation review conducted by the GCBH is comprehensive and well documented. Their team approach and partnering with their providers while conducting these reviews helps to effectively communicate findings to the provider agency under review. The reports for data analysis need more information to be useful. Having trend data, thresholds, and brief discussion of the findings would be most helpful.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 43% of all items meeting a score of Met, 14% at Not Met, and the remaining 43% at Partially Met.

EV Strengths

- The PIHP has designed and implemented an effective and well documented, team-based approach for reviews.
- Documentation of the processes and procedures used to verify the timely, accurate, and complete submission of data is comprehensive and detailed. The PIHP has also identified necessary improvements and is taking steps for their accomplishment.

EV Challenges

- Because the PIHP has not developed report analysis tools, identification of areas of the PIHP operation requiring improvement is hampered. The reports as currently structured do not provide the level of analysis necessary to understand system performance.
- Inclusion of EV results in Clinical and Data Verification Audit report obscures the detail of the EV results and may result in lack of attention to process that require attention.

EV Recommendations

1. Define and implement a data completeness standard against which all providers and the PIHP can evaluate performance.

2. Document the provider network's information systems to evaluate the capacity to produce accurate and complete encounter data.

3. Add trend data and analysis notes to reports to improve understanding of system performance and improvement needs.

4. Analyze the complete dataset evaluated in the review; i.e., if the review covers six months, analyze data for the entire six-month period.

5. Freeze the dataset being analyzed.

6. Separate and refine how the data verification elements are displayed in reports to provide more comprehensive views of the results.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Greater Columbia Behavioral Health

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		2		• The QAI Plan includes most components of a comprehensive plan, such as: goals, scope, annual review, performance improvement projects, quality indicators, accountability, and responsibilities of committees. • Plan includes policy and procedure references related to scope of the Plan. • Plan clearly describes role of Board of Directors (BOD) as responsible for PIHP operations, including the quality management program. • While the Plan states that PIHP operations and quality management are

PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				delegated, the table identifying membership on committees and the narrative in the Plan describing committee membership and relationships to the Board are confusing on this matter. • Monitoring and oversight of the utilization management subcontractor is not assigned or defined in the Plan. • The Chart of Subcommittees indicates a Quality Manager role; however, the duties are not defined in the Plan. • Monitoring methods and frequency of reporting are not discussed in sufficient detail to assure routine evaluation of service delivery. • The performance measures table is limited to contractual requirements and lacks calculation methods, thresholds for further action, and reporting frequency and responsibility. • In describing and diagramming the conceptual model, PI activities appear to overlap with RSN operations only partially. In a comprehensive QI process, PI activities would inform all aspects of RSN operations and hence be an overlay rather than an overlap. • Missing is:

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PIHP: Greater Columbia Behavioral Health

Requirement	Met	PM	Not Met	Findings Comments
				o A consumer-focused, quality of care vision; o An annual work plan of 3-4 specific quality improvement activities based on findings from the previous year and a statement of the population served.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		**3**		• The Plan specifies that the QMOC is responsible for annually updating the written plan and providing the revised Plan to stakeholders. • The QM Plan does not specify timing of the annual review activities, nor details related to incorporating results into the following year's plan.
C. Plan includes annual work plan and process for review of associated activities and progress.			**0**	• PIHP did not provide an annual work plan that includes targeted, focused quality improvement activities to be addressed for the specific year (that are not the PIPs).
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		**2**		• Plan provides for various types of reviews in description of committee structures and responsibilities. • While a degree of report frequency is specified for some monitoring functions, the frequency of reviews, reporting schedules, and use of information for *all* oversight activities is unclear. • The Plan does not reference corrective

PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				actions as part of a comprehensive review and follow-up process.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.		**3**		• Underlying assumptions for committee work identify the Advisory Board as a key forum for consumer, family, and stakeholder voice. • Membership of QMOC includes Ombuds and QRT. • Based on the committee membership table attached to the Plan, the consumer representative of the Regional Advisory Board sits on the QMOC and Clinical Directors committee. • Narrative Plan fails to emphasize and specify consumer involvement in QAI activities.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**3**		• Evidence of implementation: o Consistent agendas, minutes, and sign-in sheets for QMOC and subcommittees. o Minutes of QMOC document review of regular reports from UM staff, Ombuds, and QRT, as well as distribution of audit schedule. o Routine minutes of Multicultural Committee include discussion of committee's work plan. o BOD 11/06 minutes discuss revisions to QAI Plan; however,

PIHP: Greater Columbia Behavioral Health

Requirement	Met	PM	Not Met	Findings Comments
				notes do not clearly reflect adoption of the revisions. o Provider management and staff confirmed that performance indicators are reviewed in committees. o Plan stipulates periodic, process-focused reviews as necessary. PIHP described a specific review of this nature which they conducted. o Though provider management indicated that not all providers are represented on the QMOC, they still felt there was fair representation. Due to distance, some attend by phone. • Evidence of annual review of the QM Program was not submitted. • No evidence was submitted indicating that BOD has officially approved Plan revision. • No evidence was submitted indicating the actual frequency/consistency of QMOC subcommittee meetings.
Standard 1 Count (Target 6 Met):	**0**	**5**	**1**	**Target Points: 24 Actual: 13**

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PIHP: Greater Columbia Behavioral Health

Requirement	Met	PM	Not Met	Findings Comments
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			• Evidence was submitted indicating that chart reviews are routinely conducted: o Policy and procedures for provider audit and chart reviews. o Clinical and Data Verification Audits Summary Report for 2006. o QMOC minutes reflecting discussion of provider audits and number of charts reviewed. o Clinical Directors committee minutes reflecting discussion of review of chart audits. o Provider management confirmation of detailed chart audit analysis. o Spreadsheet containing raw data relative to 417 chart reviews conducted in 2006; included were aggregated data reports depicting levels of compliance for individual PIHPs and entire system. o Completed annual provider audit reports for several providers. o Confirmation by provider management and direct service staff

PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				that reviews are conducted as described in the plan.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.	**4**			• CRRT Tool of 86 items with Scale 0-3 or Yes/No score is an effective monitoring tool and allows for trending. • PIHP staff reported that the automated version of the CRRT provides "tripping levels", which are the thresholds for determining scores. However, evidence was not provided of the criteria for applying scores. • Chart review results in an Excel spreadsheet reflect simple averages of all elements scored; this methodology masks any outliers that might require attention. • PIHP described case-by-case consultation that occurs on-site during reviews. • Provider management and direct service staff confirmed the chart review process as described by the PIHP; staff also expressed value of side-by-side approach.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**2**		• Documents submitted provide evidence of reviewer training: o 11/06 UM staff Chart Review Audit training agenda and attendance. o QMOC Meeting notes reflecting that

PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				staff debrief after each review to address inter-rater reliability issues. • Review tool does not include criteria for applying scores; criteria used for training was not provided. • PIHP does not conduct formal inter-rater reliability exercises.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**3**		• Provider contracts include CA procedures and timelines. • Chart Review Policy and pre-audit procedures sent to agencies provide details of review and CA process. • Schedule of review process and timelines for reporting and follow-up on CAP requests provides detailed reference for internal compliance monitoring. • PIHP submitted summary chart review reports for several providers that included requests for corrective action plans; also included one provider response with requested plan. • One example of a complete process was submitted, demonstrating request for CAP through to PIHP follow-up. Dates of all activities not included. • Although not supported by submitted documentation, the PIHP reported that

PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				corrective action decisions are based on formulas in an electronic auditing system. PIHP staff stated that they are looking for improvement in some areas and compliance in others. • Provider management described the general framework for recommendations and corrective actions; however, because the thresholds for corrective action were identified to them after the audit was completed, providers do not know in advance the standards to which they will be held accountable.
Standard 2 Count (Target 4 Met):	**2**	**2**	**0**	**Target Points: 16 Actual: 13**
<u>Standard</u> **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		**1**		• QMOC met regularly through the year: reviewed reports from UM staff, Ombuds, and QRT, with infrequent "action" indicated following discussion or review of material presented. Only a few references were mentioned with

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PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				respect to results of clinical oversight activities from chart reviews. • Very little evidence was submitted to confirm PIHP review and analysis of provider chart reviews.
B. PIHP analyzes and trends individual provider performance.		**3**		• Individual annual provider audit reports include a table depicting problematic review categories (based on aggregated chart review scores). The reports also provide details for each chart reviewed. • Review findings are summarized in narrative format and include strengths and weaknesses, • Capacity for this report process is fairly new; therefore, longer term analysis is not yet available. • Provider staff noted that the new electronic chart review tool, which allows for immediate feedback, is a great improvement.
C. PIHP analyzes and trends system-wide performance.		**2**		• Clinical and Data Verification Audits Summary Report for 2006 includes a summary of findings for each provider and across the system. • Longitudinal trends are not provided. • Information regarding data sources and analytic methods was not provided. • No evidence of data analysis (report is a

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PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				summary of results).
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		**2**		• Discussion of results of clinical chart reviews occurs monthly at QMOC and in recent UMC meetings; however, detail regarding analysis and recommendations is limited. o Discussion based on review of upcoming schedules and reports provided to individual agencies. o Clinical and Data Verification Audits Summary Report for 2006 is not referenced as having been reviewed. • No evidence was submitted documenting discussion of system-wide performance related to provider chart reviews.
Standard 3 Count (Target 4 Met):	**0**	**4**	**0**	**Target Points: 16 Actual: 8**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.	**4**			• PIHP submitted complaints and grievances report by quarter; the report documents complaints, grievances, and fair hearings by type and provider and

PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				includes RSN totals. • PIHP noted at site-visit that all calls are logged and tracked by the Customer Service staff, including appeals and NOA issues. The log was provided for WAEQRO review. • Documentation was submitted with respect to tracking the entire process of the one grievance filed during the review year.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.	**4**			• February 2006 QMOC meeting indicates that QRT provides a semi-annual report which includes graphic representations of types of complaints and a discussion of their possible bases. • Minutes of QMOC include monthly reports from Ombuds and evidence of discussion and follow-up. • Exhibit N for April-Dec 2006 was submitted for WAEQRO review; evidence that this report was submitted to QMOC. • PIHP noted at site visit that complaints, grievances, and appeals data are reviewed during provider audits. • Provider management confirmed receipt of reports at QMOC meetings, as well as discussion at BOD.

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PIHP: Greater Columbia Behavioral Health				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• Ombuds stated that she reports to QMOC, RAB, MH committee, consumer voice, and DHS meetings.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	4			• Ombuds accurately described role relative to assisting consumers with appeals, grievances, and fair hearings. • Provider management and direct service staff demonstrated sufficient knowledge of procedures and requirements when interviewed. • Evidence of Ombuds, provider, and PIHP staff training related to grievances and appeals includes PowerPoint presentation and attendance rosters; training provided in person by Customer Service Staff and was made available online (confirmed by provider management and direct service staff).
Standard 4 Count (Target 3 Met):	**3**	**0**	**0**	**Target Points: 12 Actual: 12**
Grand Totals Count (Target 17 Met):	**5**	**11**	**1**	**Target Points: 68 Actual: 46**

Summary Quality Assurance and Improvement Findings

Greater Columbia Behavioral Health (GCBH) achieved the highest score possible (Met = 4 points) on 5 out of 17 possible items. Another 11 items were Partially Met and, of these, 5 items scored a 3. Only 1 item was unmet: inclusion of an Annual Work Plan to direct and focus major QI activities over the course of a year. GCBH achieved a total score of 46 points (68%) for the first review of Quality Assurance and Improvement Plan and activities, indicating that the PIHP has some excellent systems in place. The WAEQRO recommends a simplified revision of the Quality Management Plan that includes (among other elements) specific responsibilities and measurable indicators to be reviewed and analyzed on a scheduled basis under the leadership of a full-time Quality Manager. Continued development of analytic and reporting tools related to data collected at the provider and system levels is encouraged to effectively trend, analyze and report well-defined indicators. Accomplishing these tasks will produce consistent focus on critical performance measures and desired improvements.

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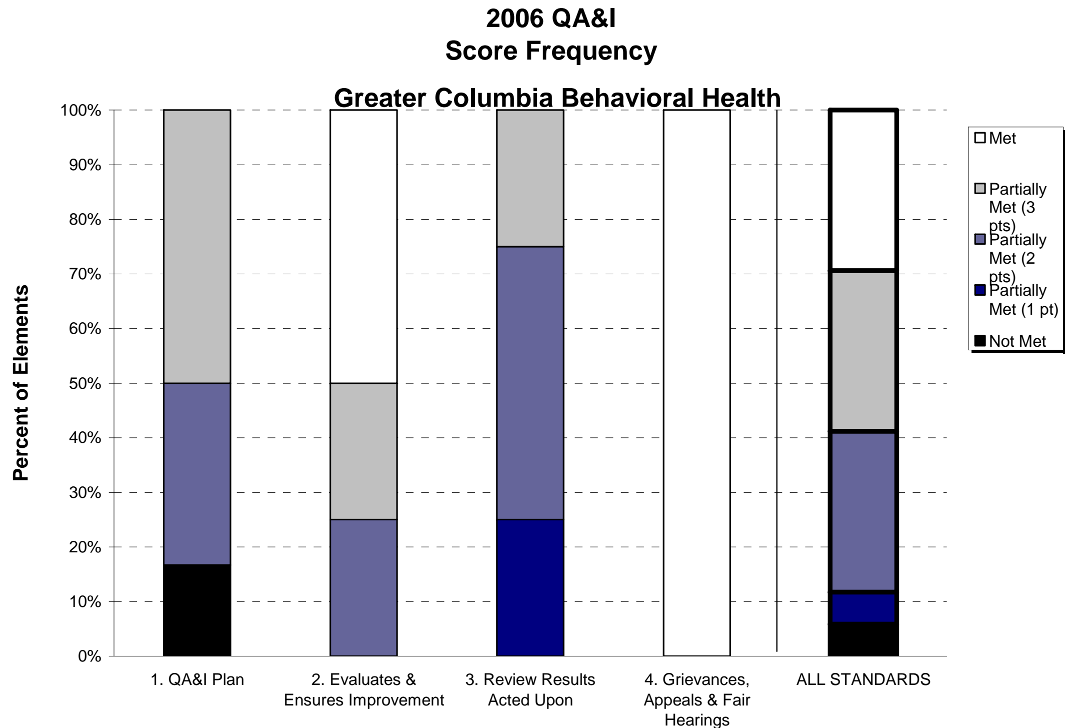


I. Frequency of Scores

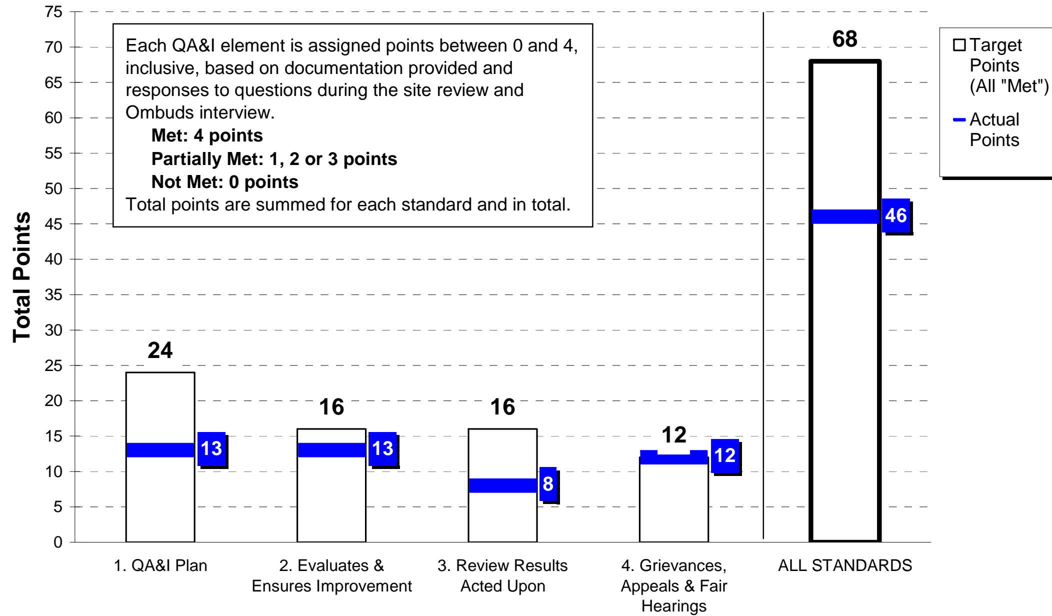
Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	0	3	2	0	1
2. Evaluates & Ensures Improvement	4	2	1	1	0	0
3. Review Results Acted Upon	4	0	1	2	1	0
4. Grievances, Appeals & Fair Hearings	3	3	0	0	0	0
ALL STANDARDS	**17**	**5**	**5**	**5**	**1**	**1**

QAI Strengths

- PIHP provided needed supports to the quality assurance and improvement system: extensive training across the system of providers; leadership of the Multi-cultural Committee; and information system enhancements for the Ombuds and QRT reporting processes.
- PIHP took effective action to include consumer voice by funding consumer representation on committees and initiating a consumer voice group.
- Quality Management team developed an effective and efficient clinical chart review process that actively involves provider staff through use of an electronic clinical chart review tool with an immediate feedback option at site visits.

QAI Challenges

- The Quality Management Plan does not provide an effective roadmap to accomplish the required oversight and improvement activities.
- While considerable data is becoming available to the PIHP, use of the data for long-term



II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	13
2. Evaluates & Ensures Improvement	16	13
3. Review Results Acted Upon	16	8
4. Grievances, Appeals & Fair Hearings	12	12
ALL STANDARDS	**68**	**46**

trending and analysis is not yet evident.

- An annual review of the quality assurance program is necessary to evaluate effectiveness of the QAI Plan and process and to analyze system-wide performance on key indicators. The PIHP did not submit evidence that this review has been conducted.

QAI Recommendations

1. Develop data analysis tools and methods to better understand results on all key performance indicators.

2. Prioritize hiring a full-time Quality Manager to assure that necessary functions of the QM program are implemented.

3. Create an Annual Work Plan that includes 3-5 improvement activities identified through data analysis. Reflect those projects in a document attached to the QM Plan and include responsible committees, details of goals, and reporting schedule. These QI activities would be in addition to the PIPs.

4. Expand Performance Measures/Indicators matrix to include detail of reporting responsibility and frequency, measurement protocol, targets for achievement, and thresholds for further action or investigation.

5. Increase detail of discussions in meeting minutes, particularly related to analysis of reports and decisions about further action or follow-up.

6. Consider redesign of quality management structure to create an oversight hierarchy that supports a clear distinction between governance and management/operations of the PIHP.

Recommendations

Subpart Recommendations

1. Revise Enrollee Rights Policy to ensure the inclusion of the enrollee's right to request and receive a copy of their medical record, and enrollee's protection of privacy as set forth in 45 CFR parts 160 and 164.

2. Determine network adequacy guidelines/standards, and manage using the existing provider database. Develop a quality improvement process for evaluating capacity and network sufficiency through the use of reports and effective management practices that makes use of report information.

3. Clarify and train PIHP and provider network staff on specific procedures related to out-of-network provider referrals, and coordination of care and payment.

4. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.

5. Revise policies and procedures to consistently and accurately reflect staff positions responsible for conducting authorizations and denials of service. Include the required qualifications of relevant staff.

6. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

7. Incorporate all required BBA requirements for Notice of Actions in policy and procedures. In addition, establish a procedure to accurately track and monitor all critical timeframes related to service access, denials, reductions, suspensions of service, and Notice of Actions (NOAs).

8. Clarify delegated PIHP functions and develop processes related to **all** subcontractor delegation:
    a. Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    b. Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    c. Review their related **performance** on an annual basis.

9. Clarify procedure to officially adopt and approve new and revised policies and procedures.

Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).

10. Prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms. To provide a reliable record of activities, create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. Ground study topic in available data that has been analyzed and prioritized for improvement of client outcomes or processes of care.

2. Design specific and provable study questions (i.e., data is available for study indicators).

3. Design a data analysis plan that provides strong support for results of study, including assessment of reliability of data and potential bias in results.

EV Recommendations

1. Define and implement a data completeness standard against which all providers and the PIHP can evaluate performance.

2. Document the provider network's information systems to evaluate the capacity to produce accurate and complete encounter data.

3. Add trend data and analysis notes to reports to improve understanding of system performance and improvement needs.

4. Analyze the complete dataset evaluated in the review; i.e., if the review covers six months, analyze data for the entire six-month period.

5. Freeze the dataset being analyzed.

6. Separate and refine how the data verification elements are displayed in reports to provide more comprehensive views of the results.

QAI Recommendations

1. Develop data analysis tools and methods to better understand results on all key performance indicators.

2. Prioritize hiring a full-time Quality Manager to assure that necessary functions of the QM program are implemented.

3. Create an Annual Work Plan that includes 3-5 improvement activities identified through data analysis. Reflect those projects in a document attached to the QM Plan and include responsible committees, details of goals, and reporting schedule. These QI activities would be in addition to the PIPs.

4. Expand Performance Measures/Indicators matrix to include detail of reporting responsibility and frequency, measurement protocol, targets for achievement, and thresholds for further action or investigation.

5. Increase detail of discussions in meeting minutes, particularly related to analysis of reports and decisions about further action or follow-up.

6. Consider redesign of quality management structure to create a hierarchy that supports a clear distinction between oversight and management of QAI activities.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Clark County
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Clark County PIHP is responsible for managing mental health care and services for Medicaid consumers in Clark County, in the state of Washington. The PIHP is located in Vancouver, Washington and is governed by a board comprised of three County Commissioners. The PIHP Administrator reports to the Director of the Department of Community Services. The PIHP contracts with eleven community mental health centers and specialty providers, which serve approximately 7500 adult and child consumers on an annual basis. Total annual Medicaid enrollment in the PIHP is about 75,000. The PIHP delegates data management to Netsmart Technologies, a privately held human services software application provider in New York State.

This report covers the period between November 28, 2005, and November 27, 2006, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and

an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	

Activity	Timeline	Documents/Content
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	October 27, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	November 13, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	November 20, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	December 12-13, 2006	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	December 14, 2006	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	January 11, 2007	
4. Debrief conference call	January 24, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	February 1, 2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities.

Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Clark County PIHP did submit a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

- For the Clark County PIHP, there were no events during the review year that had a significant impact on either the service delivery system or their administrative operations.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- A variety of document submission difficulties required post-site visit review of large numbers of additional documents to adequately evaluate the PIHP's performance.

4. 2006 Review Results

This report provides results and a summary of Clark County PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Clark County PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.242	**Health Information Systems**			
	At the time of the EQRO visit, the PIHP was not yet transmitting the HIPAA compliant 837p data to the State. With this in consideration it is not possible to state that the PIHP screens their data for completeness and consistency since their data is admittedly incomplete.	Submit a corrective action plan to the MHD by 4/29/05	CAP submitted 4/20/05	The PIHP was transmitting 837p data by the end of 2004. Additional evidence was submitted during the WAEQRO'S 2005 review describing the processes and procedures used to screen data for completeness and consistency. Although there are recommendations in this report about screening data, they address enlarging the scope of the screening as a

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CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
				quality improvement. This item should be considered closed.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Clark County PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

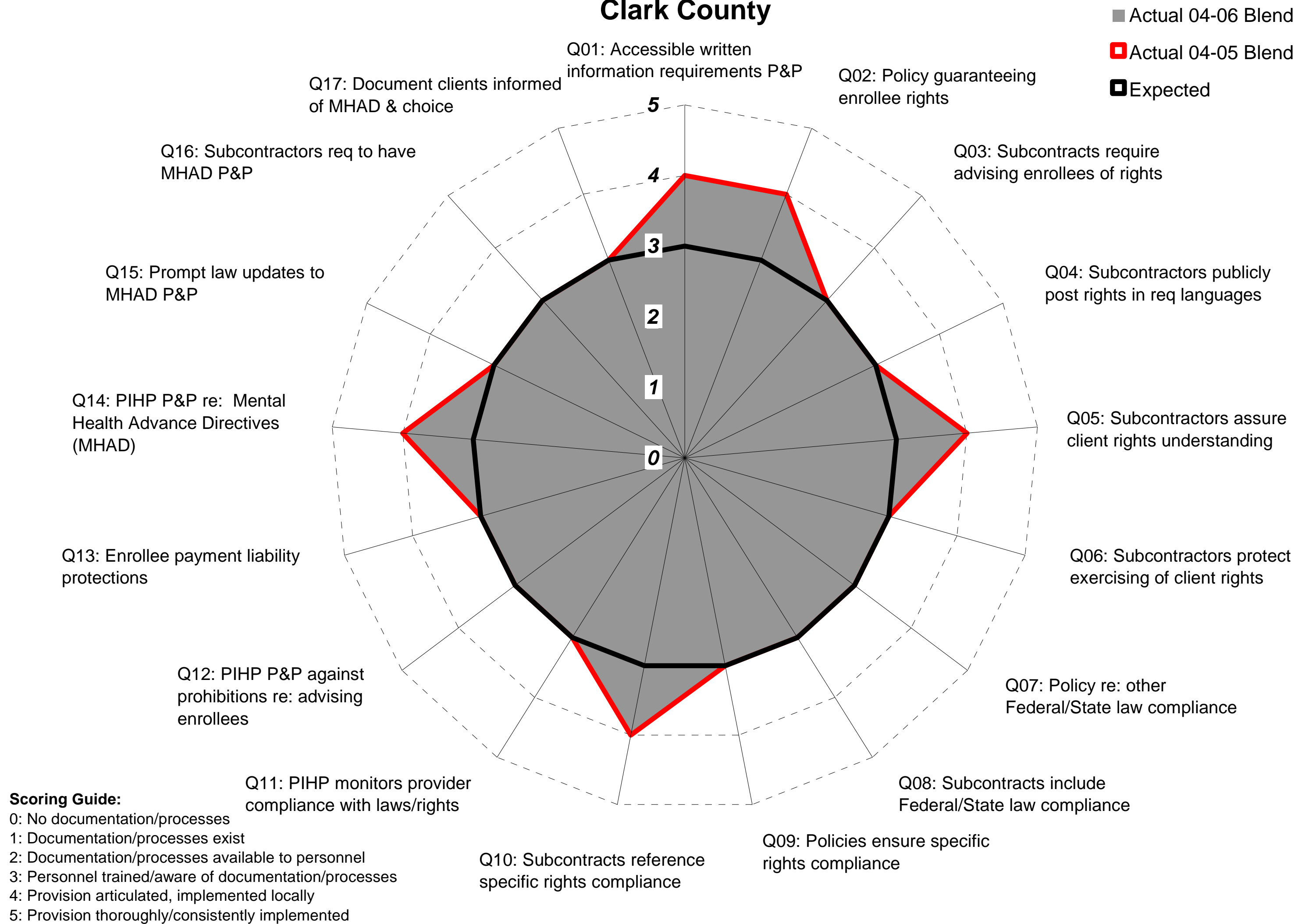
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Clark County

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

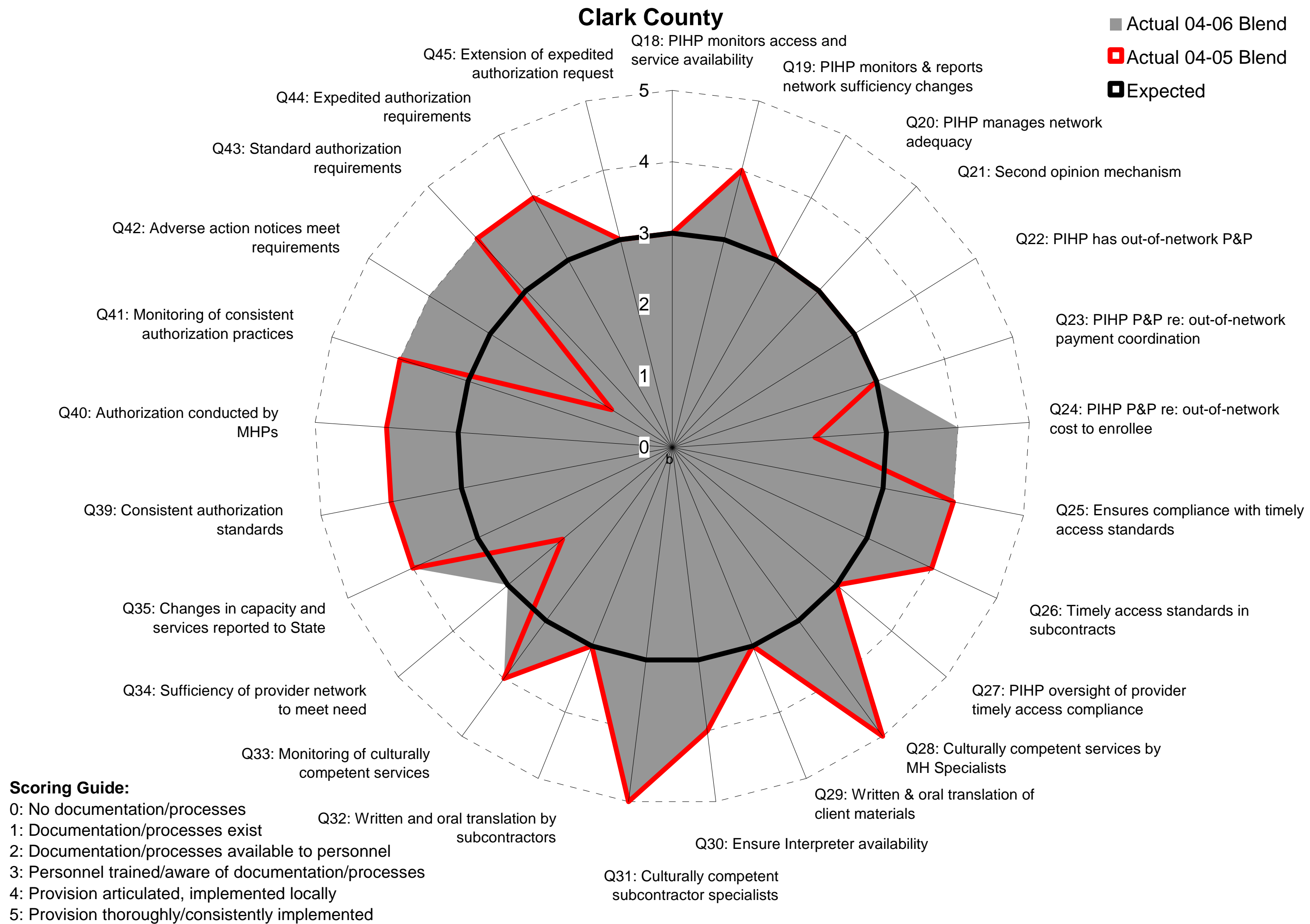
Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	4		4
Q02: Policy guaranteeing enrollee rights	4		4
Q03: Subcontracts require advising enrollees of rights	3		3
Q04: Subcontractors publicly post rights in req languages	3		3
Q05: Subcontractors assure client rights understanding	4		4
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	3		3
Q08: Subcontracts include Federal/State law compliance	3		3
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	4		4
Q11: PIHP monitors provider compliance with laws/rights	3		3
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	3		3
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	3		3

Clark County PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

Clark County PIHP achieved Expected compliance for all Subpart C scores in 2005. Therefore, no Subpart C review elements were re-scored in 2006.

Subpart D (Part 1): Access Standards



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Clark County

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
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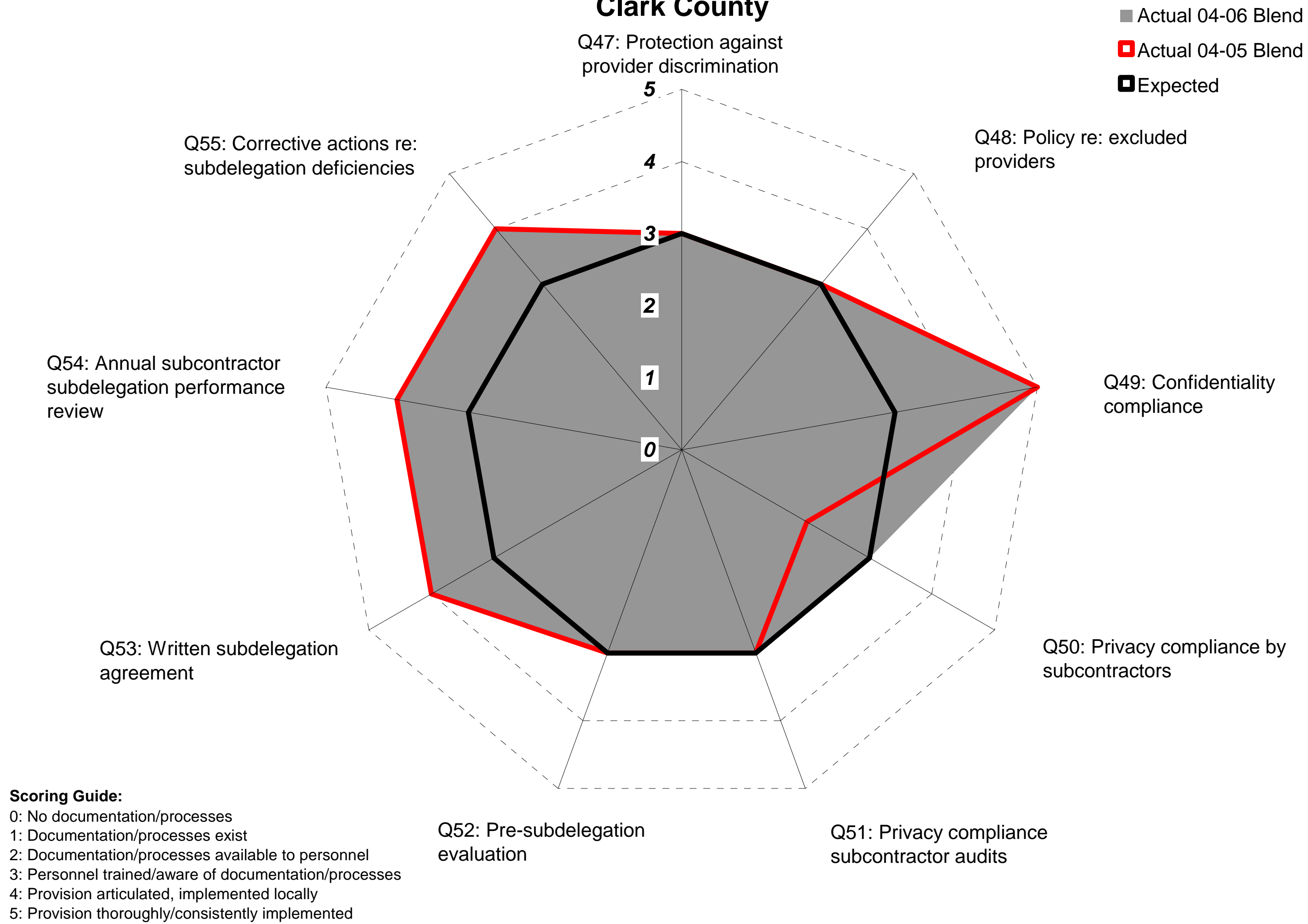
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	4		4
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	3		3
Q24: PIHP P&P re: out-of-network cost to enrollee	2	4	4
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	4		4
Q27: PIHP oversight of provider timely access compliance	3		3
Q28: Culturally competent services by MH Specialists	5		5
Q29: Written & oral translation of client materials	3		3
Q30: Ensure Interpreter availability	4		4
Q31: Culturally competent subcontractor specialists	5		5
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	4		4
Q34: Sufficiency of provider network to meet need	2	3	3
Q35: Changes in capacity and services reported to State	4		4
Q39: Consistent authorization standards	4		4
Q40: Authorization conducted by MHPs	4		4
Q41: Monitoring of consistent authorization practices	4		4
Q42: Adverse action notices meet requirements	1	4	4
Q43: Standard authorization requirements	4		4
Q44: Expedited authorization requirements	4		4
Q45: Extension of expedited authorization request	3		3



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2004-2006 Subpart Scoring Trend and Detail for
Clark County

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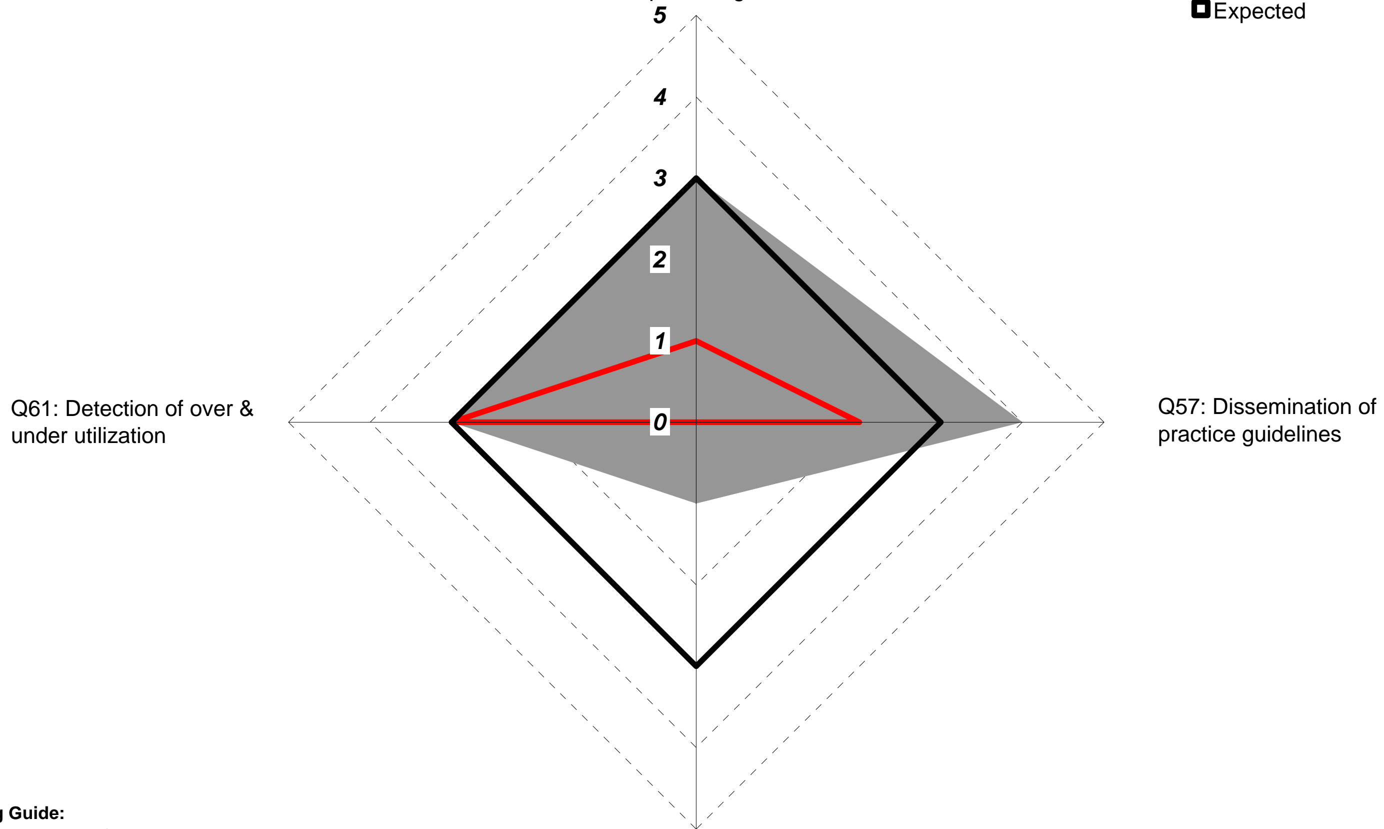
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	2	3	3
Q51: Privacy compliance subcontractor audits	3		3
Q52: Pre-subdelegation evaluation	3		3
Q53: Written subdelegation agreement	4		4
Q54: Annual subcontractor subdelegation performance review	4		4
Q55: Corrective actions re: subdelegation deficiencies	4		4



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Clark County

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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	1	3	3
Q57: Dissemination of practice guidelines	2	4	4
Q58: Application of practice guidelines	0	1	1
Q61: Detection of over & under utilization	3		3

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (b)(4)	**Delivery Network-Out of Network Providers**	

[Q24]	**Cost of out-of-network provider is no greater for enrollee than services furnished within network**
	Evidence:
	• QM23 Availability of Services policy and procedures contain procedures for out-of-network provider referrals. Procedures in this policy relating to this review element include the following:
	  o "PIHP shall pay for authorized services at no cost to the consumer.
	  o It is the responsibility of the network provider agency making the referral to procure and pay for the approved service. PIHP will reimburse the provider within the RSN provider network for the cost of procuring the approved service.
	  o The service hours must be reported in the MIS data system and the network provider will be reimbursed through the standardized cost per hour rate structure unless a different hourly rate is approved with the initial request."
	• CR01 Consumer Rights and Responsibilities policy and procedure states, the PIHP ensures that Medicaid enrolled consumers are not charged or held liable for any service provided on referral that exceeds what the PIHP would cover if provided within the network. This policy also does not describe any procedures or mechanisms related to implementing this standard.
	• Additional documents submitted for this review element:
	  o Policy Summary for Training QM23 Availability of Services –Q24—includes procedures described above.
	  o Provider Training Documentation Received 2005—document does not cover the review period timeframe.
	  o Provider Training Plan 04-05 Q24.—document does not cover the review period timeframe.
	  o Provider Training Plan 05-06—document does not include training on this review element.
	• PIHP staff and provider management reported that out-of-network providers are rarely utilized and, to their knowledge, were not used during the review period.
	• Provider management was able to articulate basic process of	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	how to access an out-of-network provider and their related responsibilities as the primary mental health care provider. • Recommend PIHP develop monitoring mechanisms to ensure providers are utilizing out-of-network providers when necessary and that expected procedures are followed in order to ensure no cost to enrollees. (Substantial Compliance)	4
438.207	**Assurances of Adequate Capacity and Services**	
[Q34]	**Sufficient number, mix and geographic distribution of Network Providers to meet anticipated need** Evidence: • QM23 Availability of Services policy and procedures stipulates the PIHP will monitor provider network service capacity by reviewing data related to capacity and access, will establish baseline data for network sufficiency and identify thresholds for the purpose of assessing network sufficiency, and, through the Quality Management Committee, will identify opportunities for quality improvement when network sufficiency indicator data show trends above or below established performance thresholds. • Utilization Management (UM) Plan-the UM Plan provides a framework for monitoring over and under utilization by identifying outliers, and evaluating trends of service delivery for quality improvements. • PIHP Minutes from a variety of meetings that document evidence of discussions regarding over and under utilization, thresholds, monitoring and use of data in service delivery, service availability, and quality improvements. • Utilization Management Committee (UMC) Charter functions as a workgroup designed to assure that utilization of mental health services and resources are consistent with the treatment service needs of the enrollee. The UMC shall accomplish this by analyzing utilization patterns and trends to include gaps in services, rates of no shows for appointments/services, billing issues, underdeveloped frequently requested services, existing services that are under- and over-utilized, and barriers to access. UMC Minutes showed evidence the committee has been reviewing utilization management reports and sorting out priorities. According to meeting minutes, the UMC will monitor system service data reports to identify and investigate outliers related to under and over utilization and system capacity. Some indicators that will be monitored include: consumers with more than four crisis contacts within one month; a significant number of hospital re-admissions, over and under utilization,	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5

	and individuals with multiple impairments. Consumers with multiple prescribers will also be monitored during chart audits.
	• Utilization Sample UM Report CSNW July 2006-Program of Assertive Community Treatment—PIHP established the upper threshold at 15 hours of service and the lower threshold at 5 hours of service. No analysis of the data or how the data was going to be used was included with the report.
	• Medicaid enrollment and penetration rate reports indicate service penetration rates are significantly below the 10% target. No analysis of the data or how the data was going to be used was included with the reports.
	• Identification and Management of Prescriber Services within the Network Documentation Summary—the sample documentation provides evidence as to how: (1) The Provider & Services Review Committee identified an issue within the network; (2) The issue was investigated and discussed in various committees and with providers; and (3) The PIHP worked with the Mental Health Division and Columbia United Providers to draft an MOU to at least partially address this issue. All relevant process documents were submitted for review. PIHP staff reported that the MOU has not yet been signed by all parties. PIHP also reported that the need for additional prescriber services continues; however, access to prescriber services seems improved. The PIHP Medical Director will begin to provide some crisis med evals and acute referrals each month. In addition, the PIHP is looking into hiring Nurse Practitioners with prescriber authority and Tele-Psychiatry.
	• Various PIHP Provider Specific Month End Review Meeting Minutes—the purpose of these meetings is to review monthly performance data, share information, and resolve issues as they arise. Meetings include review of utilization management reports and some of the outliers identified previously in this report.
	• The PIHP QM23 Availability of Services policy and procedures also stipulates the PIHP will review:
	  o Medicaid consumers' utilization of services (actual and expected);
	  o The numbers and types (in terms of training, experience and specialization) of providers available to deliver contracted Medicaid services;
	  o The geographic location of providers and Medicaid consumers, considering distance, travel time, the means of transportation ordinarily used, and whether service locations provide physical access for Medicaid consumers with disabilities;	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	○ Complaints and grievances; ○ Access (timeliness for routine, urgent and emergent service requests); ○ Consumer satisfaction; ○ Critical incidents involving access to service concerns. However, no evidence related to these data and review elements was submitted for review. • Network provider management was familiar with activities related to PIHP monitoring and managing service capacity to the anticipated need. However, provider involvement was reported to be more peripheral and less integrated than would be expected for the PIHP to achieve their identified outcomes. The penetration rate reports also support this point. Direct Service staff easily identified gaps and needed services, yet reported they did not see any indication that such gaps were being addressed. They also reported that they are not asked to participate in workgroups or activities that address the gaps in services and focus on improving service capacity. • Recommend PIHP increase involvement of provider management and interested direct service staff in developing strategies to address service gaps and improve service capacity throughout the region's system of care.	
	(Moderate Compliance)	3
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • Revised CM03 Notice of Action (NOA) policy and procedures contain the majority of requirements related to this provision. Missing from the policy is the requirement that the PIHP may extend the expedited authorization notice by up to 14 days if the consumer requests an extension, or if the PIHP needs additional information and the extension benefits the consumer. However, this requirement is included in the revised CM03-A Notice of Action-Form. Recommend including this requirement in the policy. • Outpatient Denial Log indicated that denials do occur, and NOAs are sent to the consumer and provider. Reviewer unable to determine if timeframes are being met due to lack of information in denial log such as request for service, intake date, and the like. • Three copies of completed NOAs were submitted for review. All 3 appeared to be issued within required timeframes according to information documented in the NOAs. • Latest Revision of PIHP's NOA does not include information on	

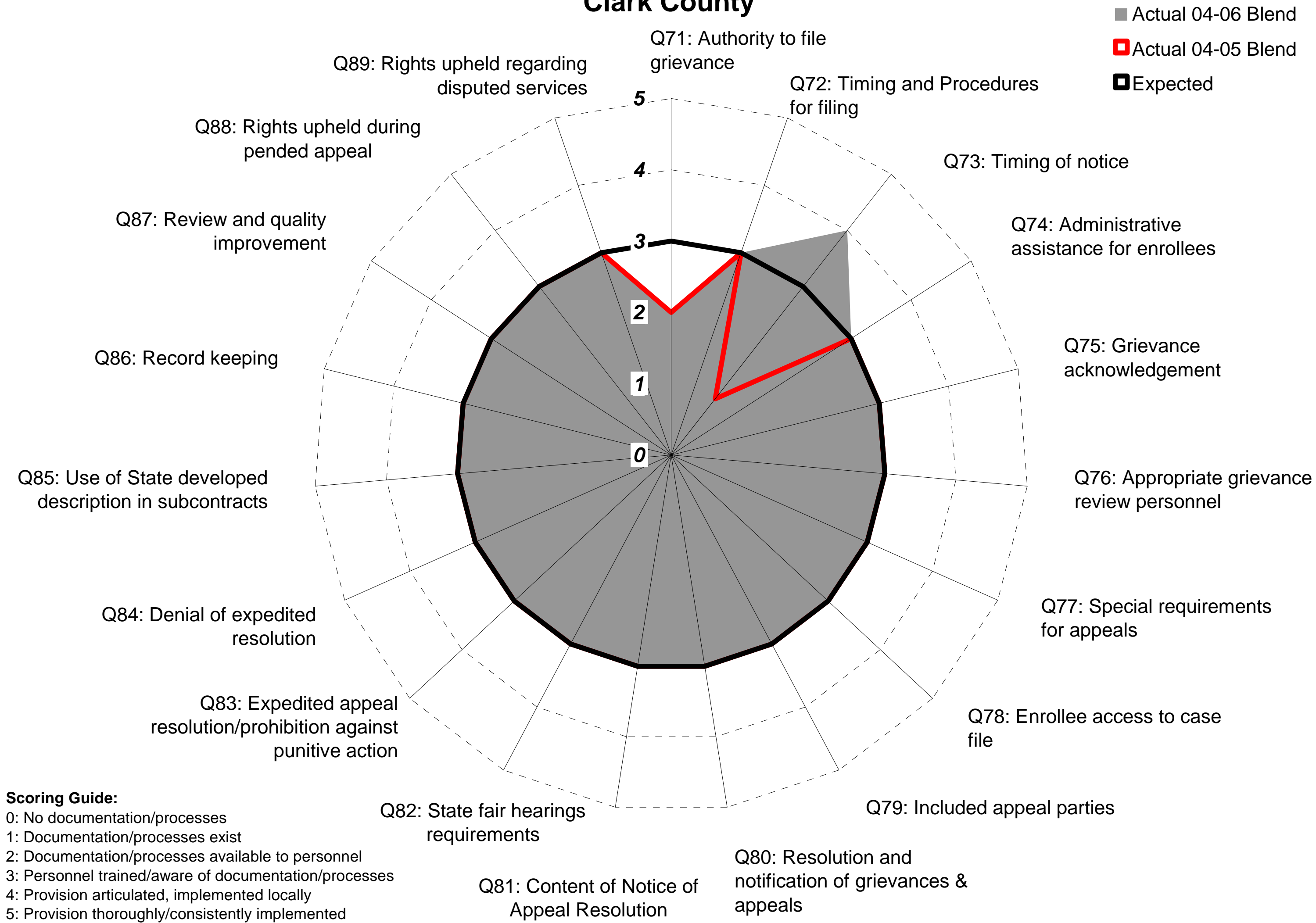
CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	how to access a second opinion, only that consumer is entitled to one. Recommend PIHP add information to the NOA that assists consumer in accessing a second opinion. • Outpatient Denial Report includes documentation of all denials between January '05 and June '06. Provides information on # of denials per age group, number of denials per diagnosis, and reasons for denials. This appears to be a useful tool for analyzing denials and identifying quality improvements related to access. • PIHP Policy and Procedure Update—November 28, 2006 email message disseminating revised CM03 Notice of Action policy and procedures, CM03-A Notice of Action-Form training summaries and provider training documentation forms. • Provider Training documentation for fourth quarter CY 2005 and first quarter CY 2006 included policies and procedures related to this provision. This document provided evidence of direct service staff training on earlier versions of above policies and procedures. • Provider management and direct service staff are familiar with NOAs and were able to articulate their basic purpose. Direct service staff were not clear on who can file a grievance or appeal on behalf of the consumer. • Additional Documentation Reviewed: o Appeal Log-Outpatient FY2006 o Fair Hearing Log o Grievance and Appeal Reports PIHP Apr 06 – Sept 06 (show evidence of monitoring grievances and fair hearings) o Policy Summary for Training CM03 Notice of Action o Policy Summary for Training CR06 Consumer Rights to Appeal. (Substantial Compliance)	4
438.224	**Confidentiality**	
[Q50]	**PIHP ensures subcontractors comply with privacy requirements** Evidence: • CR01 Consumer Rights and Responsibilities policy and procedures which state, "The consumer has the right to have his or her medical record accessed only in accordance with applicable law. The consumer has the right to expect all communications and other records pertaining to his or her care to be treated as confidential unless the law requires the sharing of information, including, but not limited to, danger to self,	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	danger to others, or court order." • PIHP Provider Network Contract for services provided during the period of July 1, 2006 through June 30, 2007 requires providers to have internal policies and procedures related to the privacy and security of protected health information in compliance with state and federal guidelines. In addition, the contract states that, by signing this contract, the Contractor certifies compliance with applicable provisions of the HIPAA Act of 1996. The contract also requires a signed statement of confidentiality for each staff and subcontractor who has access to the Contractor's mental health information system. • 2005-2006 Risk Assessment Tool and Report for Community Services Northwest of April 17, 2006—PIHP desk reviews are conducted to ensure providers have a HIPAA compliant network, and that policies and procedures are in place to address electronic security needs, disaster recovery, and all applicable provisions of the HIPAA Act. Submitted review does not indicate if the required staff-signed statement of confidentiality forms are in place as required by the PIHP contract. • May 2006 Columbia River Mental Health Services Administrative and Clinical Record Review Summary and Review Tool gives indication that the PIHP monitors clinical records for consumer-signed rights. However, review tool and report do not show evidence of monitoring for consumer-signed Authorizations to Release Information. • Provider management reported that during their annual reviews, the PIHP reviewed their HIPAA policies and procedures and personnel files for related training and staff-signed oaths of confidentiality; however, they did not conduct a security review of their information system. (Moderate Compliance)	3
438.236	**Practice Guidelines**	
[Q56]	**Adoption of practice guidelines meets established requirements** Evidence: • Revised QM06 Evidence-Based Practice (EBP) policy and procedures include the basic requirements of this provision. • May 2006 Quality Management Committee Minutes provide evidence that the Provider and Services Review Committee (PSRC) recommended final adoption of the Clinical APA Guidelines for Major Depression (adults) and Academy of Child and Adolescent Psychiatry Guidelines on Post Traumatic Stress Syndrome (PTSD) (children). The minutes showed that	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	the PSRC also began discussions regarding the criteria and measures related to meeting these standards. The 2006 recommended Clinical Practice Guidelines were adopted by the QMC and were to be forwarded to the PIHP Executive Committee for final approval. • May 2006 Executive Team Meeting Minutes shows that PTSD for children and Major Depression for adults were officially adopted by the Executive Team. • October 2005 Executive Team Meeting Minutes provide evidence that the APA Guidelines on Schizophrenia were approved by the PIHP Executive Team. • Copies of the APA Guidelines on Schizophrenia, Major Depression (adults) and American Academy of Child and Adolescent Psychiatry Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder. • PIHP Policy and Procedure Update—November 28, 2006 email message to network providers disseminating revised QM06 Evidence-Based Practice policy and procedures, training summary and provider training documentation forms. • 2005-2006 EBP Implementation Plan—provides limited information about implementation, fidelity review, and expected outcomes. • Provider management and direct service staff were able to identify the adopted practice guidelines/EBPs listed above, and included the Cultural Competency Standards adopted in 2004. In addition, provider staff reported that the PIHP recently provided trainings on all three of the practice guidelines/EBPs listed above, and required all Mental Health Professionals to participate in the trainings. • Direct service staff reported they received the syllabus on the Schizophrenia and Depression guidelines the day prior to WAEQRO interviews. In addition, they reported that treatment planning had not really changed since adoption of the practice guidelines. Some direct service staff didn't know how they were to proceed with regard to implementation of the practice guidelines. • Provider management had differing reports as to whether the PIHP elicited staff participation in the selection and adoption of the practice guidelines. (Moderate Compliance)	3
[Q57]	**Dissemination of practice guidelines to providers and enrollees upon request** Evidence: • Revised QM06 Evidence-Based Practice (EBP) policy and	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	procedures include the basic requirements of this provision. • Copies of the APA Guidelines on Schizophrenia, Major Depression (adults) and American Academy of Child and Adolescent Psychiatry Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder. • PIHP Policy and Procedure Update—November 28, 2006 email message to network providers disseminating revised QM06 Evidence-Based Practice policy and procedures, training summary, and provider training documentation forms. • November 1, 2006 Childhood PTSD Practice Guidelines Training Agenda and attendance roster. • August 24, 2006 Schizophrenia Practice Guidelines Training Agenda and attendance roster. • Provider management and direct service staff were able to identify the adopted practice guidelines/EBPs listed above, and included the Cultural Competency Standards adopted in 2004. In addition, provider staff reported that the PIHP recently provided trainings on all three of the practice guidelines/EBPs listed above, and required all Mental Health Professionals to participate in the trainings. • Direct service staff reported they received the syllabus on the Schizophrenia and Depression guidelines the day prior to WAEQRO interviews. In addition, they reported that treatment planning had not really changed since adoption of the practice guidelines. Some direct service staff didn't know how they were to proceed with regard to implementation of the practice guidelines. (Substantial Compliance)	4
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • Revised QM06 Evidence-Based Practice (EBP) policy and procedures includes the basic requirements of this provision. • May 2006 Quality Management Committee Minutes provide evidence that the Provider and Services Review Committee (PSRC) began discussions regarding the criteria and measures related to meeting these standards. • Jan and Feb 2006 Cultural Competency Meeting Minutes show evidence of identifying and prioritizing the performance indicators from SAMHSA's Standards for implementation, and developing methods to monitor these standards. • Cultural Competency Practice Guidelines Chart Monitoring Tool, Admin Review Tool, Aggregate Results, Discussion and Analysis—only 3 standards out of 15 were met by all providers reviewed by the PIHP.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• April and July 2006 Cultural Competency Meeting Minutes provide evidence of discussions pre and post PIHP provider compliance review. • No tools and methods of monitoring the additional adopted practice guidelines/EBPs were submitted for review. PIHP staff reported that they are in process of creating tools and methods to monitor fidelity, and to ensure full utilization of the practice guidelines/EBPs in clinical services. • PIHP and provider staff reported that the PIHP has not begun clinical monitoring of the adopted practice guidelines with the exception of the Cultural Competency Standards. (Insufficient Compliance)	1



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Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	2	2	2
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	1	4	4
Q74: Administrative assistance for enrollees	3		3
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	3		3
Q87: Review and quality improvement	3		3
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

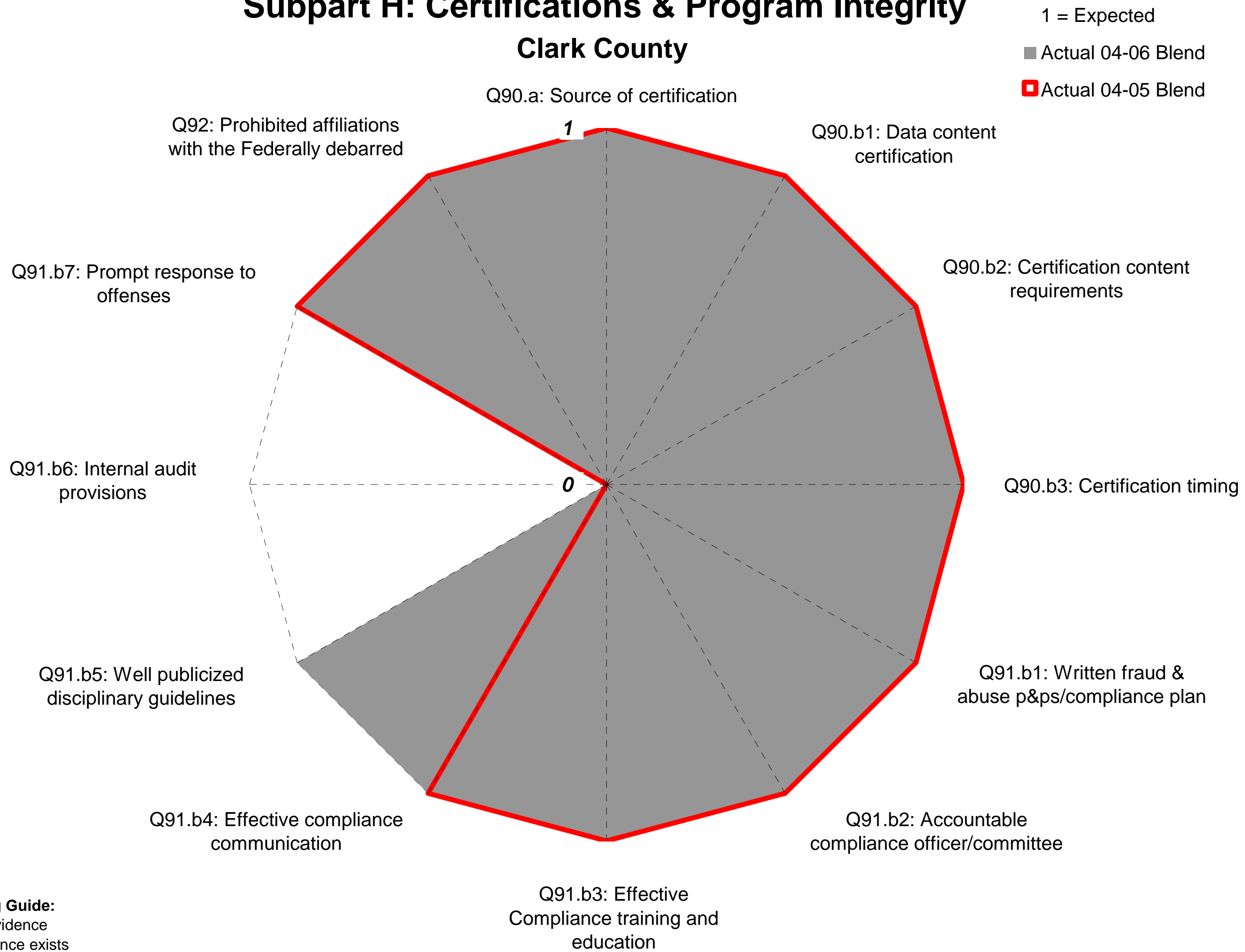
Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.402	**Grievance System**	

[Q71]	**Authority to file a grievance, appeal, or State fair hearing**
	Evidence:
	• CR03 Consumer Complaints and Grievances, CR06 Consumer Rights to Appeal, CR05 Consumer Rights to an Administrative Hearing policies and procedures contain the majority of requirements related to having a grievance system in place. However, **438.402(1)(ii) is missing** from CR06 Consumer Rights to Appeal and CR05 Consumer Rights to an Administrative Hearing policies and procedures.
	• "A community mental health agency may file a grievance on behalf of an enrollee, with the enrollee's written consent," is included in the PIHP CR03 Consumer Complaints and Grievances policy and procedures.
	• Provider Training documentation for fourth quarter CY 2005 and first quarter CY 2006 included the above-listed policies and procedures related to this provision.
	• Training policy summaries included:
	  o CR03 Consumer Complaints & Grievances,
	  o CR05 Administrative Hearing,
	  o CR06 Consumer Rights to Appeal
	• PIHP Consumer Satisfaction Survey Overall Results, April 2006-included knowledge of complaint and grievance process, by ethnicity and age group. Overall rate of 81.5% falls short of PIHP Quality Management Work Plan stated goal of 85% for FY 2006.
	• Provider management and direct service staff were able to articulate basic knowledge of the regional grievance system.
	• Score remains the same as 2005 EQR due to policies missing requirement of provision as identified above.
	(Partial Compliance)
		2

438.404	**Notice of Action-Timing of Notice**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • Revised CM03 Notice of Action (NOA) policy and procedures contain the majority of requirements related to this provision. Missing from the policy is the requirement that the PIHP may extend the expedited authorization notice by up to 14 days if the consumer requests an extension, or if the PIHP needs additional information and the extension benefits the consumer.	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	However, this requirement is included in the revised CM03-A Notice of Action-Form. Recommend including this requirement in the policy. • Outpatient Denial Log indicated that denials do occur, and NOAs are sent to the consumer and provider. Reviewer unable to determine if timeframes are being met due to lack of information in denial log such as request for service, intake date, and the like. • Three copies of completed NOAs were submitted for review. All 3 appeared to be issued within required timeframes according to information documented in the NOAs. • Latest Revision of PIHP's NOA does not include information on how to access a second opinion, only that consumer is entitled to one. Recommend PIHP add information to the NOA that assists consumer in accessing a second opinion. • Outpatient Denial Report includes documentation of all denials between January '05 and June '06. Provides information on # of denials per age group, number of denials per diagnosis, and reasons for denials. This appears to be a useful tool for analyzing denials and identifying quality improvements related to access. • PIHP Policy and Procedure Update—November 28, 2006 email message disseminating revised CM03 Notice of Action policy and procedures, CM03-A Notice of Action-Form training summaries and provider training documentation forms. • Provider Training documentation for fourth quarter CY 2005 and first quarter CY 2006 included policies and procedures related to this provision. This document provided evidence of direct service staff training on earlier versions of above policies and procedures. • Provider management and direct service staff are familiar with NOAs and were able to articulate their basic purpose. Direct service staff were not clear on who can file a grievance or appeal on behalf of the consumer. • Additional Documentation Reviewed: o Appeal Log-Outpatient FY2006 o Fair Hearing Log o Grievance and Appeal Reports PIHP Apr 06 – Sept 06 (show evidence of monitoring grievances and fair hearings) o Policy Summary for Training CM03 Notice of Action o Policy Summary for Training CR06 Consumer Rights to Appeal. (Substantial Compliance)	4



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for
Clark County

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well publicized disciplinary guidelines	0	1	1
Q91.b6: Internal audit provisions	0	0	0
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness and truthfulness of the data	
	(Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b5]	**Well-publicized disciplinary guidelines** • 13 0 Employment Standards (effective 4/18/05) and 14 0 Corrective Action (effective 4/18/05) policies and procedures contain publicized disciplinary guidelines for all Clark County employees. • Fraud and Abuse WP 2006 (July 2006-June 2007) includes the development and implementation of a Fraud and Abuse Hotline number to be disseminated to providers by November 28, 2006. Email to providers from Ron Curtin, Clark County, shows evidence of the PIHP accomplishing this goal. Reviewer called Fraud and Abuse Hotline to verify access. • PIHP staff and provider management are aware that a new Fraud and Abuse Hotline has been implemented. (Compliance)	1
[Q91.b6]	**Provisions for internal monitoring** Evidence: • Fraud and Abuse WP 2006 includes the development of an internal compliance monitoring plan, tool, and schedule by November 30, 2006. No internal compliance monitoring plan	

was submitted for review.

- No evidence of PIHP internal monitoring for fraud and abuse submitted for review.
- Consumer Voices are Born (CVAB) Compliance Review Report of May 23, 2006 shows evidence of PIHP/County financial review, audit of this subcontractor, implementation of corrective actions, and termination of contract. New contract with probation status was implemented. This provides evidence that PIHP is reviewing subcontractors for potential fraud and abuse; however, it does not give evidence of PIHP internal monitoring practices related to their own fiscal management, resource, and utilization management, conduct, conflict of interests, etc., to prevent and detect potential fraud and abuse.
- 2005-2006 Risk Assessment Report for Community Services Northwest of April 17, 2006 also provides evidence of PIHP review of subcontractors only, for potential fraud and abuse.
- Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.

(No Compliance) 0

Scoring Frequency Overview

APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Clark County

These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

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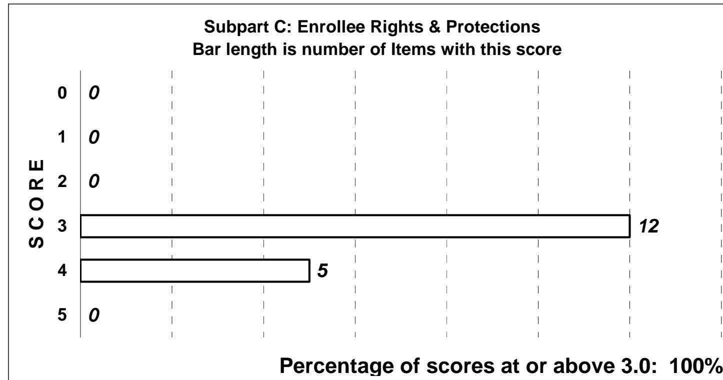
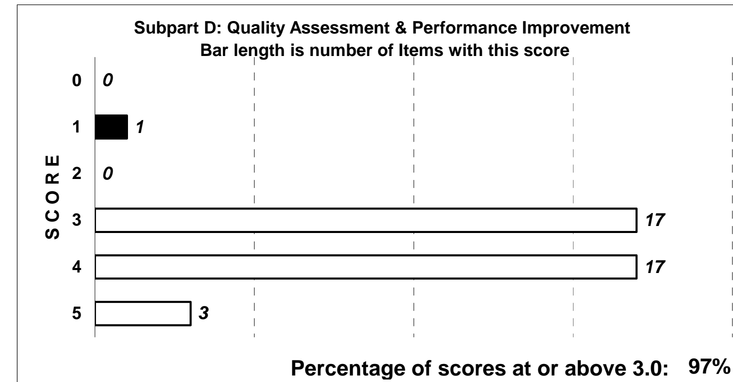
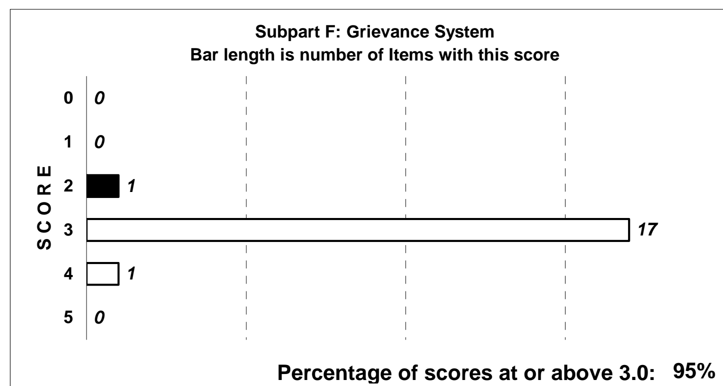
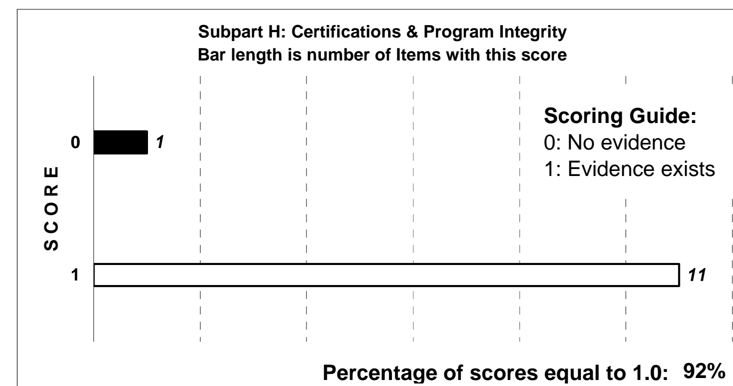








Scoring Frequency Overview Chart Discussion

The above charts depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored during each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the “blended” 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 100%
Subpart D: 97%
Subpart F: 95%
Subpart H: 92%

By prioritizing enrollee rights and protections and their grievance system, Clark County PIHP achieved Expected compliance in Subpart C in 2005.

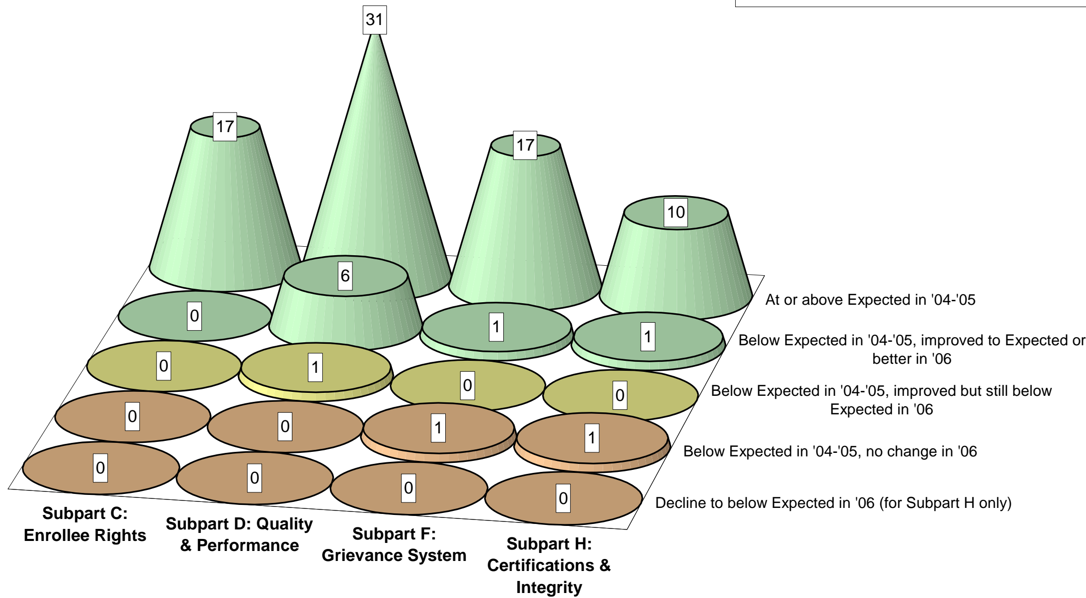
The PIHP continues to make progress with respect to Subpart D, and has achieved Expected compliance for all review elements with one exception: application of practice guidelines. Clark County has also achieved Expected compliance for all but one review element in Subpart F-Grievance Systems.

In addition, Clark County PIHP has met all but one requirement associated with Program Integrity. Provisions for internal monitoring for potential fraud and abuse have not been sufficiently implemented. Overall, Clark County has achieved a high level of Expected compliance within all four Subparts.

Score Trend Summary for:
Clark County

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Percent	Subpart D: Quality & Performance Item Count	Percent	Subpart F: Grievance System Item Count	Percent	Subpart H: Certifications & Integrity Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	0	0.0%	1	5.3%	1	8.3%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	1	2.6%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	0	0.0%	6	15.8%	1	5.3%	1	8.3%
At or above Expected in '04-'05	17	100.0%	31	81.6%	17	89.5%	10	83.3%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, Clark County PIHP performance relative to Subpart C (*Enrollee Rights*) showed 17 out of 17 items (100%) already at or above the Expected level of performance. Therefore, Clark County was not re-scored on any Subpart C review elements in 2006.

For Subpart F (*Grievance System*), Clark County PIHP entered the 2006 review with 17 of 19 items (89.5%) already at or above Expected. After the 2006 review, 18 items (94.8%) meet the Expected level of performance.

The improvement Clark County PIHP has made in all required Subparts reflects focused efforts on continuous quality improvement during 2006.

Subpart Strengths

- The PIHP Outpatient Denial Report is a useful tool for reviewing and analyzing data related to denials, identifying trends, and quality improvements linked to access..

Subpart Challenges

- PHIP staff are challenged in effectively aggregating and analyzing the large volume of data they generate and using the information for quality improvement.
- The PIHP has difficulty acknowledging and ensuring consideration of the voice and diverse, unique needs of all providers in the network.

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Incorporate into policy and procedures all required BBA requirements pertaining to the authority to file a grievance, appeal, or State fair hearing. In addition, remove procedures 5. vi-viii from CM03 Notice of Action policy due to no relevant foundation found in the BBA or MHD contract to support or validate these timeframe requirements.

3. To assist consumers in accessing a second opinion, incorporate specific steps of how to do so in NOAs.

4. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

5. As stated in the PIHP QM23 Availability of Services policy and procedures, establish baseline data for network sufficiency and identify thresholds for the purpose of assessing network capacity and sufficiency. Organize, utilize, and analyze available data to identify gaps in services and opportunities for quality improvement when data show trends above or below established performance thresholds. In addition, increase involvement of provider management and interested direct service staff in developing strategies to address service gaps and improve the service capacity throughout the region's system of care.

6. Expand privacy compliance audits of subcontractors to incorporate a management information security review.

7. Revise and update monitoring tools incorporating review elements related to the BBA and the PIHP's new and revised policies and procedures.

8. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the WAEQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited to a technical assistance review and, as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO which, if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The PIHP has a policy and procedure for the process used to update and maintain the crosswalk between non-standard codes and the codes accepted by the State data system.

2. Unique member ID
   The PIHP searches for duplicate member IDs; suspected duplicates are entered on a daily basis into a duplicate member list. This list is used to eliminate duplicate member IDs in the data system.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   PIHP staff can track individuals across product lines using client financial data in their IT system. They also maintain a history of start and end dates which enables staff to track individuals through enrollment, disenrollment, and re-enrollment.

4. Calculating member months
   The PIHP calculates member months using data made available by the MHD. The PIHP uses member months in calculating various performance measures. During the last review, the WAEQRO reported that staff were working to better understand this data and how it relates to other statistics published by the State. A report noting those differences has been forwarded to the State.

5. Member database
   The PIHP presently maintains an SQL database containing member data made available by the MHD. They are using this data as a first step in eligibility checks and for calculating various performance indicators used in management reports.

This item is tied closely to the item above, calculating member months. Variance in the systems that provide member data results in change up to eighteen months after the information is originally generated. A new State Information System, slated to replace existing systems, should have a positive impact on reducing these variances.

6. Provider Database
   The PIHP maintains provider data in a database, primarily to track credentialing.

7. Data easily under-reported
   The PIHP modified its fee-for-service method of payment to create an incentive for providers to submit all encounter data. If the provider wants to be paid for a service, they need to submit the data. This incentive reduces the risk of data easily under-reported.

PM Summary

Clark County PIHP has strong pre-submission screening processes on its data. Last year's comprehensive encounter validation showed that there were areas to improve, and the PIHP rated a Partially Met in this year's encounter validation review (described below). The general state of the PIHP's data is evaluated as "fair".

The PIHP is taking steps to raise their data quality to "good" (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- The PIHP works to understand requirements, enabling value to be added by their implementation.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two submitted PIPs for Clark County PIHP: Timely Access to Outpatient Services, which was identified by the PIHP as non-clinical. Included in the desk review were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and to evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006 (see, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator, can be found at the end of the validation tool.

The PIHP began this PIP in September 2005. Based on data from the MIS and discussions with providers and consumers, the PIHP determined that a very small percentage of consumers requesting services were being seen within the 10 day requirement. Staff developed a PIHP-centered process which attempted to identify the wider service network options for those consumers waiting too long for appointments at the first agency contacted. The study design is complicated, using both the entire universe of service-seekers, then a subset of those needing assistance with more timely appointments. This design complicates the data analysis and does not provide a clear picture of the outcome of the intervention. In addition, during reviews of the problem with providers, the PIHP discovered definition and process discrepancies as well as simple data integrity problems. The ultimate outcome was not reliable due to these issues and, even at face value, the intervention does not appear to be having the desired impact. At the end of the review year, the PIHP was focused on cleaning up process and data issues with providers and re-thinking the intervention, perhaps to develop something different.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				Considers the entire population of consumers requesting services.
1.2. Is selected following collection and analysis of data (or was selected by the State).	X				Gathered data and mapped process for managing the intake process by the providers; data indicated that significant percentage of callers were not being seen within the 10 day requirement.
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	
1.4 Includes all eligible populations that meet the study criteria.	X				
1.5. Does not exclude members with special health care needs.	X				All RSN consumers are considered to have special health care needs.
1.6 Has the potential to affect member health, functional status, or	X				Effectiveness of the initial intake process is

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
satisfaction.					critical to ongoing use of care and satisfaction.
Totals for Step 1:	**5**	**0**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 1: 1/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.		**X**			Study questions address total population and then subset of that group, thereby diluting the focus of the study. General structure, however, addresses desired outcome of an intervention with a specific population.
2.2 Is answerable/provable.		**X**			Study question needs to be limited to a single population and specify a target for improvement.
Totals for Step 2:	**0**	**2**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 2: 0/2					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.		**X**			Numerator and denominator for "question 1" identify RSN-funded consumers with routine requests for service. Should define "routine" and "RSN funded". Inclusion of 2nd "question/study group" muddies the effectiveness of the indicators and the eventual outcome. Number of days between

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					request for service and intake is measurable; however. PIP document and providers indicate that there has been disagreement about the definition of "first request for service".
3.2. Are based on practice guidelines, with sources identified.	X				Researched NCQA and other recognized standards for intake, as well as contract with State.
3.3 Allow for the study question/hypothesis to be answered or proven.	X				
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	X				Measures achievement of target % of consumers receiving intake within specified time frame as well as comparison to baseline performance.
3.5 Have available data that can be collected on each indicator.		X			Data available in MIS. Data reliability appears to be in question; baseline data indicate wide range in % of consumers seen within standard timeframe. Data reliability discussion cites discrepancies regarding entry of initial call or request and consistent definition of that first request.
3.6 Include the basis on which each indicator was adopted, if internally developed.	X				
Totals for Step 3:	**4**	**2**	**0**	**0**	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Number of shaded critical evaluation elements met for Step 3: 0/0					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					
4.1. Is accurately and completely defined.		X			As indicated above, some terminology should be clarified. In addition, the PIP defines 2 separate study groups, which confuses the study throughout.
4.2. Includes requirements for the length of a member's enrollment in the MCP.	X				Must be enrolled at time of first request.
4.3 Captures all members to whom the study question applies.			X		PIP summary indicates problems with data completeness and accuracy (no estimate of error rates), thereby acknowledging the possibility that not all requests have been captured.
Totals for Step 4:	**1**	**1**	**1**	**0**	
Number of shaded critical evaluation elements met for Step 4: 0/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).					Section not applicable as PIP is using the entire population.
5.2. Identify the sample size (or use the entire population).					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
5.3. Specify the confidence interval to be used (or use the entire population).					
5.4 Specify the acceptable margin of error (or use the entire population).					
5.5 Ensure a representative sample of the eligible population.					
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.					
Totals for Step 5:					
Number of shaded critical evaluation elements met for Step 5: N/A					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.	X				Description of data fields to be captured included in summary.
6.2. Identification of specified sources of data.	X				From MIS, based on information from Intake form and service delivery data in system.
6.3. A defined and systematic process for collecting baseline and remeasurement data.	X				
6.4. A timeline for collection of baseline and remeasurement data.		X			Monthly review of new data specified in plan; suggest less frequent analysis for purposes of

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					this PIP.
6.5. Qualified staff and personnel to abstract manual data.				X	
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.				X	
6.7 A manual data collection tool that supports inter-rater reliability.				X	
6.8 Clear and concise written instructions for completing the manual data collection tool.				X	
6.9 An overview of the study in written instructions.				X	
6.10 Automated data collection algorithms that show steps in the production of indicators.	X				
6.11 An estimated degree of automated data completeness.			X		Problems with data completeness and accuracy described; however, rate of errors not estimated.
Totals for Step 6:	**3**	**2**	**1**	**5**	
Number of shaded critical evaluation elements met for Step 6: 0/0					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.	X				Intervention: establishment of an Intake care manager at the RSN to handle any requests for which there was not an available appointment at the initial agency within the required time frame. This plan was developed, based on input from consumers, discussions with provider agencies, and data analysis over 1 quarter.
7.2 System changes that are likely to induce permanent change.		X			Unclear – there are several variables that may be related to this problem, and this intervention may not address all, especially if there are basic capacity problems.
7.3 Revised if original interventions are not successful.				X	PIP summary written just as RSN was seeing that the intervention was not having the desired effect; alternatives had not been addressed at that time.
7.4 Standardized and monitored if interventions are successful.				X	
Totals for Step 7:	**1**	**1**	**0**	**2**	
Number of shaded critical evaluation elements met for Step 7: 1/1					
Step 8: Sufficient Data Analysis and Interpretation *The data analysis:*					
8.1. Is conducted according to the data		X			Data analysis plan is complicated by the 2

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
analysis plan in the study design.					study groups and lack of clarity about what the RSN wants to measure. "Analysis plan" for group 1 does not specify what they're looking for and how they will define "success"; plan for group 2 is to compare results to group 1; however, they describe a more detailed cut of the population for this group than for the other group, and do not indicate what they will do with each of those sub-populations in the analysis process.
8.2. Allows for generalization of the results to the study population if a sample was selected.				X	Not sampled.
8.3. Identified factors that threaten internal or external validity of findings.		X			See data integrity notes above.
8.4. Includes an interpretation of findings.	X				Interpretation presented in narrative and table format.
8.5 Is presented in a way that provides accurate, clear, and easily understood information.			X		Use of the 2 groups with separate and different data analyses complicates the picture. The table does not capture information that clarifies population size being studied and therefore the result.
8.6 Identifies initial measurement and remeasurement of study indicators.			X		Does not do any comparison.
8.7 Identifies statistical differences between initial measurement and				X	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
remeasurement.					
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.				X	
8.9 Includes the interpretation of the extent to which the study was successful.		X			Summarizes apparent failure of intervention to achieve target.
Totals for Step 8:	**1**	**3**	**2**	**3**	
Number of shaded critical evaluation elements met for Step 8: 0/1					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.					Section not applicable – PIHP not seeing improvement as of this report
9.2. There is documented improvement in processes or outcomes of care.					
9.3. The improvement appears to be the result of planned intervention(s).					
9.4. There is statistical evidence that observed improvement is true improvement.					
Totals for Step 9:					
Number of shaded critical evaluation elements met for Step 9: N/A					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.					Section not applicable.
Totals for Step 10:					
Number of shaded critical evaluation elements met for Step 10: N/A					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS
*Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported ** Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported *** Not Met = Reported PIHP PIP results or plan/activities not credible
Summary of Aggregate Validation Findings * ☐ Met   * * ☒ Partially Met   *** ☐ Not Met
Summary of PIP validation findings: The study topic is important, and the PIHP has engaged in serious planning about solutions to this access problem, as evidenced by meeting minutes and discussions. PIP structure would benefit from re-design, including the study question, indicators, and data analysis plan. Overall, due to design complexity and shortcomings relative to data integrity and analysis, the results would not reliably represent the overall picture and possible positive impact of the chosen intervention.

PIP Strengths

- PIHP has chosen an important study topic that has the capacity to be measured and evaluated with some precision.
- Development of PIP has included PIHP and provider agency staff as well as consumers.

PIP Challenges

- Internal data problems have to be resolved before the PIHP can have an accurate picture of intake process/problems.
- Clarity among providers about definitions and data entry requirements, as well as achieving compliance with procedures, will be necessary to effect significant change.
- Clarification and simplification of the study design will result in increased understanding of system functioning and potential solutions.

PIP Recommendations

1. Redesign PIP to eliminate the second question/study group; analyze impact of any intervention on the total universe of service requests (or representative sample).

2. Set goal or target for performance that measures improvement over baseline. Consider incremental targets that would allow for multiple variables to be addressed which, when taken together, would have the desired impact.

Prioritize addressing procedure and data problems; then take baseline measurement and move from there.

Redesign data analysis plan to ensure that indicators are clear and easily measured, analysis of difference between 2 points in time is statistically reliable, and all variations from the standard process flow (request to first appointment) are accounted for and included in the calculations.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements (see, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff and, in some cases, a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation.

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding), and identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation, as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Met	CCRSN documents data requirements in an RSN-specific data dictionary. Staff also have a collection of manuals developed to aid implementation of their software package "Netsmart". These documents completely detail every necessary submission process and procedure. Completeness standards are located in several places. 90% are listed in the majority of documents, but one document sets forth 98% as the threshold (the document outlining results of their encounter validation activities). Also noted was inconsistent application of the 90% threshold; in only some cases did it trigger a corrective action.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The data dictionary and software manuals are key documents used by their providers as the roadmap to their requirements. These documents are large and complex, but assembled in modular fashion. Each data element is addressed on an individual sheet, allowing necessary changes only on affected pages.

Item	Rating	Comments
2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Met	Clark County RSN provided documentation of a risk analysis being completed for one of their providers as well as a set of policies and procedures outlining applicable review requirements and general processes. Although results of the risk analysis were provided, the tools used to derive them were not, making it difficult to measure effectiveness of

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		the process for this item. Provider disaster recovery plans were also submitted by the RSN, showing its level of involvement and interest in provider network operation. Although the type of study required to support this item was not conducted, previous and current documents submitted show that the RSN mandates a specific level of technology and participation in its software implementation. All providers have qualified IT personnel on staff, or are required to contract with qualified companies. All providers use RSN-supplied software and have a base level of technology to support its use. In combination, these requirements decrease the PIHP's need to study their network in order to understand each agency's risks. There may still be risks, however, in processes used, and efforts should be made to document them. As it presently stands, if a problem arises in a provider agency's ability to submit timely, accurate, and complete data to the RSN, the PIHP examines the processes to determine whether they are contributing to the problem.
3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Partially Met	The PIHP employs an array of processes to ensure that data is accurate and complete prior to submission. The PIHP does not conduct an analysis of the data it holds to validate its

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		completeness and accuracy. Its efforts to verify such data prior to transmission are excellent but do not provide the views needed to calculate actual completeness values needed in this analysis.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Partially Met	The PIHP uses standardized reports to check data in predefined processes. The various processes and tools used are documented, but again, these are used for current data. The PIHP has no specific tools to analyze its complete data set.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data analysis specific to an encounter validation is not conducted.
4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Partially Met	Documentation outlining the encounter validation process and the data to be checked does not meet the contract requirements, but the final report to the state and the work sheets submitted show that the PIHP did check elements required in the contract. This disconnect is most likely due to timing. The effective date of the contract was after the PIHP developed its encounter validation process. Although it is good to see that the PIHP made early efforts to improve consistency of its encounter documentation, staff neglected to update applicable policy and procedure when the requirements appeared in their contract. This oversight could have led to

PIHP Encounter Validation Process Review

Item	Rating	Comments
		inaccurate or incomplete encounter validation results if staff conducting the validation process were not aware of the new requirements.
PIHP includes additional data elements in matching exercise.	Partially Met	Other data elements were included in their review. The method used to select data elements to be reviewed is unknown. If the PIHP had a method to identify data that is seldom (if ever) verified, such data could be added to reviews on a rotating basis to ensure its eventual scrutiny.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Met	The tool used for the data integrity review (encounter validation) is logically laid out, and the results are readily apparent.
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Met	The report to the state is brief and includes provider agency reports as attachments. The report provides state contract sampling language, but lacks details regarding the sampling methodology. The point system is described, and individual reports are referenced for details. Data elements checked are also defined in the report. Ideally, the report should contain information requested by this tool. At a minimum, documentation should contain:

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		• A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	PIHP staff provided evidence of the practice of sharing review exercise results with their providers.
PIHP regularly reports internally for quality improvement activities.	Partially Met	There was no evidence supporting PIHP internal discussion of encounter validation results. Other reports detailing data timeliness and completeness are reviewed internally for purposes of quality improvement activities.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up	Met	The PIHP has a policy and procedure that outlines documentation and oversight activities for findings generated by review activities. Evidence

PIHP Encounter Validation Process Review

Item	*Rating*	*Comments*
activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.		was submitted demonstrating PIHP request for a corrective action plan to correct deficiencies found in the review. This document was drafted after the PIHP met with the provider agency to fully explain the findings and communicate expectations.
If warranted, evidence of follow-up activity was presented.	N/A	

Summary of Encounter Validation Findings

Score Met _54_%

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ Met	☒ Partially Met	☐ Not Met

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP meet the requirements set forth in the contract between the MHD and the PIHP. Some inconsistencies between policy and practice need to be corrected. In addition, there is no evidence that the encounter validation efforts and results are being discussed internally; the most effective way to make and maintain organizational change is for all relevant staff to be aware of the targets and any interim measures.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 54% of all items meeting a score of Met, 8% at Not Met, and the remaining 38% at Partially Met.

EV Strengths

- PIHP has strong documentation for its IT systems.
- PIHP has a mandated baseline technology and skill level required for all providers in its network.
- PIHP requires all providers in its network to use PIHP software.

EV Challenges

- Verifying encounters in an environment moving into a complete electronic record.
- Maintaining currency in the documentation developed for their IT systems throughout their network.

EV Recommendations

1. Develop completeness standards for the entire data set.

2. Update the encounter validation policy to reflect work actually being done.

Begin analysis of their entire dataset.

Develop a matrix listing all data elements collected and the process employed to monitor and/or audit its accuracy.

3. Incorporate encounter validation efforts into the PIHP's quality strategy, review findings in meeting, and develop strategies in that larger setting.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Clark County RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		3		• Plan is clearly written and describes philosophy, structure, and function of QA and I activities. • Includes matrix of indicators (as Annual Work Plan) that specifies targets for performance and reporting schedule. • Includes ongoing MIS evaluation for data integrity. • Describes participation of consumers and other interested stakeholders. • Plan does not include focus on quality and appropriateness of care. • Details of oversight, monitoring, and reports are not described in the plan –

PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				some are in the table of indicators, but the plan itself is not specific.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.	**4**			• Plan states that an annual review is conducted by QA Manager, reviewed by the QMC, and approved by the Executive team. • Plan would benefit from specificity regarding timing and process for review.
C. Plan includes annual work plan and process for review of associated activities and progress.		**2**		• Annual Work Plan is attachment to QM Plan. • Description of annual review included in QM Plan. • Annual Work Plan is table of indicators rather than selection of 3-4 quality improvement initiatives for year's focus. List of accomplishments in Exec Summary contains 2 items that could be considered QI initiatives for the year. The rest could be considered their report card.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		**2**		• Plan specifies biannual provider administrative and chart review visits and indicates that results will be presented to QMC and used for QI. • Lacks details of review, who conducts,

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PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				how scored, etc. • QM 21 Clinical and Administrative Review Policy (approved 11/05) specifies process, scope and content of review; addresses follow-up in general terms; does not describe review scoring or use of information with providers or for system QI; this policy not referenced in QI Plan.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	**4**			• Consumer and Stakeholder Affairs Committee includes consumer representation from multiple other committees and community organizations. • QRT and Ombuds report to QMC and MHAB. • Providers represented on QMC and subcommittees and participate in PIP teams. • Representatives from network on QMC (ED or clinical directors); RSN staff state that meetings are open and many more people attend. • RSN staff state that they have an expectation that provider representatives on committees share activities with all network staff.

PIHP: Clark County RSN

Requirement	Met	PM	Not Met	Findings Comments
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**3**		• Annual Review of Plan: o FY2006 Annual Review (July 2005-June 2006) submitted with detailed results on all QAI activities and recommendations for 2007; Annual work plan feedback request worksheet also submitted along with email to QM Committee members requesting input. o Staff report that they continued the FY2006 plan (dropping some indicators they couldn't measure), and are using it for 2007; still working on review cycle and currency of data. o They don't sign and date QM Plan - it's adopted by the Executive Committee. o Executive Committee minutes not provided for review; no evidence that QM Plan Review was approved and adopted. • Minutes of monthly Quality Management Committee (QMC) provided, demonstrating reporting by subcommittees and approval of recommendations. • Minutes of MHAB and other subcommittees provided; work in progress in all venues. • Ombuds and other Grievance and

PIHP: Clark County RSN

Requirement	Met	PM	Not Met	Findings Comments
				Appeal reports submitted; discussion evident in meeting minutes. • Evidence that agency site visits occur and result in follow-up activities based on result of review. • PIHP did not submit evidence of trended reports for most indicators; however, some discussion of utilization is evident in meeting minutes.
Standard 1 Count (Target 6 Met):	**2**	**4**	**0**	**Target Points: 24 Actual: 18**
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			• QM 21 P&P describes process for integrated site visit and specifics of review for each topical category; o Specifies report submission and CAP response time frames, o Sampling method description specifies random and representative; does not address statistical validity. • Minutes of Cross Functional Team planning and conducting agency site

PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				visits provided. • Reports of Chart Reviews conducted for 2 providers during Fall 2005. • FY 2006 system-wide chart review spreadsheet indicates clinical reviews conducted for all providers during Fall 05 and Spring 06. • One completed chart review submitted dated 5/9/06; difficult to see how comments are incorporated into final scoring of chart. • No documentation submitted demonstrating single provider scoring steps. • Providers reported that PIHP conducts site visits as scheduled twice per year. Last visit was focused on treatment plans – more educational in nature; providers found the strategy very helpful.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.	**4**			• Tool is comprehensive, covering both administrative requirements and quality of care. • Scoring system well-defined, with specific and clear instructions to reviewer. • Scoring is simple: yes, no, partial on

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PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				most elements; no weighting. • Spreadsheets used for analyzing results for each agency and for system; thresholds established for corrective actions and system-wide critical items identified. Those critical items are consistent with documentation of QI activities and focused chart review conducted in November 2006. • Individual chart scores entered into spreadsheet (provided for review); unable to review scoring of actual chart. • Would benefit from procedural document related to use of tool and scoring of charts. For example, reviewer had difficulty understanding what happens to items in review that are left blank.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**3**		• Analysis Notes for FY2006 chart reviews indicate changes made to some scoring guidelines to improve inter-rater reliability. • Scoring guidelines for focused review provided. • Inter-rater reliability process includes: o Team review of scoring guidelines prior to visit;

PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				○ Clinical Manager review of all scores of "partial" or "not met", using the guidelines to validate or change the score based on notes provided by reviewer. • Process would benefit from multiple people looking at charts in question or other method of comparing scores.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.	**4**			• Formal letters to providers sent after review, including full report of review results and specific requests for CAP. • CAP requests include request for evidence of completion; evidence provided to APS for review. • CAP responses for 2 providers submitted, including communication between RSN and provider re: the documentation required. • RSN staff state that documentation of CA performance/completion included in report for following chart review (approx 6 month intervals). • A specific administrative support person tracks all communication with providers. • Providers confirm that RSN communicates effectively and promptly about review results and Corrective

PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				Action Plans.
Standard 2 Count (Target 4 Met):	**3**	**1**	**0**	**Target Points: 16 Actual: 15**
Standard **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		**2**		• QMC minutes reflect discussion of CSQ-8 development and outcomes; however, no evidence that results of provider chart reviews were discussed or analyzed. • Evidence in MHAB minutes that results of chart reviews were discussed, including plan to further investigate adherence to standards for providing culturally competent services.
B. PIHP analyzes and trends individual provider performance.		**3**		• Aggregated chart review spreadsheets designed to easily see and sort for performance by provider or by element reviewed; results provided for 2 site visits in FY2006. • No evidence submitted to indicate that individual provider trends are

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PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				addressed.
C. PIHP analyzes and trends system-wide performance.		**3**		• System-wide performance readily observable from spreadsheets submitted; data provided for 2 reviews during FY2006; no comparison with earlier years. • Minutes from MHAB indicate that PIHP saw a problem with culturally competent services and initiated a plan to address it. • IS meeting minutes reflect discussion of data quality and reporting strategies; however, dates on documents and file names do not correlate.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		**3**		• Minutes of June 2006 MHAB reflect reporting of site visit results with description of trends seen and assertion that next QMC would be reviewing these results: o No evidence of the above occurring. • Evidence that chart review results were discussed at Provider and Services Review Committee and at Enrollee and Stakeholder Committee. • Brief mention of report at QMC July 2006; however, no content of analysis or discussion is included in minutes. In addition, “Action” column references

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PIHP: Clark County RSN

Requirement	Met	PM	Not Met	Findings Comments
				review by QMC (this is in the QMC minutes) and lead identified as Provider Services Review and Cultural Competence Committees – this is not consistent with cross functional team process or QMC responsibility. • Providers assert that they hear about the reviews in QMC and other subcommittees. • Agency staff is aware of some improvement initiatives underway: focus on treatment plans and work on cultural competence.
Standard 3 **Count (Target 4 Met):**	**0**	**4**	**0**	**Target Points: 16** **Actual: 11**

Standard
4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)

Requirement	Met	PM	Not Met	Findings Comments
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**3**		• Clark Policy #CR03 documents responsibility of providers to submit data re: complaints and grievances to RSN for twice yearly reporting to State. • Policy specifies RSN responsibility for compiling data and submitting to QMC for review and analysis (frequency not

PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				specified). • Logs tracking appeals as well as complaints and grievances submitted. • Grievance log has no time frames re: resolution and lacks clarity re: type of resolution and next steps. • Ombuds reports document complaints in detail.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.		**2**		• Annual Work Plan indicates that timely resolution of complaints and grievances and consumer awareness of how to file will be reviewed in Oct and Nov 2006 meetings; Oct minutes were not submitted, and no mention is made in Nov 2006 minutes. • QMC minutes submitted reflected discussion of Exhibit N reports; however, detail of analysis was not provided. • Indications in QMC minutes that these reports would be taken up in UM and ESSC committees; RSN did not provide UM minutes for review. ESSC minutes reflect Denial report also going to UM committee. • April 25, 2006 ESSC minutes reflect discussion of Exhibit N without any analysis; follow-up action regarding

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PIHP: Clark County RSN

Requirement	Met	PM	Not Met	Findings Comments
				denials identified, but not tied to anything stated in minutes. • Aggregated Ombuds data submitted; RSN states that these reports are presented to QMC twice yearly and discussed. No evidence of discussion of these aggregated reports appears in QMC minutes. • Ombuds stated that she provides required reports to QMC, MHAB, QRT, and ESSC, according to schedules, but this frequency may be more often if urgent issue needs discussion. Believes the information she provides is valued by the committees. • Ombuds took action on problem with crisis line subsequent to discussion at meeting.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	4			• July 6, 2005 agenda for an individual provider meeting included training on consumer rights, NOAs, and appeals; attendance documents provided as evidence. • Documentation for January 2006 training attendance submitted. • RSN staff report that annual onsites include review of personnel records for required training.

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PIHP: Clark County RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• RSN ensures that agency staff have relevant current information through creation of an Access database. This database sits on Case Manager desks with prompts for how to handle and categorize calls to encourage documentation and reporting. • Agency staff have adequate grasp of procedures and access to information. By requirement, direct service staff review Clients' Rights at least twice yearly with their clients, thus reinforcing their own familiarity with the information. • Ombuds is very knowledgeable about her role and responsibilities; believes her reports are valued and that action is taken when indicated.
Standard 4 Count (Target 3 Met)	**1**	**2**	**0**	**Target Points: 12 Actual: 9**
Grand Totals Count (Target 17)	**6**	**11**	**0**	**Target Points: 68 Actual: 53**

Summary Quality Assurance and Improvement Findings
While clearly written and well-organized, Clark County's QAI Plan lacks focus on quality of care, which should be a central feature of the plan. In addition, although it appears that the PIHP conducts routine clinical reviews of network agencies and is creative in designing the focus based on review of past results, there is little evidence that the Quality Management Committee consistently reviews the data or participates in decisions about agency or system-wide intervention. The Executive Committee is identified in the Plan as having final authority over all RSN activity; however, there was no evidence provided reflecting those discussions and decisions.

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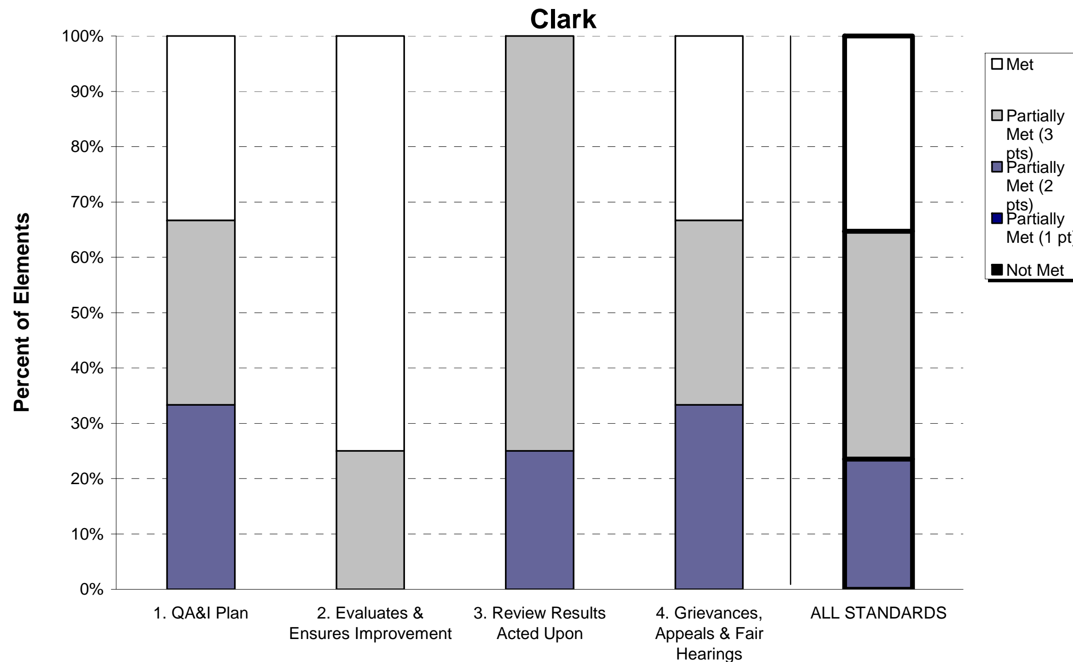

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	2	2	2	0	0
2. Evaluates & Ensures Improvement	4	3	1	0	0	0
3. Review Results Acted Upon	4	0	3	1	0	0
4. Grievances, Appeals & Fair Hearings	3	1	1	1	0	0
ALL STANDARDS	**17**	**6**	**7**	**4**	**0**	**0**

QAI Strengths

- Considerable evidence that stakeholders and consumers are involved at every level in the development and implementation of quality improvement activities.

Annual review of QAI plan is inclusive and comprehensive.

- Quality improvement activity undertaken to address low number of complaints indicates that RSN wants to provide an open and accessible system for consumers.
- Creation of database to track grievances and appeals ensures accurate and complete capture of all related information required to evaluate system performance.
- Cross functional team process supports internal coordination of activities.
- RSN is highly attuned to importance of data quality and spends considerable resources on attempting to create a clean database.

QAI Challenges

- Lack of documentation of Executive Committee review and approval of QAI activities as well as Annual Plan may result in lack

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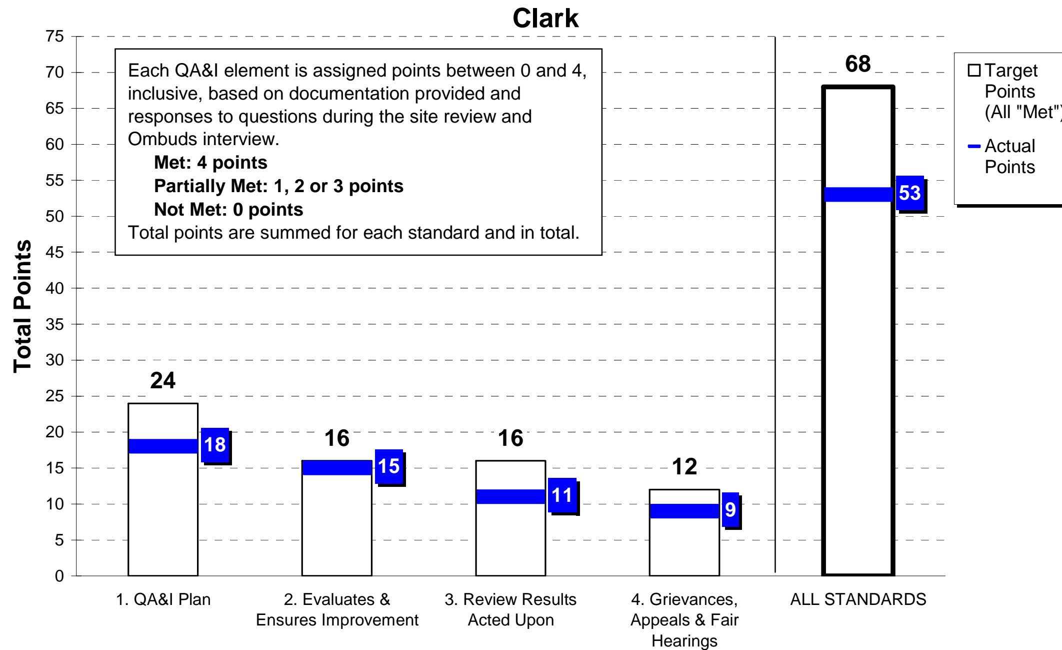

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	18
2. Evaluates & Ensures Improvement	16	15
3. Review Results Acted Upon	16	11
4. Grievances, Appeals & Fair Hearings	12	9
ALL STANDARDS	**68**	**53**

of clarity about what has been officially approved and adopted along with relevant time frames.

- Constant attention to and trouble-shooting of data quality may result in continual postponement of measuring performance.

QAI Recommendations

1. Cross reference policies with each other and with QM Plan and Indicator Matrix to provide comprehensive picture of an entire process. In addition, ensure that all current QAI procedures are formalized in Policy and Procedure documents.

2. Increase detail about discussions in meeting minutes to ensure that reader can identify key elements and outcomes, particularly when reviewing reports.

3. Expand description of quality of care oversight activities in QAI Plan with specifics regarding standards and process for review.

4. Create Annual Work Plan that identifies 2-4 quality improvement projects defined from analysis of previous year's performance.

Establish a process for reporting and tracking progress and ensuring activities achieve desired goals.

5. Include description of formal PIP selection and process in QAI Plan.

6. Create graphs and charts from databases and tables that easily demonstrate trends and allow for more focused analysis; ensure that reporting schedule is maintained and that there is substantive discussion about data provided.

7. Make decision about timing and process for annual review of QAI Plan and ensure that Executive Committee formally approves.

8. Consider revising QAI structure to achieve a well-defined and efficient process for receipt and analysis of information and a process and mechanism for approval and follow-up of recommendations.

Recommendations

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Incorporate into policy and procedures all required BBA requirements pertaining to the authority to file a grievance, appeal, or State fair hearing. In addition, remove procedures 5. vi-viii from CM03 Notice of Action policy due to no relevant foundation found in the BBA or MHD contract to support or validate these timeframe requirements.

3. To assist consumers in accessing a second opinion, incorporate specific steps of how to do so in NOAs.

4. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

5. As stated in the PIHP QM23 Availability of Services policy and procedures, establish baseline data for network sufficiency and identify thresholds for the purpose of assessing network capacity and sufficiency. Organize, utilize, and analyze available data to identify gaps in services and opportunities for quality improvement when data show trends above or below established performance thresholds. In addition, increase involvement of provider management and interested direct service staff in developing strategies to address service gaps and improve the service capacity throughout the region's system of care.

6. Expand privacy compliance audits of subcontractors to incorporate a management information security review.

7. Revise and update monitoring tools incorporating review elements related to the BBA and the PIHP's new and revised policies and procedures.

8. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. Redesign PIP to eliminate the second question/study group; analyze impact of any intervention on total universe of service requests (or representative sample).

2. Set goal or target for performance that measures improvement over baseline, perhaps with incremental targets that would also allow for multiple variables to be addressed which, when taken together, would have the desired impact.

3. Prioritize cleaning up procedures and data problems; then take baseline measurement and move from there.

4. Redesign data analysis plan to ensure that indicators are clear and easily measured, analysis of difference between 2 points in time is statistically reliable, and all variations from the standard process flow (request to first appointment) are accounted for and included in the calculations.

EV Recommendations

1. Develop completeness standards for the entire data set.

2. Update the encounter validation policy to reflect work actually being done.

3. Begin analysis of their entire dataset.

4. Develop a matrix listing all data elements collected and the process employed to monitor and/or audit its accuracy.

5. Incorporate encounter validation efforts into the PIHP's quality strategy, review findings in meeting, and develop strategies in that larger setting.

QAI Recommendations

1. Cross reference policies with each other and with QM Plan and Indicator Matrix to provide comprehensive picture of an entire process. In addition, ensure that all current QAI procedures are formalized in Policy and Procedure documents.

2. Increase detail about discussions in meeting minutes to ensure that reader can identify key elements and outcomes, particularly when reviewing reports.

3. Expand description of quality of care oversight activities in QAI Plan with specifics regarding standards and process for review.

4. Create Annual Work Plan that identifies 2-4 quality improvement projects defined from analysis of previous year's performance. Establish a process for reporting and tracking progress and ensuring activities achieve desired goals.

5. Include description of formal PIP selection and process in QAI Plan.

6. Create graphs and charts from databases and tables that clearly demonstrate trends and allow for more focused analysis; ensure that reporting schedule is maintained and that there is substantive discussion about data provided.

7. Make decision about timing and process for annual review of QAI Plan and ensure that Executive Committee formally approves.

8. Consider revising QAI structure to achieve a well-defined and efficient process for receipt and analysis of information and a process and mechanism for approval and follow-up of recommendations.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Chelan-Douglas Prepaid Inpatient Health Plan

External Quality Review 2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Chelan-Douglas PIHP is responsible for managing mental health care and services for Medicaid consumers in Chelan and Douglas counties in the state of Washington. The PIHP is located in East Wenatchee, Washington and is governed by a board comprised of a commissioner from Chelan and Douglas Counties, a city council member from East Wenatchee and Chelan, and the mayor of Rock Island. The PIHP Administrator reports to the Governing Board. The PIHP contracts with three community mental health centers and specialty providers, which serve approximately 900 adult and child consumers on a monthly basis. Total annual Medicaid enrollment in the PIHP is about 18,120. The PIHP delegates UM to Behavioral Health Options, a private MCO and data collection to Netsmart, a private IT organization.

This report covers the period between February 24, 2006 and February 23, 2007 and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;

5. an evaluation of PIHP conduct of Encounter Validation (EV); and
an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	

Activity	Timeline	Documents/Content
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	January 23, 2007	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	February 14, 2007	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	February 27, 2007	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	March 14, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	March 20, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	April 4, 2007	
4. Debrief conference call	April 16, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	April 23, 2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Chelan-Douglas PIHP did submit a written

response. The RSN requested that their response be attached to this report, see attachment 17. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

2. Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Chelan Douglas PIHP, the following change occurred:

- Developmental Disabilities services were separated from the PIHP, resulting in change of leadership of QMOC.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- For the second consecutive year, the PIHP's initial document submission failed to include much of the material required for review, necessitating an additional document request prior to the site visit. It appears that PIHP staff are challenged in understanding and effectively organizing their materials for a review such as that conducted by the WAEQRO.

- Official revision dates on policies and procedures in many cases preceded dates associated with content mark-up made available to WAEQRO; some of those mark-up dates were as recent as January, with no evidence that they had been approved. The WAEQRO was challenged in understanding which version of the policies and procedures were in effect at a given time. Review results, therefore, reflect all modifications made through the end of the review year.

- Similar timing challenges were evident in revisions of provider contracts, although evidence was submitted of formal approval by the governing board.

- PIHP staff did not submit a 2004 Corrective Action Plan update per the WAEQRO Document Submission Request. Therefore, the WAEQRO had limited information regarding the PIHP's accomplishments related to implementation of their 2004 Corrective Action Plan.

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4. 2006 Review Results

This report provides results and a summary of Chelan-Douglas PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Chelan-Douglas PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.100(c) [Q6]	**Protection of enrollees' right to exercise rights with no adverse treatment effects**			
	No evidence of contract language that spoke to enrollee's treatment not being adversely affected due to the exercising of the rest of their rights.	Submit a corrective action plan to the MHD by 4/4/05. Initial CAP response accepted with modifications—submit additional Info to MHD by 6/16/05.	CAP submitted 4/4/05. WAEQRO has no evidence of second submission.	Relevant PIHP policies and procedures include the requirements of this provision, and provider staff have been trained. PIHP has attained a score of **3-Moderate Compliance**.
438.207 [Q34]	**Sufficient number, mix and geographic distribution of Network Providers to meet anticipated need**			
	Assurances of Adequate Capacity and Services. No evidence that policy is being measured	Submit a corrective action plan to the MHD by 4/4/05.	CAP submitted 4/4/05.	Relevant policies and procedures include requirements of this provision.

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	and monitored.	Initial CAP response accepted with modifications—submit additional Info to MHD by 6/16/05.	WAEQRO has no evidence of second submission.	However, PIHP staff were not able to provide documented evidence of Network adequacy guidelines or standards, nor evidence of a current quality improvement process associated with access and availability of services. PIHP has attained a score of **2-Partial Compliance**.

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.242	**Health Information Systems**			
	No evidence of reports that are used to verify the accuracy of data submitted.	Submit a corrective action plan to the MHD by 4/4/05. Initial CAP response accepted with modifications—submit additional Info to MHD by 6/16/05.	CAP submitted 4/5/05. WAEQRO has no evidence of second submission.	As of January 2005, CDRSN began utilizing additional reports to verify data accuracy between the provider and the RSN database and between the RSN and MHD database. The reports are reviewed bi-weekly, and monthly reports summarize these

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
				activities. This item should be considered closed.
	No evidence there were ample controls over the screening of the data for completeness, logic and consistency.	Submit a corrective action plan to the MHD by 4/4/05. Initial CAP response accepted with modifications—submit additional Info to MHD by 6/16/05.	CAP submitted 4/4/05. WAEQRO has no evidence of second submission.	The system used by the PIHP has built-in logic that will not let a transaction post until all necessary data elements are present. In most cases, core data fields are required. Edit reports have been created and are distributed to providers for review. On-site data reviews data are conducted, and EDI reports are worked weekly, at a minimum. Additional reports are reviewed monthly. This item should be considered closed.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Chelan-Douglas PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

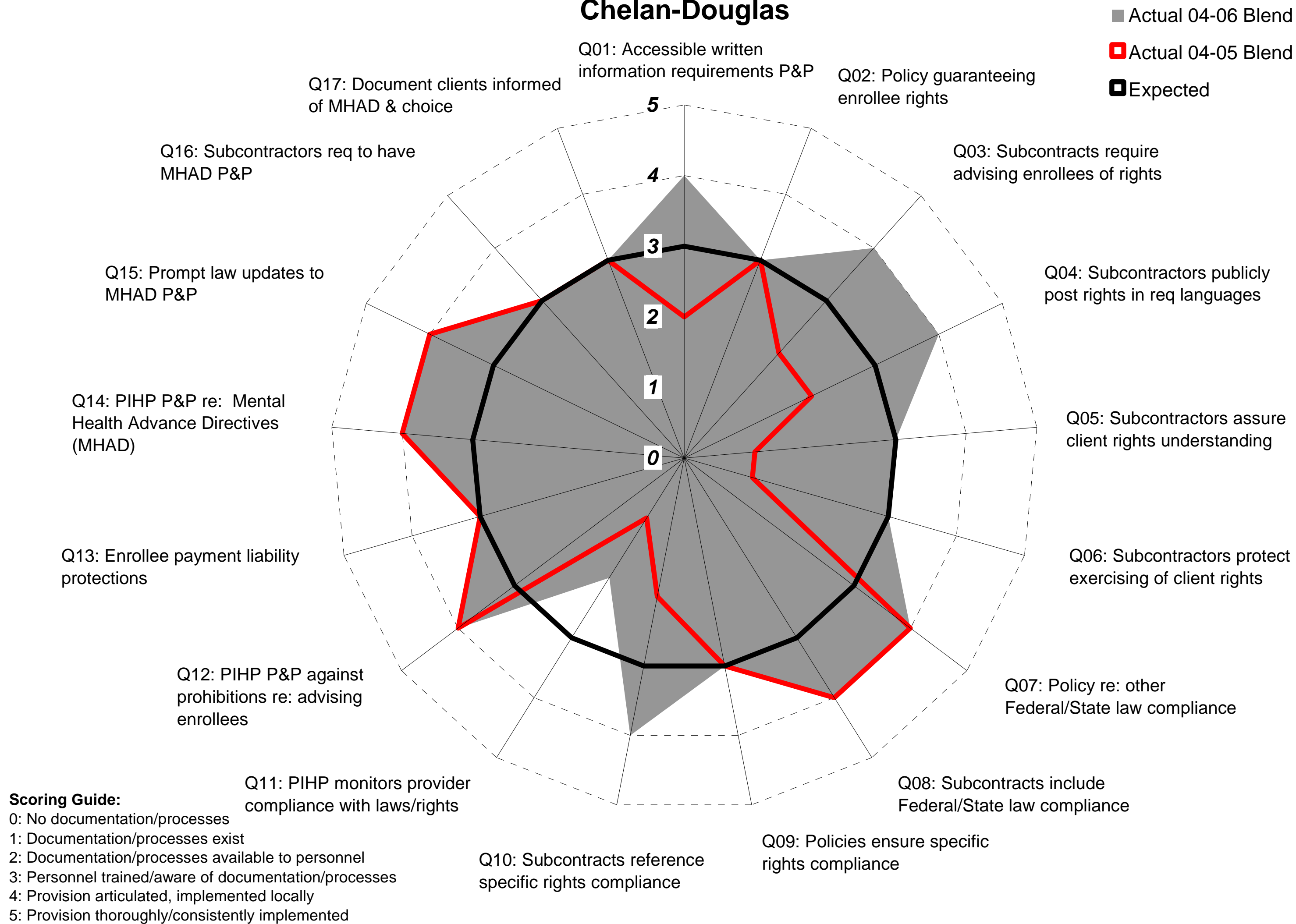
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.


Subpart C: Enrollee Rights & Protections
Chelan-Douglas
Actual 04-06 Blend
Actual 04-05 Blend
Expected
Q01: Accessible written information requirements P&P
Q02: Policy guaranteeing enrollee rights
Q03: Subcontracts require advising enrollees of rights
Q04: Subcontractors publicly post rights in req languages
Q05: Subcontractors assure client rights understanding
Q06: Subcontractors protect exercising of client rights
Q07: Policy re: other Federal/State law compliance
Q08: Subcontracts include Federal/State law compliance
Q09: Policies ensure specific rights compliance
Q10: Subcontracts reference specific rights compliance
Q11: PIHP monitors provider compliance with laws/rights
Q12: PIHP P&P against prohibitions re: advising enrollees
Q13: Enrollee payment liability protections
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)
Q15: Prompt law updates to MHAD P&P
Q16: Subcontractors req to have MHAD P&P
Q17: Document clients informed of MHAD & choice
5
4
3
2
1
0
Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
Chelan-Douglas

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	2	4	4
Q02: Policy guaranteeing enrollee rights	3		3
Q03: Subcontracts require advising enrollees of rights	2	4	4
Q04: Subcontractors publicly post rights in req languages	2	4	4
Q05: Subcontractors assure client rights understanding	1	3	3
Q06: Subcontractors protect exercising of client rights	1	3	3
Q07: Policy re: other Federal/State law compliance	4		4
Q08: Subcontracts include Federal/State law compliance	4		4
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	2	4	4
Q11: PIHP monitors provider compliance with laws/rights	1	2	2
Q12: PIHP P&P against prohibitions re: advising enrollees	4		4
Q13: Enrollee payment liability protections	3		3
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	4		4
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	3		3

Chelan-Douglas PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
438.100(b)	**Specific Enrollee Rights**	
[Q1]	**Written policies and procedures addressing accessible information requirements** Evidence: • 8.1 Consumer Driven MH System Evaluation Consumer Rights and 8.1.1 Consumer Driven MH System Evaluation Enrollee Rights policies and procedures collectively contain all the requirements of this provision. • DSHS Public Mental Health System Benefits Booklet translated in 8 DSHS required languages. • Enrollee Rights in 8 DSHS-required languages. • Enrollee intake forms translated in Spanish. • September 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart C Monitoring Tool and related PIHP materials. • Provider management and direct service staff able to articulate understanding of the requirements and implementation of this provision. (Substantial Compliance)	4
[Q3]	**Subcontracts require advising enrollees of their rights in their primary language** Evidence: • '06-'07 PIHP-Provider Contract stipulates that prior to an intake, subcontractors must ensure that all clients be advised of, and clearly understand their rights in their primary language, and are guaranteed the ability to exercise their rights without adversely affecting their treatment. • 8.1 Consumer Driven MH System Evaluation Consumer Rights policy and procedures, state, "It is the policy of the CDRSN/PIHP that its Medicaid clients, are in their primary language, made aware of and understand their rights and their responsibilities prior to the completion of an intake assessment…Providers will give all clients that are initially admitted into care a copy of the DSHS Benefits Booklet (in their primary language)." The '06-'07 Provider Contract stipulates	

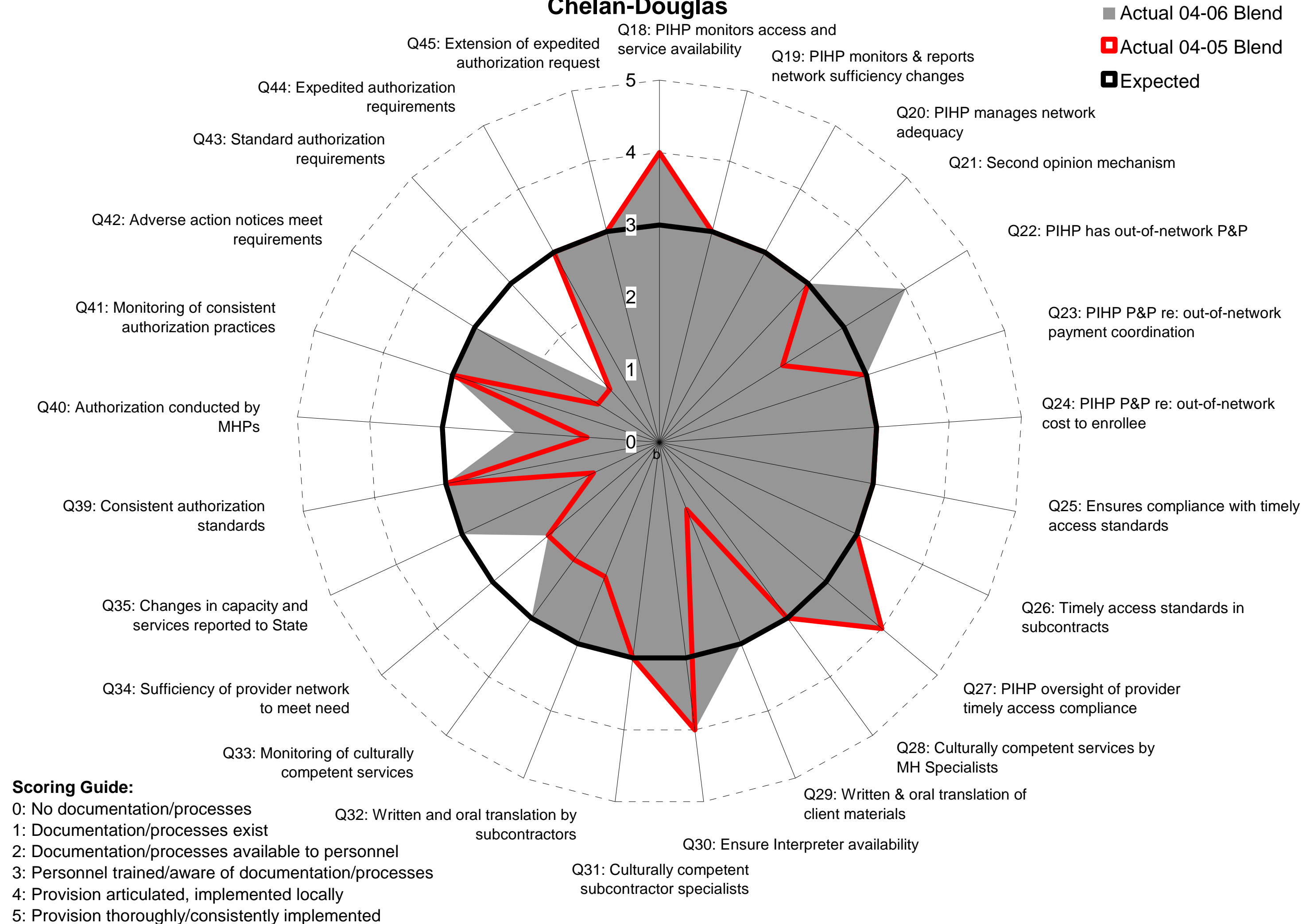
CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	that services will be provided in accordance with CDRSN/PIHP policies and procedures. • September 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart C Monitoring Tool and related PIHP materials. • Provider management and direct service staff were able to articulate understanding of the requirements and implementation of this provision. (Substantial Compliance)	4
[Q4]	**Subcontract requires providers to post client rights in public places in all prevalent languages** Evidence: • ’06-’07 PIHP Provider Contract stipulates that subcontractors shall post in DSHS required languages and make known to Medicaid enrollees their rights (including complaint, grievance procedures, and the availability of Ombuds services. • 8.1 Consumer Driven MH System Evaluation Consumer Rights policy and procedures, state, “The provider must post a written statement of consumer rights in all seven (7) DSHS languages and English in public areas, with a copy available to consumers. Rights will be made available in alternative formats for clients who are blind or deaf, and shall be translated to the most commonly used languages in the service area on request (large print, brail, or cassette recordings. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours.” • Enrollee Rights in 8 DSHS required languages. • September 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart C Monitoring Tool and related PIHP materials. • Provider management and direct service staff had knowledge of where client rights were posted and in what languages. (Substantial Compliance)	4
[Q5]	**Subcontracts require assurance of clients' understanding of rights** Evidence:	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	• <u>’06-’07 PIHP Provider Contract</u> stipulates subcontractors must ensure that all clients clearly understand their rights and are guaranteed the ability to exercise their rights without adversely affecting their treatment. • <u>8.1 Consumer Driven MH System Evaluation Consumer Rights</u> policy and procedures, state, “It is the policy of the CDRSN/PIHP that its Medicaid clients, are in their primary language, made aware of and understand their rights and their responsibilities prior to the completion of an intake assessment.” • Enrollee Rights in 8 DSHS required languages. • <u>September 2006 Attendance Rosters</u>—PIHP provider staff training on policy and procedures. Training included policies listed above. • <u>February 2007 Attendance Rosters</u>—PIHP provider network training on the WAEQRO Subpart C Monitoring Tool and related PIHP materials. • Provider direct service staff described process of reviewing consumer rights with consumers. In addition, staff explained that consumers sign a Consumer Rights form which states that they have been given a copy of their rights, and that these rights have been explained and are understood. • 3 client-signed <u>Provider Notification of Client Rights</u>—contain enrollee signature; however, do not include a statement indicating that client understands their rights. Recommend that a statement of understanding be added to client rights notification forms and be discussed with clients. (Moderate Compliance)	3
438.100(c)	**Free Exercise of rights**	
[Q6]	**Protection of enrollees' right to exercise rights with no adverse treatment effects** Evidence: • <u>’06-’07 PIHP Provider Contract</u> stipulates, “enrollees must be guaranteed the ability to exercise any and all rights and that their treatment will not be adversely affected when they do exercise their rights…Subcontractor shall maintain a non-retaliation policy to ensure that service recipients and other family members are free from retaliation (or the perception of retaliation), for accessing services and protections outlined in this contract…” • No provider non-retaliation policies were submitted by the PIHP as review evidence. • <u>February 2007 Attendance Rosters</u>—PIHP provider network training on the WAEQRO Subpart C Monitoring Tool and related	

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
	PIHP materials. • Provider management is aware of this requirement; had difficulty describing how this provision is ensured. Management did not mention the non-retaliation policy contract requirement. • PIHP has no clearly defined monitoring mechanisms established for this provision. (Moderate Compliance)	3
438.100(d)	**Compliance with Other Federal and State law**	
[Q10]	**Subcontracts require compliance with a client's right to a second opinion, involvement in their mental health treatment, and access to clinical records** Evidence: • '06-'07 PIHP Provider Contract contains references to ensure provider compliance with a client's right to a second opinion, involvement in their mental health treatment, and access to clinical records. • 1.4.2.1 HIPAA Right to Access policy and procedures states, "CDRSN will consider all requests from clients or former clients (Requestor), to review and/or amend their PHI that is maintained by CDRSN in a designated record set for as long as we maintain it, regardless of whether such information was created or obtained prior to the HIPAA compliance date." • 3 client-signed Provider Notification of Client Rights—contain enrollee signature. • 3 client-signed Intake Signature Form—shows minimal evidence of client participation in treatment decisions and planning. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart C Monitoring Tool and related PIHP materials. • Direct service staff was able to articulate a basic understanding of procedures related to a client's right to a second opinion, participation in their treatment decisions, and access to their clinical records. • Network provider management reported that the PIHP reviews client access to a second opinion via quarterly provider report, and participation in treatment decisions via regular chart reviews, ensuring that the provider has relevant policies and procedures. • PIHP staff and provider management reported that client access to their clinical record and relevant provider processes have not been reviewed by the PIHP. (Substantial Compliance)	4

CFR Reference	Compliance Determination Report *Subpart C*	Score 0-5
[Q11]	**PIHP monitors subcontractor compliance with Federal and State laws and client rights** Evidence: • 8.1 Consumer Driven MH System Evaluation Consumer Rights policy and procedures, state, "The CDRSN/PIHP shall use contract monitoring, the authorization process, utilization reviews, retrospective case reviews, Ombuds reports and QRT surveys of enrollees and allied providers to assess provider agency compliance with requirements regarding client rights and provision of required information. Problems requiring corrective action shall be documented and sent to the identified provider agency." • No evidence demonstrating implementation of the monitoring activities outlined in the policy was submitted by the PIHP for review. • Network Provider Quarterly Second Opinion Letters—show evidence of no client requests for second opinions. • ADA Reviews—last conducted in May 2005, outside of current review period. No other evidence was submitted related to monitoring provider compliance with antidiscrimination laws. • Network provider management reported that the PIHP reviews client access to a second opinion via quarterly provider report, and participation in treatment decisions via regular chart reviews, ensuring that the provider has relevant policies and procedures. • PIHP staff and provider management reported that client access to their clinical record and relevant provider processes have not been reviewed by the PIHP. (Partial Compliance)	2

Subpart D (Part 1): Access Standards



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Chelan-Douglas

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4: Provision articulated, implemented locally
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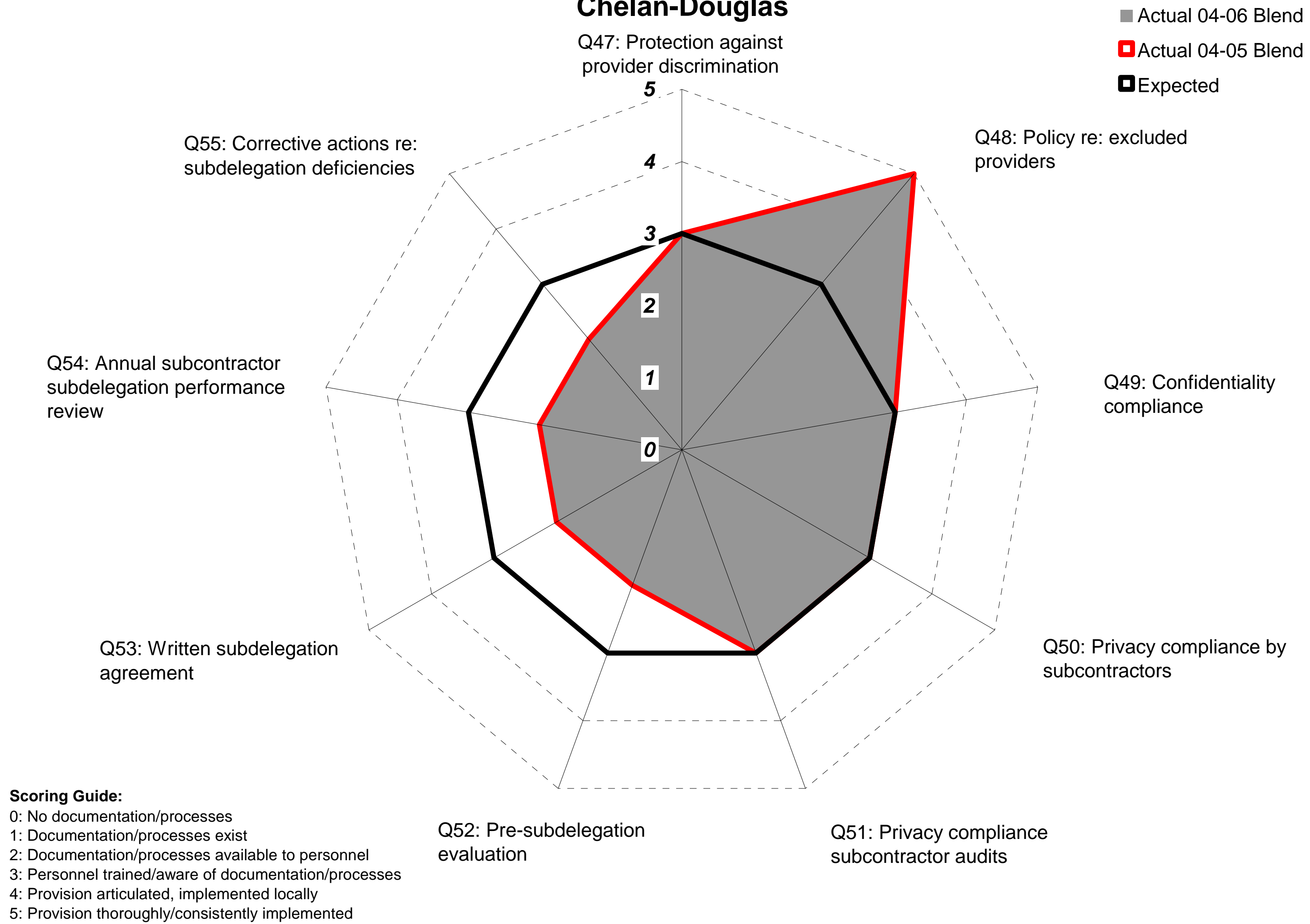
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	4		4
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	2	4	4
Q23: PIHP P&P re: out-of-network payment coordination	3		3
Q24: PIHP P&P re: out-of-network cost to enrollee	3		3
Q25: Ensures compliance with timely access standards	3		3
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	4		4
Q28: Culturally competent services by MH Specialists	3		3
Q29: Written & oral translation of client materials	1	3	3
Q30: Ensure Interpreter availability	4		4
Q31: Culturally competent subcontractor specialists	3		3
Q32: Written and oral translation by subcontractors	2	3	3
Q33: Monitoring of culturally competent services	2	3	3
Q34: Sufficiency of provider network to meet need	2	2	2
Q35: Changes in capacity and services reported to State	1	3	3
Q39: Consistent authorization standards	3		3
Q40: Authorization conducted by MHPs	1	2	2
Q41: Monitoring of consistent authorization practices	3		3
Q42: Adverse action notices meet requirements	1	3	3
Q43: Standard authorization requirements	1	1	1
Q44: Expedited authorization requirements	3		3
Q45: Extension of expedited authorization request	3		3

Subpart D (Part 2): Structure and Operation Standards

Chelan-Douglas



Scoring Guide:
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1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Chelan-Douglas

Scoring Guide for Subparts C, D and F:
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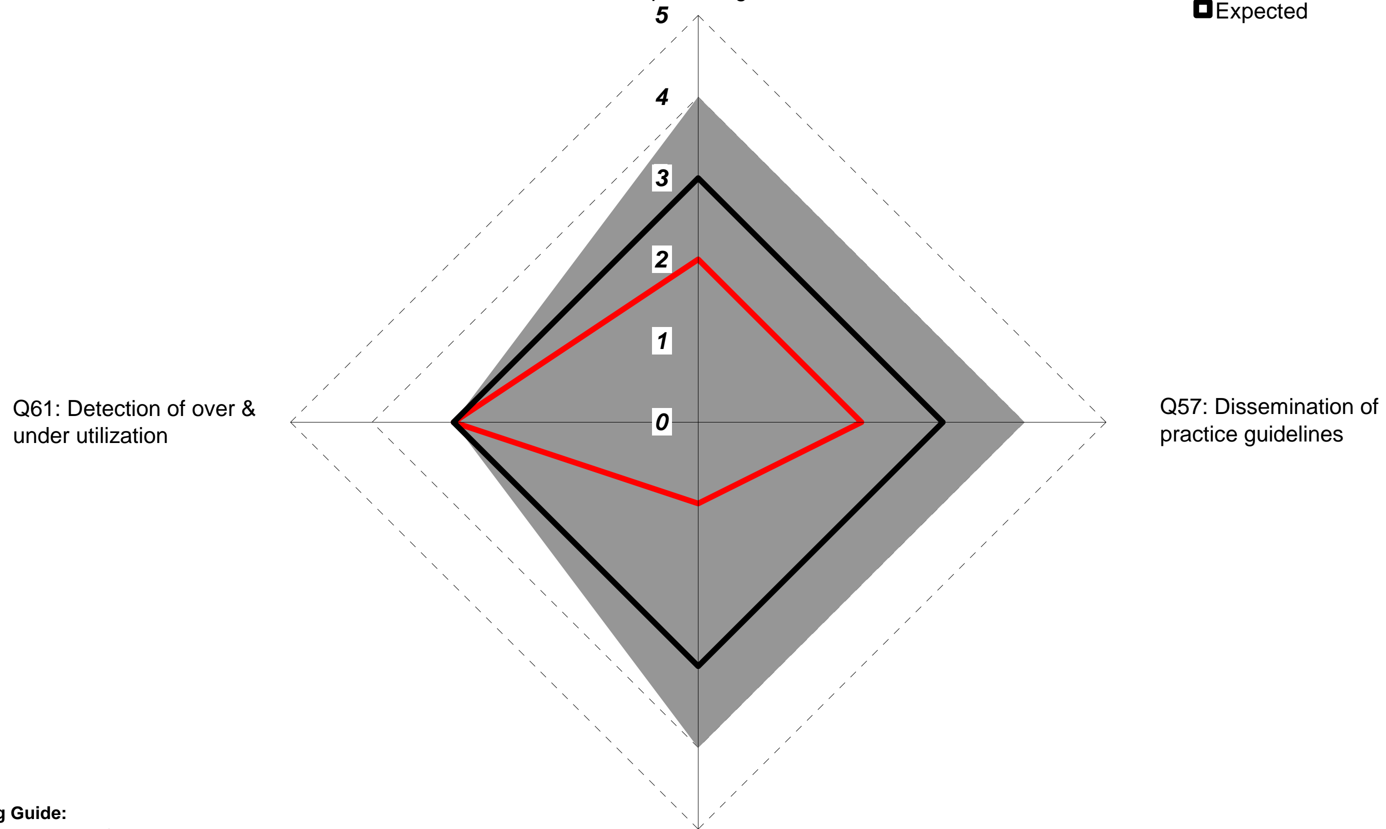
5: Provision thoroughly/consistently implemented

Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	5		5
Q49: Confidentiality compliance	3		3
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	3		3
Q52: Pre-subdelegation evaluation	2	2	2
Q53: Written subdelegation agreement	2	2	2
Q54: Annual subcontractor subdelegation performance review	2	2	2
Q55: Corrective actions re: subdelegation deficiencies	2	2	2

Subpart D (Part 3): Measurement and Improvement Standards

Chelan-Douglas



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2004-2006 Subpart Scoring Trend and Detail for
Chelan-Douglas

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5: Provision thoroughly/consistently implemented

Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	2	4	4
Q57: Dissemination of practice guidelines	2	4	4
Q58: Application of practice guidelines	1	4	4
Q61: Detection of over & under utilization	3		3

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
438.206 (b)(4)	**Delivery Network-Out of Network Providers**	
[Q22]	**PIHP has out-of-network policy and procedures, and subcontractors are making referrals as needed** Evidence: • 2.15 Managed Care Services – Referral/Transferring Consumer Services policy and procedures contains requirements related to out-of-network providers. • No evidence of out-of-network service contracts, service reports, invoices, or related monitoring activities. • June 2006 Attendance Rosters—PIHP policy and procedures training for provider Clinical Directors. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Provider management aware of out-of-provider network policy and were able to articulate basic purpose and processes for referral and payment. • Direct service staff reported basic procedures for making out-of-network referrals; would seek supervisor assistance. (Substantial Compliance)	4
438.206 (c)(2)	**Furnishing of Services Continued**	
[Q29]	**Written and oral translation of client materials** Evidence: • '06-'07 PIHP Provider Contract & 8.1 Consumer Driven MH System Evaluation Consumer Rights policy and procedures together generally meet the basic requirements for written and oral translation of client materials. • DSHS Public Mental Health System Benefits Booklet translated in 8 DSHS-required languages. • Enrollee Rights in 8 DSHS-required languages. • Enrollee intake forms in Spanish. • September 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Direct service staff were able to articulate languages that must be available in oral translation. Staff reported that they would use the ATT language line for interpreters and would need to seek assistance from supervisor for how to access face-to-face interpreters, including those for American Sign Language. • There remain inconsistencies among provider management staff as to the specific client materials required to be translated in all seven prevalent languages and made available in alternative formats for persons with sensory impairments. Recommend that PIHP identify in provider contracts specific client materials to be translated and identify the required languages and formats in which materials are to be made available. (Moderate Compliance)	3
[Q32]	**Client materials translated according to WAC 388-865-0330 requirements related to language thresholds** Evidence: • ’06-’07 PIHP Provider Contract & 8.1 Consumer Driven MH System Evaluation Consumer Rights policy and procedures together generally meet the basic requirements for written and oral translation of client materials. • DSHS Public Mental Health System Benefits Booklet translated in 8 DSHS-required languages. • Enrollee Rights in 8 DSHS-required languages. • Enrollee intake forms in Spanish. • September 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Direct service staff were able to articulate languages that must be available in oral translation. Staff reported that they would use the ATT language line for interpreters and would need to seek assistance from supervisor for how to access face-to-face interpreters, including those for American Sign Language. • There remain inconsistencies among provider management staff as to the specific client materials required to be translated in all seven prevalent languages and made available in alternative formats for persons with sensory impairments. Recommend that PIHP identify in provider contracts specific client materials to be translated and identify the required languages and formats in which materials are to be made	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	available. (Moderate Compliance)	3
[Q33]	**Mechanisms for oversight of culturally competent service standards** Evidence: • 1.9.1 Culturally & Linguistic Competency Standard policy and procedure includes a variety of mechanisms for oversight of culturally competent service standards. No evidence of implementation of these oversight mechanisms was submitted by the PIHP for review. • PIHP staff reported that the policy is newly revised and approved. Development of the monitoring mechanisms outlined in the policy "is a work in progress," according to PIHP staff. • February 2007 Attendance Rosters—PIHP policy and procedures training for provider management. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. (Moderate Compliance)	3
438.207	**Assurances of Adequate Capacity and Services**	
[Q34]	**Sufficient number, mix and geographic distribution of Network Providers to meet anticipated need** Evidence: • 1.6 MH Provider Network Provider Selection policy and procedure states, "The CDRSN/PIHP will develop a capacity management plan biennially and track and monitor the plan annually in order to plan ongoing development of mental health services throughout the region by the completion of the Capacity management report. Consumer, stakeholder and provider representation will form a work group to map current services and develop a set of factors (to include but not limited to a. waiting lists, b. timely access to intake assessments, c. MHCP caseloads d. availability of complete service package of service modalities, and e. consumer complaints) that will be trended across time to indicate need for additional network capacity, new services and/or additional service locations. The Capacity management report shall be completed by June first of each year and submitted to the Quality Management Oversight Committee for review and action as needed." • The PIHP did not submit the above-referenced Capacity Management Plan or evidence of the described workgroup and	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	related activities for review. • October 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. No evidence was submitted by the PIHP indicating that the Capacity Management Report or workgroup activities described in the above policy were included in training. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. No evidence was submitted by the PIHP indicating that the Capacity Management Report or workgroup activities described in the above policy were included in training. • PIHP staff reported that there are no provider wait lists and never had a provider reach capacity and turn referrals away. • PIHP staff were not able to show documented evidence of Network adequacy guidelines or standards and were not able to show evidence of a currently implemented, methodical, quality improvement process associated with access and availability of services. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q35]	**Timely reporting to State of substantial changes affecting capacity and services** Evidence: • February 2007 Provider Capacity Reports for all 3 Network Providers—include a list of mental health providers, their degree and license status, Mental Health Specialist status, services provide they provide, whether they are a contract employee or consultant only, and their zip code. • The PIHP reported that in November 2006, they submitted to MHD a report similar to that described in the above bullet, and that it was within the 90-day contractual requirement. (Moderate Compliance)	3
438.210(b)	**Authorization of Services**	
[Q40]	**Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise** Evidence: • 2.7.1 Managed Care Services –Service Authorization, 2.9 Managed Care-Residential Level of Care Authorization, and 5.2 Inpatient Psychiatric Services collectively contain the requirements to this provision. • June, October and November 2006 Attendance Rosters—PIHP	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	policy and procedures training for provider management. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • No evidence of BHO staff training. • PIHP sub-delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. • 3-completed electronic outpatient authorizations were submitted for review. Credentials of professional conducting authorization were not included on printed authorization screens. In addition, no job descriptions or credentials of professionals performing authorizations were submitted for review; as a result, WAEQRO is unable to verify whether the MHP requirement for outpatient authorizations is practiced. • 3-completed hard copy inpatient authorizations were submitted for review. Signatures and credentials of professionals conducting authorizations are included on the form and meet the MHP requirement. • No oversight monitoring or related QA&I activities were submitted by the PIHP to show evidence of ensuring that authorizations for outpatient and inpatient are conducted by MHPs. • PIHP staff reported that during last year's on-site visit of BHO they met with staff performing authorizations, and reviewed BHO's NCQA certification. PIHP staff were not able to verify that those same credentialed staff have been conducting their authorizations. • Provider management reported their understanding is that BHO staff who conduct authorizations are Masters prepared, however do not know if they meet MHP qualifications. (Partial Compliance)	2
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • 9.1.3 Complaints, Conflicts and Disputes and 9.2 Complaints Conflicts & Disputes - Conflict Resolution policies and procedures collectively incorporate the Notice of Action (NOA) requirements contained in this provision. • One notification to PIHP from BHO of denial with copy of denial attached. Reviewer is unable to determine if the required timeframes were followed as notice does not contain pertinent dates for service junctures. • No PIHP denial and/or NOA tracking logs were submitted for	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	review (detailing timeframes from request of service forward). • November 2006 Executive Summary—shows number of inpatient and outpatient denials and authorizations by month, quarter and year to date. This report does not provide the information needed to ensure that required NOA timeframes are being met. • June 2006 Attendance Rosters—PIHP policy and procedures training for provider Clinical Directors. Training included policies listed above. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Provider management and direct service staff are familiar with NOAs and were able to articulate their basic purpose. Provider staff have variable knowledge of timeframes related to NOAs. • No related QA&I activities were submitted by PIHP for review. (Moderate Compliance)	3
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • 2.7.1 Managed Care Services –Service Authorization policy and procedures contain the requirements of this provision with the exception of 438.210(d)(1)(ii) "The PIHP justifies to the State agency upon request, a need for additional information and how the extension is in the enrollee's interest." • 3-completed electronic standard outpatient authorizations were submitted by PIHP for review. Date of enrollee request for service is not included on authorization screen. Reviewer is unable to determine if authorization timeframes meet requirements. • October 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Provider management and direct service staff were able to articulate 14-calendar day authorization requirement. Staff were also aware that enrollee or the enrollee's representative can request an extension. Staff reported that they do not know if the BHO or the PIHP can request an extension. • Score remains the same as 2005 EQR because the above-referenced policy does not contain all the requirements of this provision.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	(Insufficient Compliance)	1
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • 2.27 Delegation Agreements policy and procedures contains the basic requirements of this provision. The policy states, "Before contracting for a sub delegated function the CDRSN/PHIP will conduct all appropriate due diligence activities including (as appropriate) the examination of the financial viability of the entity through financial and annual reports; staff professional credentials; affiliation with professional credentialing entities; policies and procedures and references." • PIHP staff reported that the pre-delegation evaluation of Behavioral Health Option's ability to perform authorizations and utilization management (UM) functions included the procedures outlined in the above bullet. The evaluation reportedly included a review of BHO's URAC accreditation, financial statements, stock market analysis of BHO's parent company, and a face-to-face meeting with 4 of their top management. • The PIHP was unable to provide documented evidence related to pre-delegation review of BHO as described above. • PIHP reported the documented evidence related to the pre-delegation evaluation of Netsmart Technologies' ability to perform management information service/information technology (MIS/IT) functions is on file at Clark County PIHP, and as a result, did not submit this evidence for review. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • 2.27 Delegation Agreements policy and procedures contain basic requirements for written delegation agreements. • BHO Services Contract—PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. Subcontract specifies the activities and responsibilities delegated to BHO and provides for revoking delegation. Subcontract does not specify other sanctions if the subcontractor's performance is inadequate.	

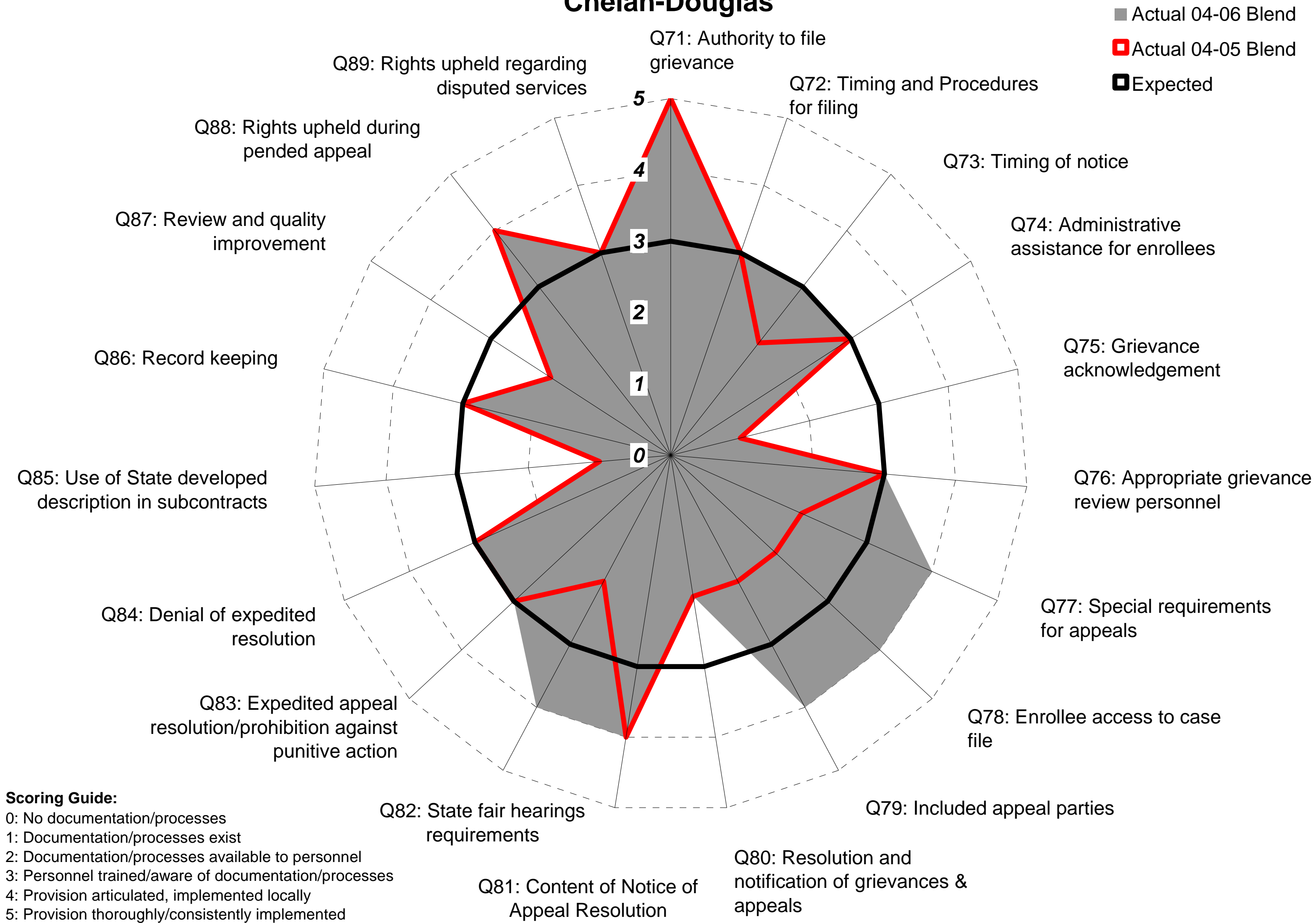
CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	• Modification of Inter-local Agreement for Clark County and CDRSN/PIHP (un-dated)—addresses covered lives chart and a variety of fee schedules and charts. Does not include specific MIS/IT-delegated functions, activities, or responsibilities to Clark County PIHP or Netsmart Technologies. In addition, the original Inter-local Contract between Clark County and CDRSN/PIHP was not submitted for review by the PIHP; therefore, WAEQRO is unable to determine if the inter-local contract meets the requirements of this provision. • Recommend that PIHP delegation subcontracts explicitly outline potential sanctions related to sub-standard performance (in addition to termination). • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • 2.27 Delegation Agreements policy and procedures includes basic monitoring activities related to subcontractor performance of delegated functions. • PIHP conducted a site visit of BHO in March 2006. PIHP did not submit a formal performance review or report; however, they submitted an email summarizing the points of discussion and desired quality improvements from the perspective of the BHO Clinical Account Executive. • September 19, 2005 PIHP BHO Letter of Corrective Action related to violation of HIPAA regulations associated with BHO's Notice of Action process. September 27, 2005 BHO Corrective Action Response Letter—describes corrective action employed to alleviate potential future HIPAA violations. • Recommend that the PIHP delineate review standards for each of the delegated functions. Stipulate in each delegation subcontract the frequency and manner by which delegates will be reviewed. In addition, recommend that the PIHP conduct a comprehensive annual review of BHO's performance relevant to the PIHP's requirements, standards, and expected outcomes and document the results along with any quality improvements, and warranted corrective actions. • No annual performance review or other monitoring activities of Netsmart Technologies was submitted for review; unable to determine if PIHP is monitoring the performance of Netsmart on a regular basis. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	(Partial Compliance)	2
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • 2.27 Delegation Agreements policy and procedures stipulates that corrective actions will be taken to address any areas of deficiency. • PIHP conducted a site visit of BHO in March 2006. PIHP did not submit a formal performance review or report; however, they submitted an email summarizing the points of discussion and desired quality improvements from the perspective of the BHO Clinical Account Executive. • September 19, 2005 PIHP BHO Letter of Corrective Action related to violation of HIPAA regulations associated with BHO's Notice of Action process. September 27, 2005 BHO Corrective Action Response Letter—describes corrective action employed to alleviate potential future HIPAA violations. • Recommend that the PIHP delineate review standards for each of the delegated functions. Stipulate in each delegation subcontract the frequency and manner by which delegates will be reviewed. In addition, recommend that the PIHP conduct a comprehensive annual review of BHO's performance relevant to the PIHP's requirements, standards, and expected outcomes and document the results along with any quality improvements, and warranted corrective actions. • No annual performance review or other monitoring activities of Netsmart Technologies was submitted for review; unable to determine if PIHP is monitoring the performance of Netsmart on a regular basis. Also unable to determine if the PIHP has imposed any quality improvements or corrective actions. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
438.236	**Practice Guidelines**	
[Q56]	**Adoption of practice guidelines meets established requirements** Evidence: • 7.7 QI&U Measurement & Improvement Practice Guidelines policy and procedures includes the basic requirements of this provision. • Practice guidelines for Major Depression and Pediatric ADHD. • October 25, 2005 Clinical Team Meeting Minutes—show evidence of dissemination of practice guidelines and training	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	provided to agency Clinical Directors. • December 13, 2005 Clinical Team Meeting Minutes—indicate that one provider had completed practice guideline training with their direct service staff. Also include discussions about Conner's scale, Beck Depression scale, and medication for individuals with depression. • October 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Provider management and direct service staff were able to identify the adopted practice guidelines. They reported that direct service staff were trained and are using the practice guidelines with consumers diagnosed with Major Depression or Pediatric ADHD. • Provider management also reported that the PIHP is monitoring via provider written report on the number of consumers receiving services consistent with the practice guidelines. In addition, management reported that the PIHP Clinical Director reviews for the incorporation of practice guidelines in the plan of care during clinical record reviews. No documentation of the latter was submitted by the PIHP for review. (Substantial Compliance)	4
[Q57]	**Dissemination of practice guidelines to providers and enrollees upon request** Evidence: • 7.7 QI&U Measurement & Improvement Practice Guidelines policy and procedures includes the basic requirements of this provision. • Practice guidelines for Major Depression and Pediatric ADHD. • October 25, 2005 Clinical Team Meeting Minutes—show evidence of dissemination of practice guidelines and training provided to agency Clinical Directors. • December 13, 2005 Clinical Team Meeting Minutes—indicate that one provider had completed practice guideline training with its direct service staff. These minutes also include discussions about Conner's scale, Beck Depression scale, and medication for individuals with depression. • October 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Provider management and direct service staff were able to identify the adopted practice guidelines. They reported that direct service staff were trained and are using the practice guidelines with consumers diagnosed with Major Depression or Pediatric ADHD. • Provider management also reported that the PIHP is monitoring via provider written report on the number of consumers receiving services consistent with the practice guidelines. In addition, management reported that the PIHP Clinical Director reviews for the incorporation of practice guidelines in the plan of care during clinical record reviews. No documentation of the latter was submitted by the PIHP for review. (Substantial Compliance)	4
[Q58]	**Processes of care are consistent with practice guidelines** Evidence: • 7.7 QI&U Measurement & Improvement Practice Guidelines policy and procedure includes the basic requirements of this provision. • Practice guidelines for Major Depression and Pediatric ADHD. • October 25, 2005 Clinical Team Meeting Minutes—show evidence of dissemination of practice guidelines and training provided to agency Clinical Directors. • December 13, 2005 Clinical Team Meeting Minutes—indicate that one provider had completed practice guideline training with its direct service staff. These minutes also include discussions about Conner's scale, Beck Depression scale, and medication for individuals with depression. • October 2006 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • November 2006 & February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart D Monitoring Tool and related PIHP materials. • Provider management and direct service staff were able to identify the adopted practice guidelines. They reported that direct service staff were trained and are using the practice guidelines with consumers diagnosed with Major Depression or Pediatric ADHD. • Provider management also reported that the PIHP is monitoring via provider written report on the number of consumers receiving services consistent with the practice guidelines. In addition, management reported that the PIHP	

CFR Reference	Compliance Determination Report *Subpart D*	Score 0-5
	Clinical Director reviews for the incorporation of practice guidelines in the plan of care during clinical record reviews. No documentation of the latter was submitted by the PIHP for review.	
	(Substantial Compliance)	4



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2004-2006 Subpart Scoring Trend and Detail for Chelan-Douglas

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Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	5		5
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	2	3	3
Q74: Administrative assistance for enrollees	3		3
Q75: Grievance acknowledgement	1	1	1
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	2	4	4
Q78: Enrollee access to case file	2	4	4
Q79: Included appeal parties	2	4	4
Q80: Resolution and notification of grievances & appeals	2	2	2
Q81: Content of Notice of Appeal Resolution	4		4
Q82: State fair hearings requirements	2	4	4
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	1	1	1
Q86: Record keeping	3		3
Q87: Review and quality improvement	2	2	2
Q88: Rights upheld during pended appeal	4		4
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

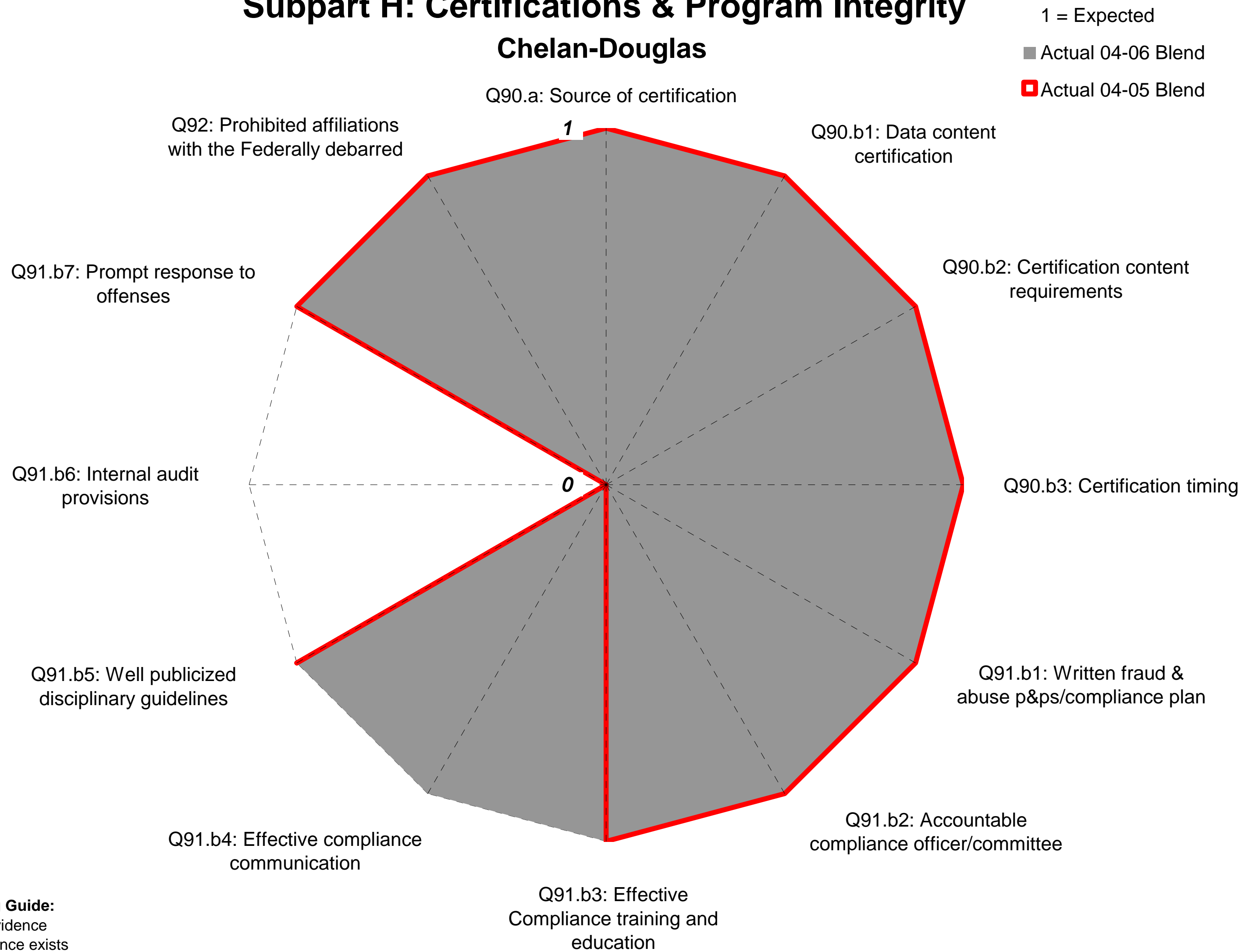
CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
438.404	**Notice of Action-Timing of Notice**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures contain the required timeframes related to Notice of Actions in this provision. • One notification to PIHP from BHO of denial with copy of denial is attached. Reviewer is unable to determine if the required timeframes were followed as notice does not contain pertinent dates for service junctures. • No PIHP denial and/or NOA tracking logs were submitted for review (detailing timeframes from request of service forward). • PIHP reports that BHO (Utilization Management Subcontractor) tracks denials and NOAs; however, no BHO tracking logs were submitted for review. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • Provider management and direct service staff are familiar with NOAs and were able to articulate their basic purpose. Provider staff have variable knowledge of timeframes related to NOAs. • No related QA&I activities were submitted by PIHP for review. (Moderate Compliance)	3
438.406	**Handling of Grievances and Appeals**	
[Q75]	**Acknowledgement of receipt of each grievance and appeal** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures states, "The CMHA, PIHP, or Ombuds will give verbal (via telephone) acknowledgement to the enrollee of receipt of the appeal the next working day **when possible, but no later than 72 hours later**, and provide written acknowledgement within five (5) working days." Above bolded phrase is not included in the MHD Exhibit N Template. • No format or timeframe of acknowledgement to the enrollee of PIHP receipt of grievance was submitted by the PIHP for	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	review. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • No related QA&I activities were submitted by the PIHP for review. • Score remains the same as 2005 EQR due to policy containing an inaccurate timeframe related to PIHP oral acknowledgement of receipt of appeal, and insufficient documentation and evidence of requirements related to acknowledgement of receipt of grievance. (Insufficient Compliance)	1
[Q77]	**Oral appeal inquiries treated as appeals; opportunity to present evidence and allegations of fact or law in person and in writing** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures incorporates requirements of oral appeals and enrollee's right to present evidence and allegations of fact or law in person and in writing. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • Provider direct service staff were able to articulate basic understanding of an enrollee's right to present evidence during an appeal. • No related QA&I activities submitted by PIHP for review. (Substantial Compliance)	4
[Q78]	**Enrollee and representative opportunity to examine case file, medical records, other documents related to appeal process** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures includes language to ensure enrollee and their representatives have access to medical records and related	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	appeal process documents. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • Provider direct service staff were able to articulate basic requirements of this provision by identifying that client has access to their clinical record and any information associated with the actions they are appealing with the exception of 3rd party information. • No related QA&I activities submitted by PIHP for review. (Substantial Compliance)	4
[Q79]	**Included parties to the appeal** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures stipulate parties to the appeal may include the enrollee and his/her representative, or the legal representative of a deceased enrollee's estate. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • Provider direct service staff were able to articulate potential parties that may be included in an appeal. • No related QA&I activities submitted for review. (Substantial Compliance)	4
438.408	**Resolution and Notification of Grievances and Appeals**	
[Q80]	**Resolution and notification for grievance and appeals** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures contains requirements related to resolution and notification for appeals; however, it does not include requirements for the resolution and notification of grievances. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • Provider direct service staff were able to articulate a basic understanding of the resolution and notification process for grievances and appeals. • No related QA&I activities were submitted by PIHP for review. • Score remains the same as 2005 EQR due to insufficient documentation and evidence related to grievance resolution and notification requirements. (Partial Compliance)	2
[Q82]	**State fair hearings requirements** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures accurately stipulates the State Fair Hearings requirements. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • Provider direct service staff were able to articulate a basic understanding of State Fair Hearings and their purpose. • No related QA&I activities were submitted by PIHP for review. (Substantial Compliance)	4
438.414	**Information About the Grievance System to Community Mental Health Agents of the PIHP**	
[Q85]	**Use of State developed description in subcontracts** Evidence: • No evidence was submitted by the PIHP to show that it provides information about the grievance system as specified in 438.10(g)(1) to all subcontractors at the time they enter into a contract using a State-developed description. • PIHP staff reported that the most recent version of the Exhibit N-Washington State Mental Health Division Grievance Template is not incorporated as an attachment or otherwise included in their provider contracts.	

CFR Reference	Compliance Determination Report *Subpart F*	Score 0-5
	• Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
438.416	**Record Keeping and Reporting Requirements**	
[Q87]	**Mechanisms for reviewing grievances and appeals and creating quality improvements** Evidence: • 9.2 Complaints Conflicts & Disputes - Conflict Resolution policy and procedures contain basic requirements of this provision. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • December 2006 & January 2007 Attendance Rosters—PIHP provider staff training on policy and procedures. Training included policies listed above. • Additional Training Curriculum – Appeal of Notice of Action Flow Chart & – Grievance/Fair Hearing Flowchart. • February 2007 Attendance Rosters—PIHP provider network training on the WAEQRO Subpart F Monitoring Tool and related PIHP materials. • 4/3/06 and 8/2/06 Ombuds Reports to the Advisory Board. • 4/3/06 and 8/7/06 Ombuds Reports to the Governing Board • Provider management reported that the PIHP Clinical Director reports quarterly on grievances and appeals at QMOC. Management did not describe a process for creating quality improvements. • April-August-October 2006 QMOC Meeting Minutes show Ombuds report on complaints and Exhibit N. No evidence was submitted of PIHP quarterly reports on grievances and appeals as reported by provider management. • April-September 2006 Exhibit N Report—no PIHP analysis was submitted by PIHP for review. • No additional QA&I activities were submitted by PIHP for review. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for
Chelan-Douglas

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	1	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	0	1	1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	0	0	0
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Compliance Determination Report *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) <u>Content Certification.</u> (1) To the accuracy, completeness, and truthfulness of the data (Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness, and truthfulness of the documents specified by the State. (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification. (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b4]	**Effective lines of communication between Compliance Officer and employees** Evidence: • <u>CDRSN Fraud and Abuse Compliance Plan</u> (adopted in November 2005) includes a basic process for effective communication between the Compliance Officer and employees. • MHD Compliance Training PowerPoint. • PIHP staff Compliance Training Certificates. • PIHP staff were familiar with the PIHP policies related to program integrity and had participated in fraud and abuse training during the review period. (Compliance)	1
[Q91.b6]	**Provisions for internal monitoring** Evidence: • <u>CDRSN Fraud and Abuse Compliance Plan</u> (adopted in November 2005) references an <u>Internal Audit Plan</u> designed to address: o Integrate the findings from previous years' audits into Fraud and Abuse prevention plans and activities;	

- Identify risk areas as part of ongoing risk assessment activities;
- Review high volume services for both clinical quality and fiscal accountability;
- Claims accuracy via encounter validation checks and ensuring the data PIHP receives from CMHAs is accurate and complete.

- No Internal Audit Plan or internal audit was submitted by the PIHP for review.
- CDRSN Fraud and Abuse Compliance Plan—focuses on monitoring network providers via:
  - CDRSN-conducted Provider Site Reviews;
  - Review of Provider quarterly Financial information;
  - Requirement of Annual Independent Audit;
  - Profiling of Provider Client Data;
  - Review of Community Inpatient Claims;
  - Quality Review Team Site Visit;
  - Ombuds;
  - Grievance;
  - Utilization Management Operations; and
  - Review MHD Provider Licensing Reports.
- Christopher House (CH) Site Visit—shows evidence of PIHP fiscal monitoring of CH handling of an enrollee's account and verification of fund balance. Errors found—reimbursements made—no fraud & abuse findings—quality improvements were issued.
- Inpatient Reconciliation Process.
- August 17, 2006 State Audit of Douglas County was submitted as evidence of oversight of internal operations. The report included one condition significant to report which related to a lack of adequate supporting documentation for payments made by the PIHP to a provider.
- Majority of evidence submitted by PIHP reflected monitoring activities related to outpatient and inpatient providers for potential fraud and abuse. This does not constitute evidence of PIHP internal monitoring practices related to their own fiscal management, resource, and utilization management, conduct, conflict of interests, etc., to prevent and detect potential fraud and abuse.
- Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase.

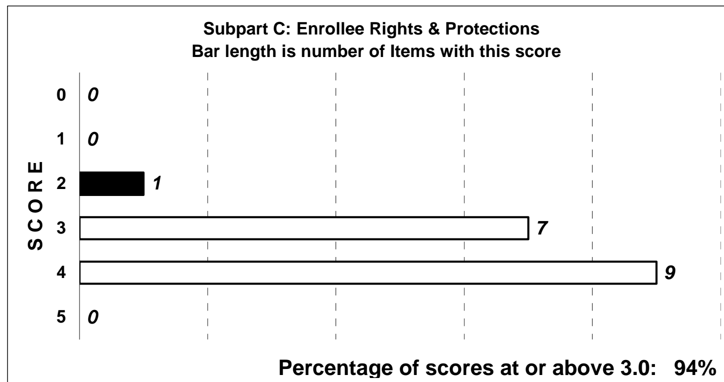
(No Compliance) 0

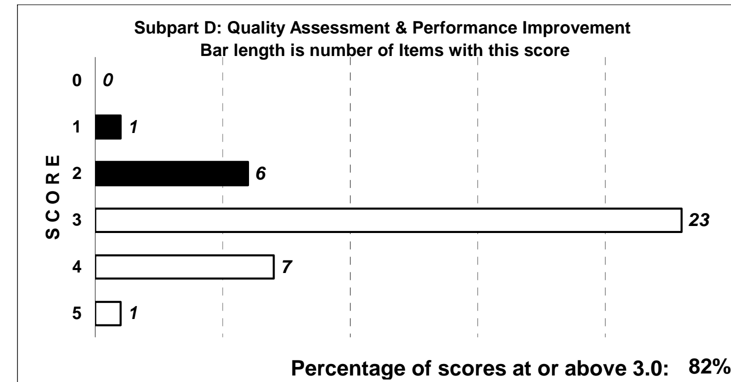
Scoring Frequency Overview

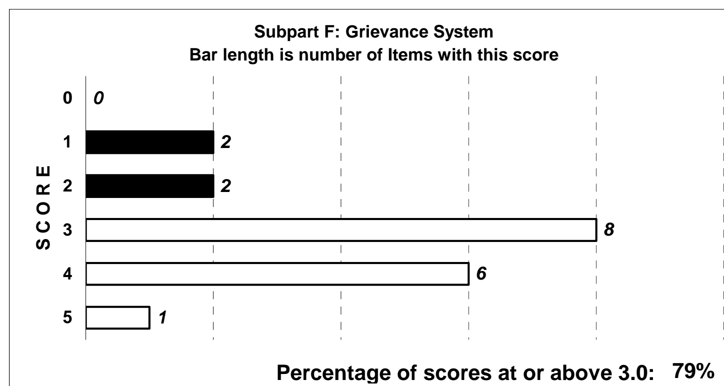
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Chelan-Douglas

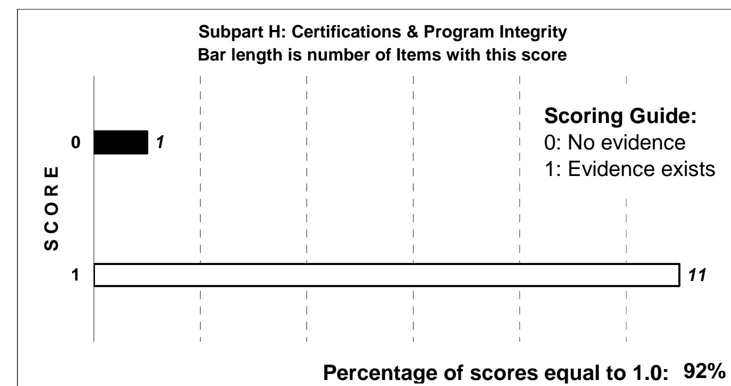
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 94%
Subpart D: 82%
Subpart F: 79%
Subpart H: 92%

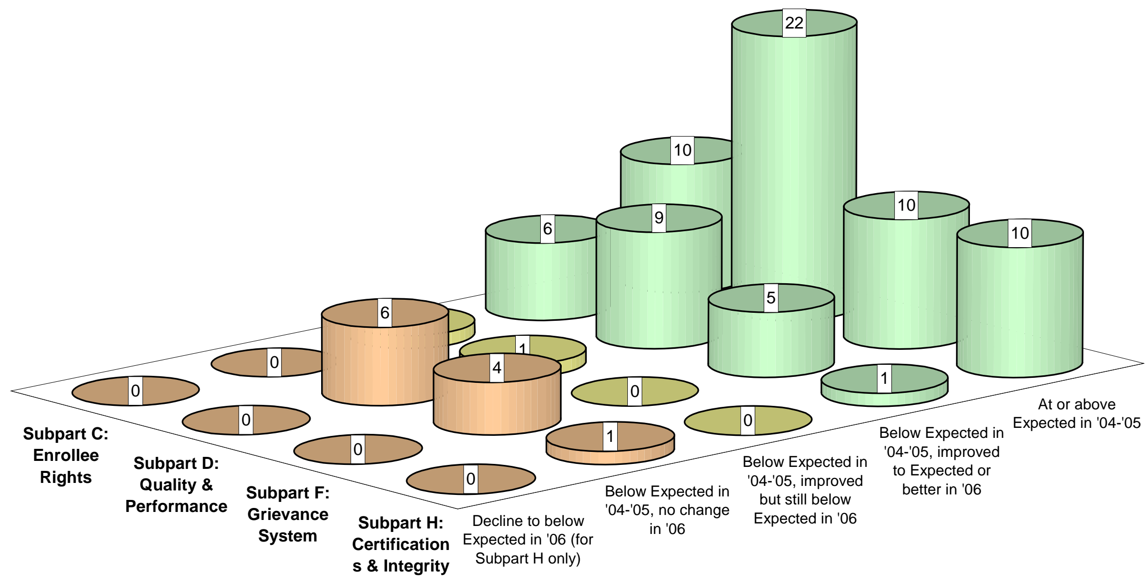
Chelan-Douglas PIHP meets the minimum standard for a great majority of the specific requirements in Subparts C and H. The PIHP has prioritized Subpart C by ensuring that direct service staff are knowledgeable about rights and protections and that they provide this information to consumers. With respect to Subpart H, PIHP staff have also met nearly all of the minimum standards by ensuring that all data certifications meet source, content, and timing requirements, and that all but one of the required elements for program integrity are in place.

The PIHP made the greatest improvement in Subpart D-Quality Assessment and Performance Improvement, and continues to make progress with respect to Subpart F-Grievance System. However, relevant policies and procedures remain underdeveloped and are missing key requirements. Moreover, WAEQRO was unable to find evidence of their implementation. Specific areas that remain a challenge include, but are not limited to, elements related to sufficiency of provider network, authorization standards and timeframes, delegation of PIHP functions, grievance and appeal acknowledgement, and resolution notification.

Score Trend Summary for:
Chelan-Douglas

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Percent	Subpart D: Quality & Performance Item Count	Percent	Subpart F: Grievance System Item Count	Percent	Subpart H: Certifications & Integrity Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	6	15.8%	4	21.1%	1	8.3%
Below Expected in '04-'05, improved but still below Expected in '06	1	5.9%	1	2.6%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	6	35.3%	9	23.7%	5	26.3%	1	8.3%
At or above Expected in '04-'05	10	58.8%	22	57.9%	10	52.6%	10	83.3%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, Chelan-Douglas PIHP performance relative to Subpart C (*Enrollee Rights*) showed 10 out of 17 items (58.8%) already at or above the Expected level of performance. After the 2006 review, 16 items (94.1%) are at the Expected level, reflecting improvement in 6 out of 7 elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), Chelan-Douglas PIHP entered the 2006 review with 10 of 19 items (52.6%) already at or above Expected. After the 2006 review, 15 items (78.9%) meet the Expected level of performance, indicating that 5 out of 9 elements improved to Expected or better from 2005 to 2006.

The improvement Chelan-Douglas PIHP has made in all four (4) Subparts reflects focused efforts on continuous quality improvement during 2006. This information also indicates where management priorities can be focused to gain similar improvement in the coming year.

Subpart Strengths

- Creative service options, based on fundamental values of recovery and normalization, are under development to meet diverse enrollee needs.
- Throughout the review year, the PIHP prioritized and conducted multiple trainings related to their new and revised policies and procedures, as well as the BBA requirements.
- The PIHP staff prioritized training and implementation of their adopted practice guidelines. They are taking initial steps to ensure that processes of care are consistent with the practice guidelines.

Subpart Challenges

- PIHP staff are unclear as to which PIHP functions require conducting formal delegation activities.
- Procedures and protocols are deficient with respect to implementation of requirements stipulated in policies and procedures. In addition, policies lack procedures specific to quality assurance and improvement activities.
- Despite PIHP Administrator assurance that all revisions to policies were approved and signed, revision dates in the text of the documents were not consistent with the last formal approval dates, demonstrating the PIHP's need to review and tighten their procedures for policy revision and approval.

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Incorporate into policy and procedures all BBA requirements pertaining to the grievances, appeals, and State fair hearings.

3. Develop implementation procedures for Standard Authorization and Expedited Authorization decisions and requests for extensions. Ensure that appropriate controls are in place for authorization processes, and develop monitoring mechanisms to ensure adherence to required timeframes.

4. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, and date Notice of Actions (NOAs) was sent.

5. Include monitoring of antidiscrimination laws and client access to clinical records as part of annual clinical reviews.

6. In provider contracts, stipulate specific client materials to be translated and identify the required languages and formats in which materials are to be made available.

7. Develop a Capacity Management Plan as described in the PIHP 1.6 MH Provider Network Provider Selection policy and procedures, establish baseline data for network sufficiency, and identify thresholds for the purpose of assessing network capacity and sufficiency. Analyze available data to identify gaps in services and

opportunities for quality improvement when data show trends above or below established performance thresholds.

8. Ensure that all authorizations are conducted by Mental Health Professionals.

9. Clarify delegated PIHP functions and develop processes related to sub-delegation:
    - Conduct a formal written evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    - Review and document their related performance on an annual basis.

10. Modify current monitoring tools, and develop effective monitoring mechanisms that incorporate review elements related to BBA requirements and PIHP standards outlined in new and revised policies and procedures.

11. Create a procedure to officially adopt and approve revised policies and procedures.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The PIHP's information system does not allow the use of non-standard codes and maintains a crosswalk to change local Provider codes to the State standard. Submissions that have not been previously mapped to the standard are returned to the Provider. The PIHP stipulates that there is a procedure for providers to have their changes incorporated into the crosswalk.

2. Unique member ID
   The PIHP uses the State's data dictionary definition, which specifies requirements for one unduplicated member ID. The PIHP also described procedures to ensure that only one member ID is used for each individual. Duplicates are identified and merged by the PIHP's IT staff. The PIHP has a Policy and Procedure to manage duplicate member IDs.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The PIHP can track members, regardless of changes in status, periods of enrollment and disenrollment, or changes across product lines.

4. Calculating member months
   The PIHP calculates member months and is using them in their monthly reports.

5. Member database
   Chelan-Douglas PIHP now maintains a member database. Data made available to the PIHPs by MHD for creating and maintaining a member database is imported into an SQL database as a first stop toward defining Medicaid financial eligibility.

6. Provider Database
   The PIHP maintains provider data in a database for various internal uses. Data from hospitalizations is maintained in this database, as is transitional housing and clubhouse data. PIHP staff also track MHP credentialing in this database; however, they do not use provider data to manage their provider network.

7. Data easily under-reported
   There was no data collected that met this requirement.

PM Summary

Chelan-Douglas RSN has strong pre-submission screening processes on its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. The PIHP's efforts met the requirements of this year's encounter validation review (described below). The overall score of Partially Met in the 2006 encounter validation review has a depressing impact on the general state of the PIHP's performance measure accuracy. The general state of the PIHP's data is evaluated as "fair". Steps are being taken to help bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- The PIHP works to ensure that its data is timely, accurate, and complete in its pre-submission screening processes.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs whenever possible.

APS reviewed the only PIP submitted by Chelan Douglas: Timeliness of Access to Outpatient Care, which was identified by the PIHP as non-clinical. Included in the desk review were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and to evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006 (see, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

For validated PIPs ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

The PIP submission included a summary description of the project, data reports from the MIS, relevant policies and procedures, survey results, and a self validation for one of two study questions. Meeting minutes provided subsequent to the site visit reflected minimal discussion of the study topic and no mention that the PIP was being discussed. The project summary was structured to reflect the CMS protocol, an improvement over the 2005 submission; however it was identified as the Year One plan with an adoption date of September 2005. No update was provided. The study topic had been selected "based on contractual, research-based, and performance data considerations." Chelan Douglas reviewed its data related to meeting the requirement for intakes to occur within 10 days of first request for service and found no serious problem, particularly when compared to the other RSNs. They proceeded, however, to create a project that was essentially a tracking process, without defining an intervention that would improve their performance on this measure. While there were multiple problems with the project as described in the submitted summary, the project was validated using the formal tool, and comments were provided addressing both strengths and problem areas. The detail is provided below. Discussion during the site visit included work currently being done in QMOC to design a PIP related to high drop-out rate between initial request and first appointment.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				High volume: all intakes for study period (approx 76/month across region)
1.2. Is selected following collection and analysis of data (or was selected by the State).		X			Original impetus for study topic was State requirement; PIHP looked at access data for region for period Oct 2005 through Dec 2006: performance was between 85% and 92%. State performance indicators reveal that this PIHP performing better than most. Because the State changed its requirement, to allow PIHPs the option of selecting their own study topics, it is not clear why CDRSN chose to study a process of care that is not a problem for them.
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	This references multiple PIPs over time; PIHP does not have the history to be evaluated on this item.
1.4 Includes all eligible populations that	X				Baseline data reflects all intakes; plan to study

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
meet the study criteria.					all intakes for re-measure.
1.5. Does not exclude members with special health care needs.				X	All consumers served by PIHP are considered to have special healthcare needs.
1.6 Has the potential to affect member health, functional status, or satisfaction.			X		Research cited supports impact on clinical outcomes of prompt engagement of members requesting services. Study as it is designed will not impact consumer experience.
Totals for Step 1:	**2**	**1**	**1**	**2**	
Number of shaded critical evaluation elements met for Step 1: 0/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.			X		Question designed as tracking exercise; does not include an intervention to address a problem. Structure of question loses the focus and includes 2 separate questions.
2.2 Is answerable/provable.			X		Does not include the targeted performance levels.
Totals for Step 2:	**0**	**0**	**2**	**0**	
Number of shaded critical evaluation elements met for Step 2: 0/2					
Step 3: Clearly Defined Study Indicators					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Study indicators:					
3.1. Are well defined, objective, and measurable.		X			Indicator #1 is well-defined and measurable Indicator #2 is confusing; with multiple variables for numerator and denominator
3.2. Are based on practice guidelines, with sources identified.		X			Standard of 10 days between request and intake established by State and supported in literature.
3.3 Allow for the study question/hypothesis to be answered or proven.			X		No – see 3.1
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.			X		No; concept of change not addressed as this is tracking rather than improvement process.
3.5 Have available data that can be collected on each indicator.	X				Data from MIS and Telesage surveys available.
3.6 Include the basis on which each indicator was adopted, if internally developed.			X		Reference to NCQA standards does not address client satisfaction.
Totals for Step 3:	**1**	**2**	**3**	**0**	
Number of shaded critical evaluation elements met for Step 3: 0/0					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
4.1. Is accurately and completely defined.		X			Additional detail regarding ages, Medicaid status, time frames would be useful.
4.2. Includes requirements for the length of a member's enrollment in the MCP.				X	
4.3 Captures all members to whom the study question applies.		X			Not clear
Totals for Step 4:	**0**	**2**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 4: 0/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).			X		Numbers discussed are confused; related to problematic indicator numerator and denominator and confusing study questions.
5.2. Identify the sample size (or use the entire population).				X	Will not sample, but rather use the entire population.
5.3. Specify the confidence interval to be used (or use the entire population).				X	Will not sample, but rather use the entire population.
5.4 Specify the acceptable margin of error (or use the entire population).				X	Will not sample, but rather use the entire population.
5.5 Ensure a representative sample of the eligible population.				X	Will not sample, but rather use the entire population.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.				X	Will not sample, but rather use the entire population.
Totals for Step 5:	**0**	**0**	**1**	**5**	
Number of shaded critical evaluation elements met for Step 5: 0/0					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.		X			Data fields from MIS described; however reader does not know clearly that each of these fields will be included in collection.
6.2. Identification of specified sources of data.	X				
6.3. A defined and systematic process for collecting baseline and remeasurement data.			X		Details of running reports and analyzing data not provided.
6.4. A timeline for collection of baseline and remeasurement data.			X		Timeline for data collection confuses baseline period and re-measurement periods.
6.5. Qualified staff and personnel to abstract manual data.	X				
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.				X	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
6.7 A manual data collection tool that supports inter-rater reliability.				X	
6.8 Clear and concise written instructions for completing the manual data collection tool.				X	
6.9 An overview of the study in written instructions.			X		
6.10 Automated data collection algorithms that show steps in the production of indicators.		X			Algorithms provided; however because indicators are not accurately or well-defined, use of results would be questionable.
6.11 An estimated degree of automated data completeness.			X		Not addressed.
Totals for Step 6:	**2**	**2**	**4**	**3**	
Number of shaded critical evaluation elements met for Step 6: 0/0					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.			X		Not described in any detail, and order of data collection and intervention does not conform to this protocol.
7.2 System changes that are likely to induce permanent change.				X	
7.3 Revised if original interventions are not				X	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
successful.					
7.4 Standardized and monitored if interventions are successful.				X	
Totals for Step 7:	**0**	**0**	**1**	**3**	
Number of shaded critical evaluation elements met for Step 7: 0/1					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					
8.1. Is conducted according to the data analysis plan in the study design.			X		Data analysis plan is incomplete; lacks consistent timelines, thresholds for acceptable performance, and, given problematic structure of study questions and indicators, requires redesign.
8.2. Allows for generalization of the results to the study population if a sample was selected.				X	
8.3. Identified factors that threaten internal or external validity of findings.	X				Addressed data completeness and accuracy concerns.
8.4. Includes an interpretation of findings.			X		Data reports provided with some tallies; however, no analytic tools used to graph/chart the information and demonstrate performance on any of the indicators.
8.5 Is presented in a way that provides accurate, clear, and easily understood			X		See 8.4

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
information.					
8.6 Identifies initial measurement and remeasurement of study indicators.			X		Did not clearly describe or report on these results.
8.7 Identifies statistical differences between initial measurement and remeasurement.			X		Identifies a 9% improvement for Oct-Dec 2006, but not clear what the baseline was or period considered.
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.			X		
8.9 Includes the interpretation of the extent to which the study was successful.		X			Brief statement of 9% improvement but not sustained achievement of 90% of intakes within 10 days of request.
Totals for Step 8:	**1**	**1**	**6**	**1**	
Number of shaded critical evaluation elements met for Step 8: 0/1					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.			X		Document lacks clear description of pre- and post measurement plan; makes conflicting statements about improvement, provides no data or statistical analysis.
9.2. There is documented improvement in processes or outcomes of care.			X		

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
9.3. The improvement appears to be the result of planned intervention(s).			X		
9.4. There is statistical evidence that observed improvement is true improvement.			X		
Totals for Step 9:	**0**	**0**	**4**	**0**	
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.				X	Data not provided.
Totals for Step 10:	**0**	**0**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 10: N/A					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS
***Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported**
**** Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported**
***** Not Met = Reported PIHP PIP results or plan/activities not credible**
Summary of Aggregate Validation Findings
* ☐ **Met**   * * ☐ **Partially Met**   *** ☒ **Not Met**
Summary of PIP validation findings: PIHP provided Summary document from Year 1 of this study (2005), with no update, and describes a tracking process without valid pre- and post-measurement on either side of a well-developed intervention. The PIHP's initial assessment of their performance on the 10 day requirement demonstrated that they did not have a significant problem in averaging a 90% target; they did not, however, choose to select another topic for which their available data indicated a true problem to be addressed. They complicated their study with the addition of a 2nd study question related to a consumer satisfaction and outcomes questionnaire, and did not fully develop that study, including a clear description of the relevant indicators. They did not provide evidence that this PIP was discussed or developed in the context of QI committee activities.

PIP Strengths

- The PIHP appears to have a better understanding, compared to the 2005 review, of the PIP process and the skills and activities required to conform to the CMS protocols.
- The data system is robust enough to support the data collection and reporting necessary to evaluate the results of a PIP.

PIP Challenges

- The PIHP does not appear to have the *data analysis* capabilities necessary to assess the effectiveness of an intervention and validity of results.
- Different staff members attended each of the State's two PIP trainings, which were intended to build depth of knowledge for the PIHPs.

PIP Recommendations

1. Collect and analyze data related to all performance indicators on a regular basis, and select a project based on significant problems identified through analysis process. Use this data as baseline.

2. Prior to re-measuring, develop and implement a comprehensive intervention based on discussion of possible causes/barriers related to the results of the indicator.

3. Design a data analysis plan that includes clearly defined indicators (just a few) that reference target performance or desired percent improvement; use statistical analysis tools to measure and evaluate validity of results.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	CD RSN documents data requirements in an RSN/PIHP-specific data dictionary, trading partner agreements, and in contracts with their providers. The PIHP does not have a completeness standard.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The PIHP clearly communicates its data requirements to the providers in its network.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Partially Met	The PIHP has documented the technical schema and has collected disaster recovery plans from their provider networks. PIHP staff stated that there had been no follow-up on the disaster recovery plans collected. These efforts aside, there were no other efforts to assess and document the processes, capabilities, and potential vulnerabilities of their provider agencies' IT systems.

3. Analysis of provider agencies' data for accuracy and completeness

PIHP Encounter Validation Process Review

Item	Rating	Comments
PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.	Not Met	The PIHP does not conduct a specific data analysis to validate completeness and accuracy. Efforts to verify such data prior to transmission are excellent, but do not provide the views needed to calculate actual completeness values needed in this analysis.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Not Met	Data analysis specific to an encounter validation is not done.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data analysis specific to an encounter validation is not done.

4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Partially Met	The PIHP has a policy and procedure that describes their process at a high level. However, greater detail in the definition would make the process more accurately repeatable. The process described and used meets the basic requirements stated in the contract between the MHD and the PIHP.
PIHP includes additional data elements	Partially Met	Through the use of a native translation audit tool (basically a printout of the

PIHP Encounter Validation
Process Review

Item	Rating	Comments
in matching exercise.		client's electronic record that is compared to the clinical record), additional data elements are checked. If the PIHP had a method to identify data that is seldom (if ever) verified, such data could be added to reviews on a rotating basis to ensure its eventual scrutiny.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Met	The tools used for the encounter validation process were submitted for review. These tools effectively capture the information necessary for conducting this exercise.
5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report to the state details the basic encounter validation requirement set forth in their contract with the state. A brief description is listed with respect to the sampling used and numbers achieved. This is followed by a brief process description and findings. Ideally, the report should contain the information requested by this tool. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed;

PIHP Encounter Validation Process Review

Item	Rating	Comments
		• Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	PIHP staff provided evidence showing the practice of sharing results of these review exercises with their providers.
PIHP regularly reports internally for quality improvement activities.	Not Met	PIHP staff provided no evidence showing the practice of sharing results of these review exercises internally.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.	Not Met	No policy and/or procedure was submitted for the EV review with respect to follow-up activities or corrective actions as a result of these or other activities.
If warranted, evidence of follow-up	N/A	

PIHP Encounter Validation Process Review

Item	Rating	Comments
activity was presented.		

Summary of Encounter Validation Findings

Score **Met _23_%**

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ **Met** ☒ **Partially Met** ☐ **Not Met**

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP met the requirements set forth in the contract between the MHD and the PIHP. The encounter validation review included all items specified in the contract, and the sampling method met the requirements listed

in the body of their contract with the state. The clients' electronic record is compared to the clinical record as a further check on agreement between data sources. An analysis of the PIHP's data for the purpose of an encounter validation was not conducted.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 23% of all items meeting a score of Met, 38.5% at Not Met, and the remaining 38.5% at Partially Met.

EV Strengths

- Comparison of the electronic record to the clinical record helps to ensure that the two versions are complete and in synch.

EV Challenges

- Documentation of EV processes is insufficient to support replication of EV activities over time, across the network.

EV Recommendations

1. Define and implement a data completeness standard against which all providers and the PIHP can evaluate performance.

2. Document the provider network's information systems to evaluate the capacity to produce accurate and complete encounter data.

3. Analyze the complete dataset evaluated in the review; i.e., if the review covers six months, analyze data for the entire six-month period.

4. Freeze the dataset being analyzed.

5. Provide more specific detail in the policy that defines the encounter validation process to enable accurate duplication of efforts.

6. Develop a tool that cross-references data collected to the process checking data accuracy. This tool would help the PIHP ensure that they are checking all of their data over time.

7. Provide more specifics in the report to the state. The report should outline all elements listed in #5 (in the tool above).

8. Develop and document a policy and procedure outlining the steps taken should a corrective action be necessary for this or any other process.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1,2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		**2**		• Both the Quality Management and Improvement Plan approved 2/14/07 and the QM Plan Update of May 2005 were submitted for review. The WAEQRO review focuses on the 2007 QM Plan. • Final authority for oversight of QA& I rests with the Governing Board; the Board delegates to the PIHP Administrator responsibility for all aspects of PIHP operations, including oversight and approval of the Quality Management Plan and associated activities.

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• As described in the Plan, committee structure and related operational responsibilities are confusing: o Designation of a chair for QMOC is not addressed in the Plan. o The diagram presented in "Quality Management Plan Integration, Figure #1" places the Quality Manager at the same level of the organization chart as the entities that report to the committee; e.g., QRT, Ombuds, and Clinical Team Director. o The QM diagram and wording of the Plan do not identify specific subcommittees of the QMOC that would carry out the work and report back. o Staffing the QMOC is described as a major component of the PIHP Quality Assurance Manager's responsibilities; however, no Quality Manager position is identified in the PIHP's staff roster. o No PIHP staff are identified as QMOC members. o Although the Plan attributes Board delegation of responsibility for all QM oversight and activity to the PIHP Administrator, it later indicates that

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				the Administrator serves in an advisory capacity. o The Plan does not specify committee membership/participation of all network providers. • The written description of the Plan is repetitious and inconsistent. • Elements of a comprehensive plan that are generally present include: mission and guiding principles, scope, and goals of plan. • Several components are present that need more detail or consistency (see sections that follow): annual review, committee structure, quality indicators, monitoring methods, reporting, and improvement processes. • Most areas of PIHP operation are discussed in the QM Plan with broad categorical identification of data collected and reporting responsibility; however, the indicators lack benchmarks, thresholds or targets, and a reporting schedule. • Missing is a discussion of performance improvement plans (PIPs), and an annual work plan of 3-4 specific quality improvement activities.

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		**1**		• Inconsistent language about an annual review is evident in several sections. o The QM Plan states that the Governing Board is responsible for adoption of the QM Plan, annual updates, and review of recommendations for the annual evaluation. o The section immediately following states that the QM Plan is evaluated biennially. o Section J states: "PIHP prepares an annual report to the Mental Health Division that documents the progress and effectiveness of CDRSN/PIHP's quality management activities and process." o The timing and scope of the annual reviews, evaluations, and reports are not defined.
C. Plan includes annual work plan and process for review of associated activities and progress.			**0**	• Inconsistency in language about an annual work plan is evident in several sections: o QMOC is responsible for a biennial work plan and biennial evaluation of Provider Network Quality Management Plans. o Structure and Function (subpart d) is titled, "Annual Quality Work Plan";

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PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				however, the narrative that follows describes the components of the QM Program. o Reference to the Annual Work Plan (Exhibit A) in the QM Plan Update of May 2005 was not included in the 2007 QM Plan.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		**2**		• The Plan specifies monthly chart reviews, which were changed to quarterly during the review year. Annually, the PIHP is to review 10% of all charts across its network. • Specifics with respect to the scope of clinical activities reviewed are not detailed in the Plan. • The Plan references communication with providers related to results of reviews and required clinical quality improvements or corrective actions. • The Plan indicates that review results will be reviewed annually for individual provider reports and included in the annual review of the QM Plan. • Fourteen general indicators are listed for clinical chart reviews; however, they lack: o performance goals expressed as percentages or numerical targets, o thresholds defined for taking action,

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				and o scoring methodology.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.		**3**		• The PIHP Administrator stated at the site review that the QMOC membership includes: Ombuds, two consumers, an Advisory Board representative, three providers at the management/supervisor level, allied providers, and at least one at-large community member. • QRT representatives conduct consumer and allied provider surveys and sit on the Advisory Board and QMOC. • The Plan does not specify committee membership/participation of all network providers.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**2**		• Implementation is demonstrated by the following: o Meeting minutes of the Clinical Team, and Advisory and Governing Boards reflect routine reporting of QMOC, Ombuds, and QRT as described in plan. o Memos to each provider in response to administrative contract monitoring results were submitted. o The PIHP Administrator indicated that a draft of the QM Plan was being reviewed by the Governing Board; minutes provided

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				documented the discussion. o The Information Systems Subcommittee regularly reports to QMOC and was charged with developing a timeline for reviewing reports, per QMOC minutes dated 10/06. o Discussion of access to care reports is reflected in QMOC minutes (reports provided). • QMOC minutes reflect that the needs for PIHP data are not adequately met, such as UM data, system flow chart, and quarterly provider reports; data that is submitted and discussed is not acted upon, such as the Community Assessment Tool and Access to Care data. • Reports submitted were insufficient to verify that all indicators defined in the Plan are being reported to QMOC. • QMOC minutes do not reflect discussion of UM activities or reports as described in the Plan. • Details of discussions at QMOC are not reflected in minutes, nor are follow-up activities related to discussions. • QMOC minutes were missing for April-June, August, September, and

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				November, 2006.
Standard 1 Count (Target 6 Met):	**0**	**5**	**1**	**Target Points: 24 Actual: 10**
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care. (2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.		**3**		• Excel spreadsheets for one provider substantiated that clinical service reviews are conducted per schedule. • The clinical director stated at the site visit that he reviews 10% of cases for each provider over the course of a year. • Both providers interviewed concurred with the frequency of chart review audits and stated that feedback was immediate with written documentation by letter received within a week of the audit. • Documents requested were not provided sufficient to assure that all reviews were conducted as scheduled. Missing were: o Annual summary reports for each provider, o Summaries for two of three providers lacked detail relative to the number of charts reviewed or specific

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				findings.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**2**		• The "Case Record Review Tool" tracks about 140 possible responses, following the format used by the State licensing agent. A general interpretive guide provides direction for simple yes/no answers without option for comment. • No policy, procedure, or summary report was submitted describing the scoring methodology. • No examples of completed monitoring tools were provided as requested. • Evidence to suggest the tool is not being used to its full capacity: o While the scoring method allows for trending; no trended reports were submitted with respect to individual providers or system-wide results. o No analysis of data beyond sums and percentages was submitted for review. o No discussion of clinical chart review findings, analysis, or recommendations for quality improvement appears in QMOC, Clinical Team and Governing Board meeting minutes.

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PIHP:

Requirement	Met	PM	Not Met	Findings Comments
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		2		• Neither the QM Plan nor policies and procedures address inter-rater reliability; however, a narrative note submitted for review indicated that only one person conducts all chart reviews.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		3		• Letter of expectation for "quality improvement" sent to a provider documented the first step of the corrective action process as described in the QM Plan. • The Clinical Director described the corrective action process as reflected in letters to providers, and the process was confirmed by provider management staff at the site review. • One corrective action letter submitted included a requirement for staff training, to be documented and completed by a specific date. • Timely follow-up was demonstrated by two corrective action letters submitted for review. One included a response with the attached corrective action plan. • Missing was documentation from the PIHP indicating that the corrective action plans were approved and resolved.
Standard 2 Count (Target 4 Met):	**0**	**4**	**0**	**Target Points: 16 Actual: 10**

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
<u>Standard</u> **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		**2**		• QMOC minutes reflect standard agenda items (Access to Care, Continuity of Care, High Utilizers), and reports from Ombuds and QRT; however, no data was reported from clinical services reviews. • While utilization dashboard reports generated from clinical chart reviews are referenced in QMOC meetings, no examples were submitted. • Missing was discussion or data to support corrective action oversight.
B. PIHP analyzes and trends individual provider performance.		**2**		• Two letters from PIHP to providers following chart reviews support analysis of individual provider performance. • Two Excel spreadsheets for one provider tally individual scores for each chart review item and sum for all reviews, with graphic representations of results. • Meeting minutes do not indicate that

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				trends or remediation for individual providers were discussed.
C. PIHP analyzes and trends system-wide performance.		**2**		• No analysis of system-wide clinical chart review data was submitted for review; however, QMOC minutes of 3/06 reported that chart review summary graphs were distributed and trends were discussed.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		**2**		• Management Team, Advisory Board, and Governing Board minutes regularly include reference to the clinical chart review process; however, these minutes lacked detail of discussion and no data reports were attached. • The PIHP Clinical Director and one provider management staff member confirmed that aggregated data from a clinical chart review were distributed about one year ago.
Standard 3 Count (Target 4 Met):	**0**	**4**	**0**	**Target Points: 16 Actual: 8**

Standard

4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**2**		• Grievance Policy and Conflict Resolution Policies were last reviewed in 2006 (no proof of adoption was provided). Both documents state that the PIHP will take corrective action if a review of the grievance system indicates such need. • PIHP staff confirmed at site visit that they have no tracking mechanism for compliance with grievance system timeframes; it is a rural system with only one grievance this year, and one person provides direct and immediate oversight. • Ombuds stated that she submits complaints and grievances in Exhibit N format to PIHP, which in turn compiles data from all sources.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.		**3**		• An appeals and grievance process is incorporated into the QM Plan with process and responsibilities clearly defined. • QM policy states that grievances and appeals are reviewed annually as part of the contract compliance audit for each provider, and are reported biennially to MHD; however, no current contract compliance audits were submitted for review. • Ombuds stated that she attended and

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				routinely reported at QMOC, Advisory, and Governing Board meetings. This participation is confirmed by meeting minutes. • Ombuds/QRT reported that the Advisory Board actively and routinely seeks her input on complaints and grievances/appeals. • Ombuds stated that the following action was taken: o PIHP addressed a report that consumer phone calls were not getting returned. A recent QRT survey indicated that consumers reported prompt response to phone calls. QMOC minutes reflected this improvement. o A blind consumer survey process was implemented in response to concerns about the survey distribution method. QMOC minutes documented discussion of this matter. o QRT modified the consumer survey to address consumer dignity concerns being verbally reported. Once the survey data validated the verbal reports, QRT advised the PIHP and network of the issue.

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				Governing Board minutes confirmed the discussion.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	**4**			• How the PIHP monitors grievance system training for employees of providers was not specifically stated in the QM Plan; however, o a schedule of trainings provided evidence that various internal and external groups received Grievance System training on 6/30/06; o Clinical supervisory and case management staff received grievance/appeals system training from December 2006 to February, 2007; and o the PIHP funds Ombuds training. • Ombuds stated that she was given individual training by WIMIRT staff. WIMIRT provides quarterly meetings/trainings that Ombuds attends. • Ombuds and provider staff interviewed expressed a clear and accurate description of the complaints and grievances process. • One provider management staff member reported that the PIHP Clinical Director attends quarterly staff meetings to provide an update of complaints and grievances. Staff accurately reported

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				how to obtain more detailed information, if needed, including reference to PIHP and MHD websites.
Standard 4 Count (Target 3 Met):	**1**	**2**	**0**	**Target Points: 12 Actual: 9**
Grand Totals Count (Target 17 Met):	**1**	**15**	**1**	**Target Points: 68 Actual: 37**

Summary Quality Assurance and Improvement Findings
Chelan Douglas Regional Support Network (CDRSN) achieved the highest score possible (Met = 4 points) on 1 out of 17 possible items. Another 15 items were Partially Met and, of these, 4 items were nearly met. 1 item was unmet related to defining and implementing an Annual Work Plan. CDRSN achieved a total score of 37 points (54%) for its first review of Quality Assurance and Improvement Plan and related activities. Findings reflect a quality management system that struggled for much of the year with changes in leadership and loss of focus. The WAEQRO recommends revision of the Quality Management Plan for clarity of structure and process. WAEQRO recommends that a Quality Manager role be assigned from within the PIHP staff and that PIHP senior management from UM, Fiscal, and IS staff actively participate on the QMOC to bring needed resources and focus. Continued development of analytic and reporting tools related to data collected at the provider and system levels is encouraged to effectively trend, analyze, and report well-defined indicators. Accomplishing these tasks will produce consistent focus on critical performance measures and desired improvements.

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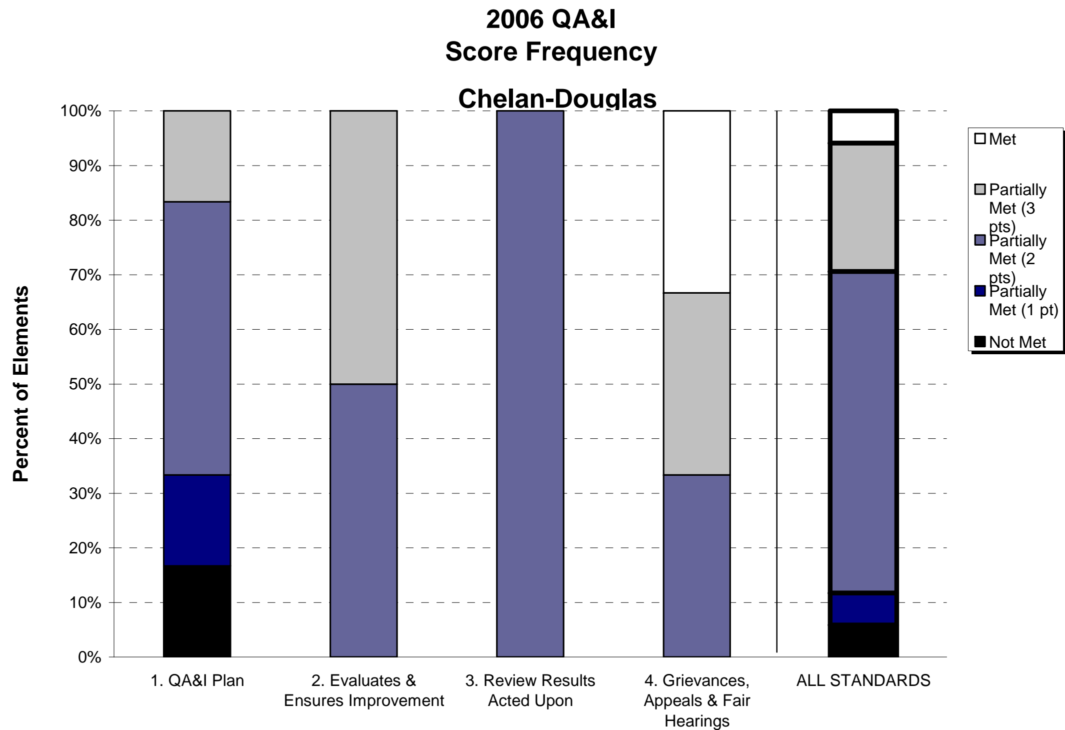

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	0	1	3	1	1
2. Evaluates & Ensures Improvement	4	0	2	2	0	0
3. Review Results Acted Upon	4	0	0	4	0	0
4. Grievances, Appeals & Fair Hearings	3	1	1	1	0	0
ALL STANDARDS	**17**	**1**	**4**	**10**	**1**	**1**

QAI Strengths

- Long-term, experienced Ombuds routinely attended consumer forums such as NAMI and Promise Club meetings to seek out consumer input. The PIHP has recently contracted with another firm experienced in providing Ombuds services to mental health consumers.
- Provider staff demonstrated basic knowledge related to appeals, grievances, and fair hearings.
- Ombuds is exceptionally knowledgeable about appeals, grievances, and fair hearings processes.
- The prevalence and involvement of consumer advocacy groups in PIHP meeting forums is a system strength.
- QMOC recognized its inability to effectively implement assigned functions; QMOC addressed this issue with PIHP Administration and received some needed support.
- The PIHP provides timely and useful information to providers about site visit results and follows through with Corrective Action requests

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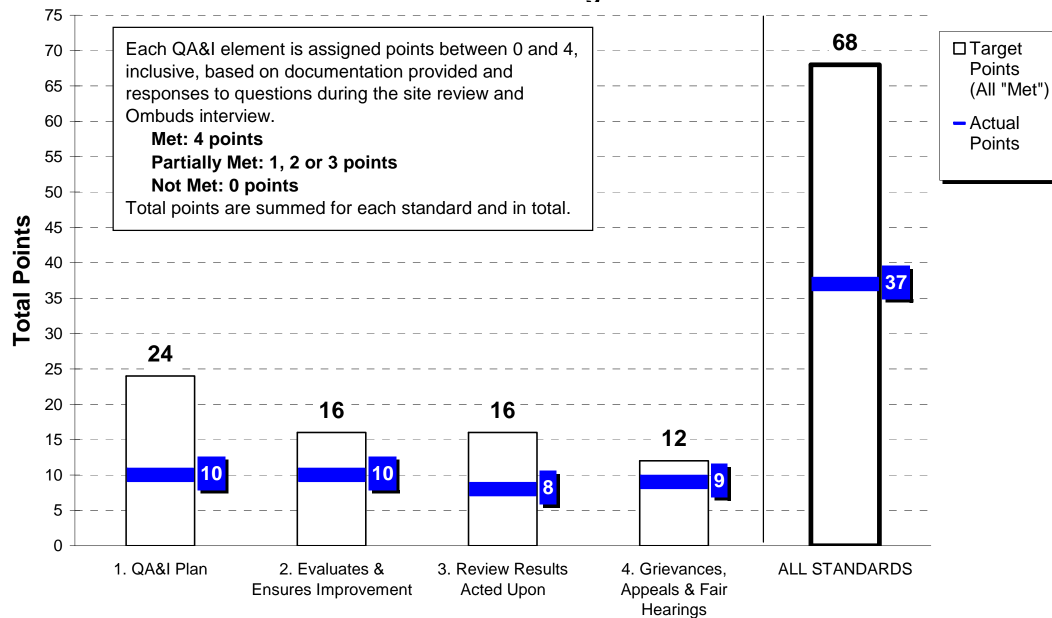

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	10
2. Evaluates & Ensures Improvement	16	10
3. Review Results Acted Upon	16	8
4. Grievances, Appeals & Fair Hearings	12	9
ALL STANDARDS	**68**	**37**

QAI Challenges

- The Quality Management Committee structure and related operational responsibilities are confusing as described in the Plan.
- There is no identified Quality Manager position with the authority to effectively implement the QM Plan.
- The PIHP appears to be understaffed relative to the activities required to ensure consistent application of its QM plan.

QAI Recommendations

1. Revise the QAI Plan to eliminate redundancy and increase the clarity of structure and process.

2. Assign a Quality Assurance Manager from senior management staff within the PIHP; ensure that QM Manager decision-making and oversight authority is appropriately defined.

3. Include PIHP senior management from UM, MIS, and Finance on the Quality Management Committee to ensure that all aspects of PIHP operations are integrated and participating in the QAI process.

4. Establish and maintain a reporting schedule, and document results of discussions, including plans and responsibility for any follow-up activities. Consider attaching to the Plan a matrix of indicators that specifies definition, method of measurement, targets for achievement, threshold for considering/taking action, and reporting schedule and responsibilities.

5. Expand meeting minutes to reflect attendees/roles, greater detail of discussions, analysis and action, and attach copies of reports.

6. Include the chart review scoring methodology in QM procedures or in a policy/procedure related to conducting clinical chart reviews. Consider developing methods to analyze scores that ensure capture of high-quality performance areas as well as agency and system problems.

7. Develop trend reports that display data in a manner that facilitates problem identification. Develop longitudinal (quarter over quarter or year over year) trending of performance to aid in the analysis.

8. Include a description of formal PIP selection and process in the QAI Plan.

Recommendations

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Incorporate into policy and procedures all BBA requirements pertaining to the grievances, appeals, and State fair hearings.

3. Develop implementation procedures for Standard Authorization and Expedited Authorization decisions and requests for extensions. Ensure that appropriate controls are in place for authorization processes, and develop monitoring mechanisms to ensure adherence to required timeframes.

4. Establish a procedure to track and monitor denials, reductions and suspensions of service, and timeframes related to requests for service, date of intake, authorization/denial date, and date Notice of Actions (NOAs) was sent.

5. Include monitoring of antidiscrimination laws and client access to clinical records as part of annual clinical reviews.

6. In provider contracts, stipulate specific client materials to be translated and identify the required languages and formats in which materials are to be made available.

7. Develop a Capacity Management Plan as described in the PIHP 1.6 MH Provider Network Provider Selection policy and procedures, establish baseline data for network sufficiency, and identify thresholds for the purpose of assessing network capacity and sufficiency. Analyze available data to identify gaps in services and opportunities for quality improvement when data show trends above or below established performance thresholds.

8. Ensure that all authorizations are conducted by Mental Health Professionals.

9. Clarify delegated PIHP functions and develop processes related to sub-delegation:
    - Conduct a formal written evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    - Review and document their related performance on an annual basis.

10. Modify current monitoring tools, and develop effective monitoring mechanisms that incorporate review elements related to BBA requirements and PIHP standards outlined in new and revised policies and procedures.

11. Create a procedure to officially adopt and approve revised policies and procedures.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. Collect and analyze data related to all performance indicators on a regular basis, and select a project based on significant problems identified through analysis process. Use this data as baseline.

2. Prior to re-measuring, develop and implement a comprehensive intervention based on discussion of possible causes/barriers related to the results of the indicator.

3. Design a data analysis plan that includes clearly defined indicators (just a few) that reference target performance or desired percent improvement; use statistical analysis tools to measure and evaluate validity of results.

EV Recommendations

1. Define and implement a data completeness standard against which all providers and the PIHP can evaluate performance.

2. Document the provider network's information systems to evaluate the capacity to produce accurate and complete encounter data.

3. Analyze the complete dataset evaluated in the review; i.e., if the review covers six months, analyze data for the entire six-month period.

4. Freeze the dataset being analyzed.

5. Provide more specific detail in the policy that defines the encounter validation process to enable accurate duplication of efforts.

6. Develop a tool that cross-references data collected to the process checking data accuracy. This tool would help the PIHP ensure that they are checking all of their data over time.

7. Provide more specifics in the report to the state. The report should outline all elements listed in #5 (in the tool above).

8. Develop and document a policy and procedure outlining the steps taken should a corrective action be necessary for this or any other process.

QAI Recommendations

1. Revise the QAI Plan to eliminate redundancy and increase the clarity of structure and process; assign a Quality Assurance Manager role from senior management staff within the

PIHP and place that role at the level of the QMOC in the committee organization structure to ensure that decision-making and oversight authority is appropriately in place.

2. Assign a Quality Assurance Manager from senior management staff within the PIHP; ensure that QM Manager decision-making and oversight authority is appropriately defined.

3. Include PIHP senior management from UM, MIS, and Finance on the Quality Management Committee to ensure that all aspects of PIHP operations are integrated and participating in the QAI process.

4. Establish and maintain a reporting schedule, and document results of discussions, including plans and responsibility for any follow-up activities. Consider attaching to the Plan a matrix of indicators that specifies definition, method of measurement, targets for achievement, threshold for considering/taking action, and reporting schedule and responsibilities.

5. Expand meeting minutes to reflect attendees/roles, greater detail of discussions, analysis and action, and attach copies of reports.

6. Include the chart review scoring methodology in QM procedures or in a policy/procedure related to conducting clinical chart reviews. Consider developing methods to analyze scores that ensure capture of high-quality performance areas as well as agency and system problems.

7. Develop trend reports that display data in a manner that facilitates problem identification. Develop longitudinal (quarter over quarter or year over year) trending of performance to aid in the analysis.

8. Include a description of formal PIP selection and process in the QAI Plan.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

Washington External Quality Review Organization

Timberlands
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

Timberlands PIHP (TRSN) is responsible for managing mental health care and services for Medicaid consumers in Wahkiakum, Lewis, and Pacific counties, in the state of Washington. The PIHP is located in Cathlamet, Washington and is governed by a board comprised of a commissioner from each county, an attorney, and a business owner. The PIHP Administrator reports to the TRSN Governing Board. The PIHP contracts with three (3) community mental health centers and specialty providers, which serve approximately 900 adult and child consumers monthly. Total annual Medicaid enrollment in the PIHP is approximately 18,000. In addition, the PIHP delegates outpatient and inpatient authorization of services to a private managed care company located in Las Vegas, NV.

This report covers the period between September 23rd, 2005 and September 22nd, 2006 and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);
3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;

5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions	June-August, 2006	

Activity	Timeline	Documents/Content
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	August 22, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	September 12, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	September 27, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	October 12 and 13, 2006	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	October 19, 2006	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	November 14, 2006	
4. Debrief conference call	November 28, 2006	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	December 6, 2006	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities.

Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. Timberlands PIHP submitted a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the Timberlands PIHP, significant events include:

- The PIHP continued to operate without an RSN Administrator during this review year and also accepted the (September 2006) resignation of the IT Manager, who had held the position for just a year. Such staffing shortages/turnover pose a challenge for a small organization, especially during a period of required changes to meet new contract expectations.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- The policies and procedures submitted for review contained the date of Governing Board adoption; however had no approval signatures and no date indicating when relevant policy originally went into effect. Consequently, the WAEQRO was unable to determine whether all policies and procedures submitted for review had been officially adopted and approved. They were, however, considered in the scoring.

- The PIHP's sample network provider contract submitted for review was not signed by either party. The WAEQRO was unable to determine if the contract was officially executed. The sample contract, however, was considered in scoring the Subparts.

- Minutes of the Quality Management Committee did not reflect discussions in sufficient detail to ascertain the extent to which issues were analyzed and action plans generated and monitored.

2006 Review Results

This report provides results and a summary of Timberlands PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. Status of 2004 Corrective Actions

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of Timberlands PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.242	**Health Information Systems**			
	No evidence that reports that are used to verify the accuracy of the data submitted. No evidence that the PIHP does a check between the electronic record and the physical record over the previous 12 months.	Submit a corrective action plan to the MHD by 4/4/05	CAP submitted 4/4/05	The PIHP has since changed software. A series of reports were developed for this new software to check data accuracy and timeliness. Presently, the PIHP does check data accuracy and timeliness using these reports. The PIHP has also made significant efforts checking between the electronic records and the physical records their data system represents.

B. Subpart Review

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year),
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Question 62 that reviews for mechanisms to assess the quality and appropriateness of care to enrollees with special health care needs, as this was covered under the Quality Assessment and Improvement review discussed in a separate section of this report;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year, and
- All items associated with the Performance Improvement Projects (PIPs), as the PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);

- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);
- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the Timberlands PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

Subpart Radar Charts

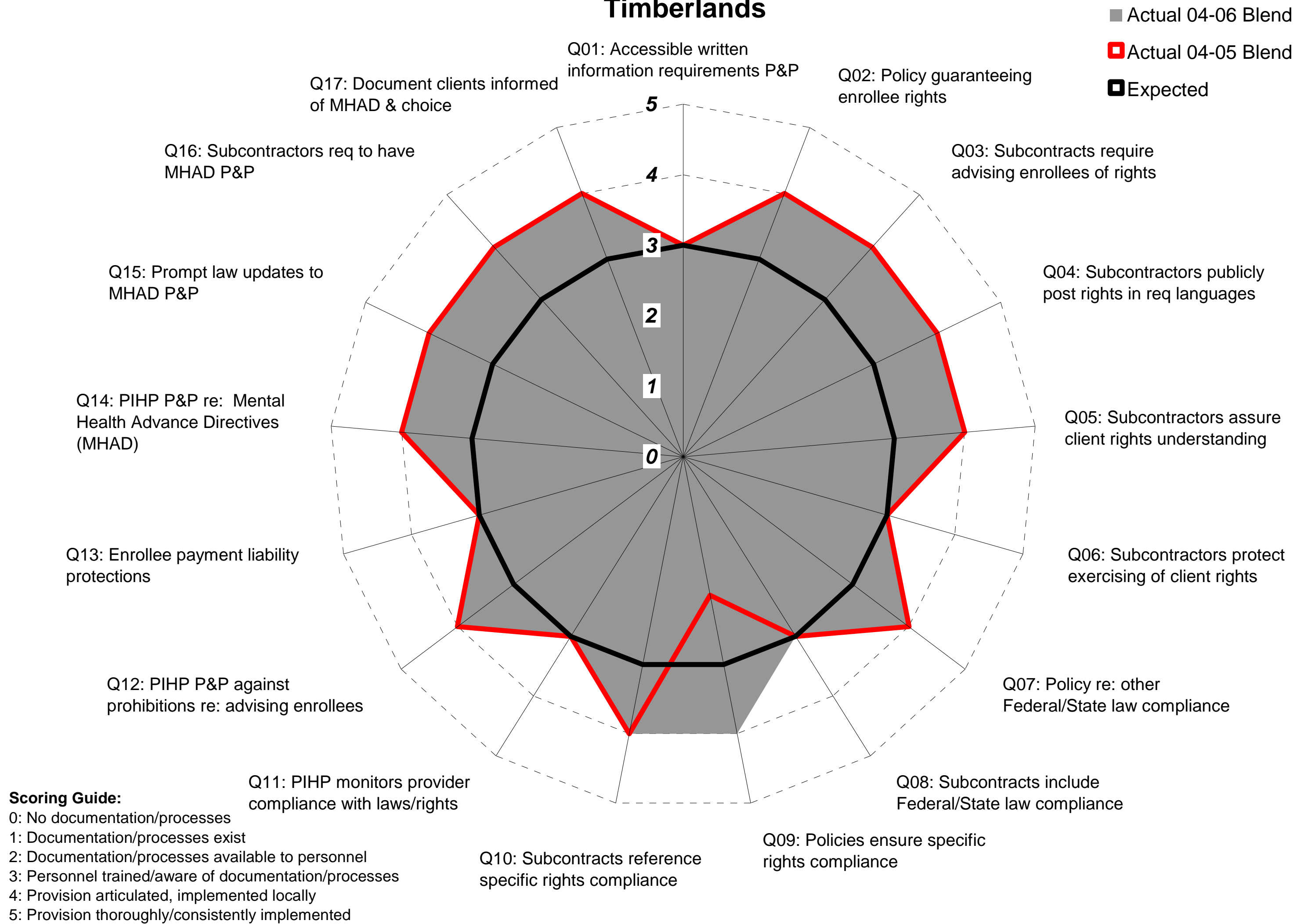
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing

for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Timberlands

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	3		3
Q02: Policy guaranteeing enrollee rights	4		4
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	4		4
Q05: Subcontractors assure client rights understanding	4		4
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	4		4
Q08: Subcontracts include Federal/State law compliance	3		3
Q09: Policies ensure specific rights compliance	2	4	4
Q10: Subcontracts reference specific rights compliance	4		4
Q11: PIHP monitors provider compliance with laws/rights	3		3
Q12: PIHP P&P against prohibitions re: advising enrollees	4		4
Q13: Enrollee payment liability protections	3		3
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	4		4
Q16: Subcontractors req to have MHAD P&P	4		4
Q17: Document clients informed of MHAD & choice	4		4

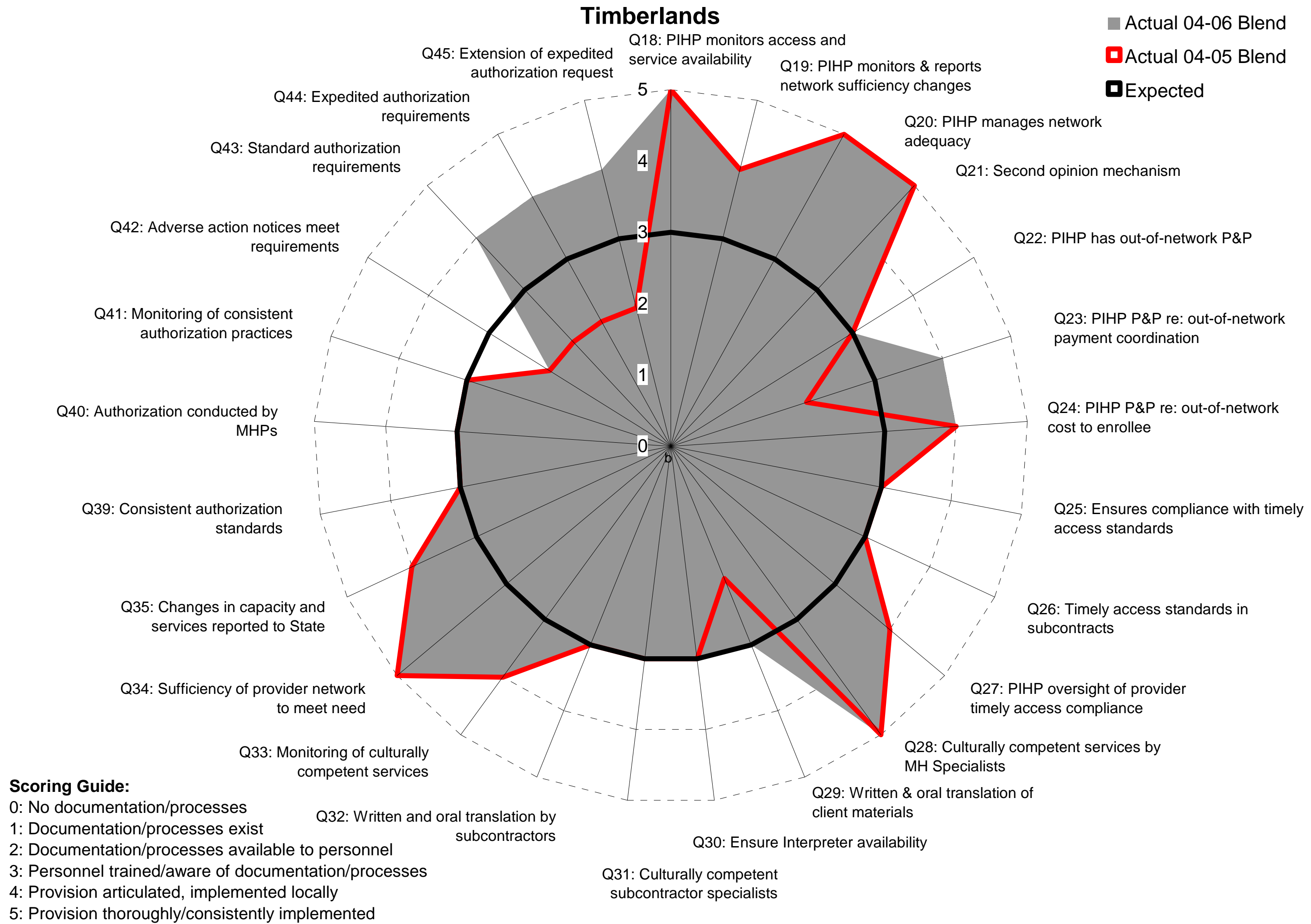
Timberlands PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
438.100(d)	**Compliance with Other Federal and State law**	
[Q9]	**PIHP policies assure compliance with right to a 2nd opinion, client participation in treatment, and access to clinical records** Evidence: • Enrollee Rights policy and procedure references the 3 client rights called out in this review element. Additionally, the policy refers to the TRSN Client Handbook which provides an explanation of enrollee rights to a second opinion, to be an active partner in planning their treatment, to access their medical record, and their right to direct access to a specialist. • The Enrollee Rights policy also states providers shall follow PIHP procedures when reporting second opinions. This includes use of an administrative code when a second opinion is requested, and a Second Opinion Report form which documents the circumstances of the request and its outcome, and is sent to the TRSN Clinical Director. • PIHP also uses its advocacy newsletter, Voices and Choices to help educate enrollees about their rights and related topics. Copy of newsletter was included in review materials. • Right to a Second Opinion outlines in detail the right to access, procedures, responsible parties, what is included in a second opinion, and how the assessment is to be reviewed with the client and incorporated into treatment. • PIHP Clinical Director holds quarterly ITC trainings for provider staff with focus on client and family involvement in treatment planning and decision making. Supportive documentation included Ideas for Increasing Client Involvement in Treatment Planning, Tally Form-- follow up survey summary conducted after providers met with staff to see which approaches staff were using in their practice. • Resource Management Plan addresses client voice and involvement in the assessment and care planning process, as well as other venues for client voice such as surveys and participation on QRT, Quality Management Committee or the Advisory Board. • Provider records of trainings related to client rights, second opinions and BBA policies and procedures are included in review materials. Training submissions are limited in scope and detail.	

CFR Reference	Subpart Review Results *Subpart C*	Score 0-5
	• Provider direct service staff accurately described approaches and processes related to client access to second opinion, client participation in treatment planning and client access to clinical records. • Provider management reported means by which PIHP monitors access to second opinion and client participation in treatment planning and decisions. Reported they are not aware if PIHP is monitoring for client access to clinical records other than reviewing their policies. (Substantial Compliance)	4

Subpart D (Part 1): Access Standards



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

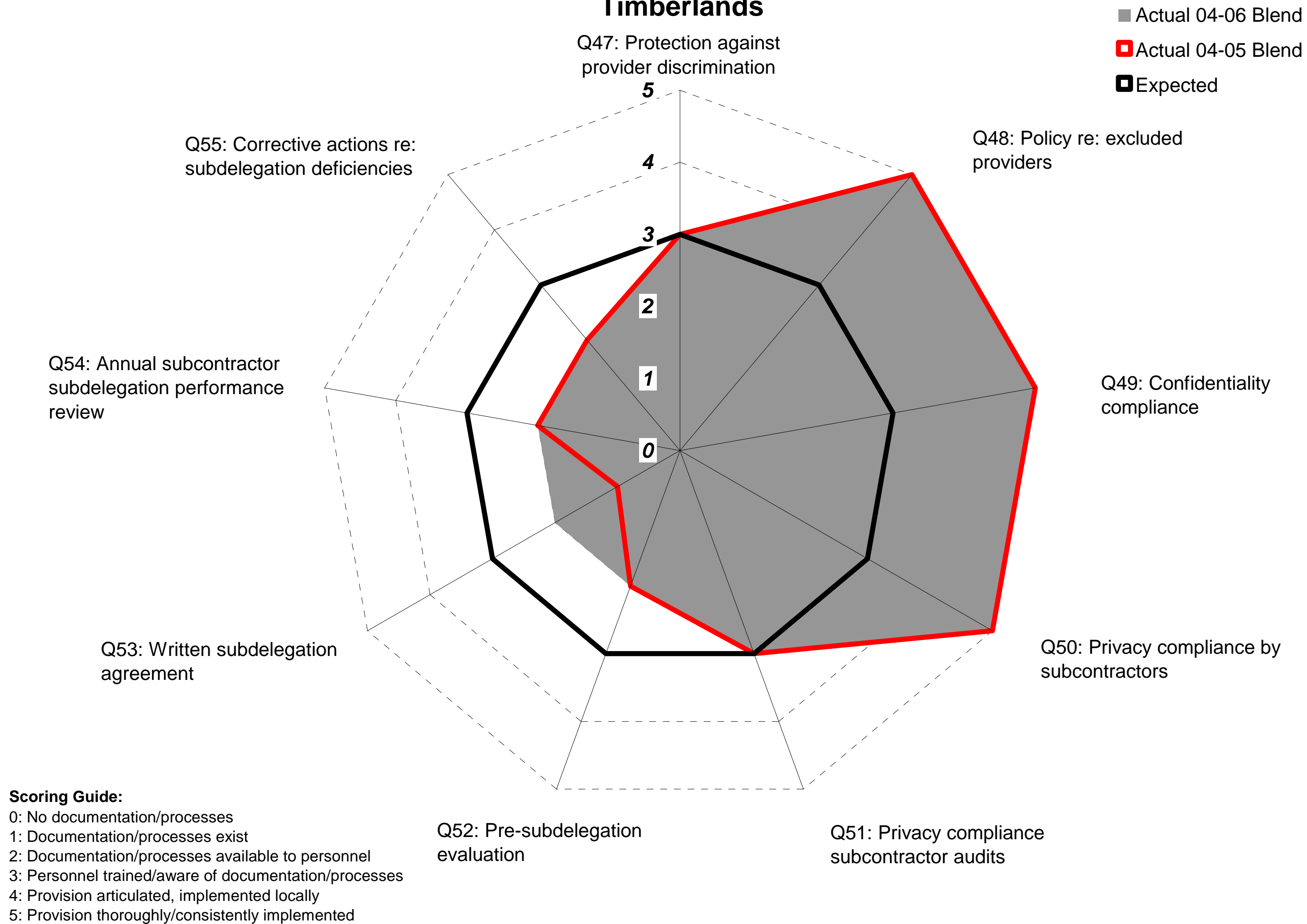
2004-2006 Subpart Scoring Trend and Detail for Timberlands

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	5		5
Q19: PIHP monitors & reports network sufficiency changes	4		4
Q20: PIHP manages network adequacy	5		5
Q21: Second opinion mechanism	5		5
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	2	4	4
Q24: PIHP P&P re: out-of-network cost to enrollee	4		4
Q25: Ensures compliance with timely access standards	3		3
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	4		4
Q28: Culturally competent services by MH Specialists	5		5
Q29: Written & oral translation of client materials	2	3	3
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	3		3
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	4		4
Q34: Sufficiency of provider network to meet need	5		5
Q35: Changes in capacity and services reported to State	4		4
Q39: Consistent authorization standards	3		3
Q40: Authorization conducted by MHPs	3		3
Q41: Monitoring of consistent authorization practices	3		3
Q42: Adverse action notices meet requirements	2	2	2
Q43: Standard authorization requirements	2	4	4
Q44: Expedited authorization requirements	2	4	4
Q45: Extension of expedited authorization request	2	4	4

Subpart D (Part 2): Structure and Operation Standards

Timberlands



Scoring Guide:
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2004-2006 Subpart Scoring Trend and Detail for Timberlands

Scoring Guide for Subparts C, D and F:
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4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	5		5
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	5		5
Q51: Privacy compliance subcontractor audits	3		3
Q52: Pre-subdelegation evaluation	2	2	2
Q53: Written subdelegation agreement	1	2	2
Q54: Annual subcontractor subdelegation performance review	2	2	2
Q55: Corrective actions re: subdelegation deficiencies	2	2	2

Subpart D (Part 3): Measurement and Improvement Standards

Timberlands

Actual 04-06 Blend
Actual 04-05 Blend
Expected

Q56: Adoption of evidenced based practice guidelines

5
4
3
2
1
0

Q61: Detection of over & under utilization

Q57: Dissemination of practice guidelines

Q58: Application of practice guidelines

Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for Timberlands

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	5		5
Q57: Dissemination of practice guidelines	4		4
Q58: Application of practice guidelines	4		4
Q61: Detection of over & under utilization	3		3

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (b)(5)	**Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment**	
[Q23]	**Out-of-network policy and procedures include coordination with respect to payment** Evidence: • Revised Out of Network Payment Coordination policy and procedure requires PIHP providers to contract for any medically necessary covered services needed by an enrollee authorized for services they cannot provide. The provider shall be responsible for appropriate contracting and for payment, as part of their full risk contracts. Included are out-of-network services needed in connection with specialist consultations, second opinions, interpreters, and direct services that are part of the Medicaid state plan. Providers are required to document all out-of-network services provided in the medical record as well as in their payment records. • PIHP Clinical Director reported that services needed by enrollees outside of the State Plan may be covered by exceptional care funds if authorized by the PIHP. Sometimes PIHP and the provider have split costs. • The policy states the PIHP will monitor for out-of-network services arranged and paid for by providers as part of their annual contract monitoring, through review of payment records to all contracted interpreters, specialists, and others reported to have provided services on behalf of enrollees. • Provider records of trainings related to client rights, second opinions and BBA policies and procedures are included in review materials. Training submissions are limited in scope and detail. • Provider management accurately described policy and reported they seldom use out-of network services. Also validated that PIHP conducts desk review of provider policies and procedures and fiscal monitoring for out-of network services during annual review. • No evidence showing PIHP review of out-of-network services or payment submitted. (Substantial Compliance)	4

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (c)(2)	**Furnishing of Services Continued**	
[Q29]	**Written and oral translation of client materials** Evidence: • Revised Enrollee Rights and Culturally Competent Services policy and procedures in combination contain requirements for translation of materials into languages in covered population, oral interpretation in any language and written interpretation in 7 DSHS prevalent languages. Policies also address client materials in alternative formats for individuals that have sensory impairments. • Culturally Competent Services policy and procedures specifically identifies the client materials the PIHP requires to be translated and available to enrollees (i.e. Medicaid Benefits Booklet, Client Rights, Grievance and Appeals Procedures, HIPAA Privacy Statement, and Advance Directives). • '05-'06 PIHP Provider Contract contains language requiring the availability of oral interpretation in any language at client's request and client materials to be available and translated in all 7 DSHS languages. • Language Line Poster—enrollees point to their preferred language. • Provider records of trainings related to client rights, second opinions and BBA policies and procedures are included in review materials. Training submissions are limited in scope and detail. • No examples of translated client materials submitted for review. • Provider management and direct service staff had variable descriptions of which client materials were to be translated and in what languages and alternative formats. • Annual PIHP provider contract monitoring reports include PIHP's review of access to interpreters (sign and language), posting of client rights in 7 DSHS languages and ensuring Medicaid Benefits booklets are handed out (describes access to translated client materials). (Moderate Compliance)	3
438.210(c)	**Notice of Adverse Action**	
[Q42]	**Ensure that Notice of Adverse Actions meet all requirements** Evidence: • Revised Notice of Action policy and procedures contains all requirements of this provision with the exception of 438.404(4)(i)(ii) which address extensions of timeframes. • Actual NOA letter to enrollee based on no covered mental	

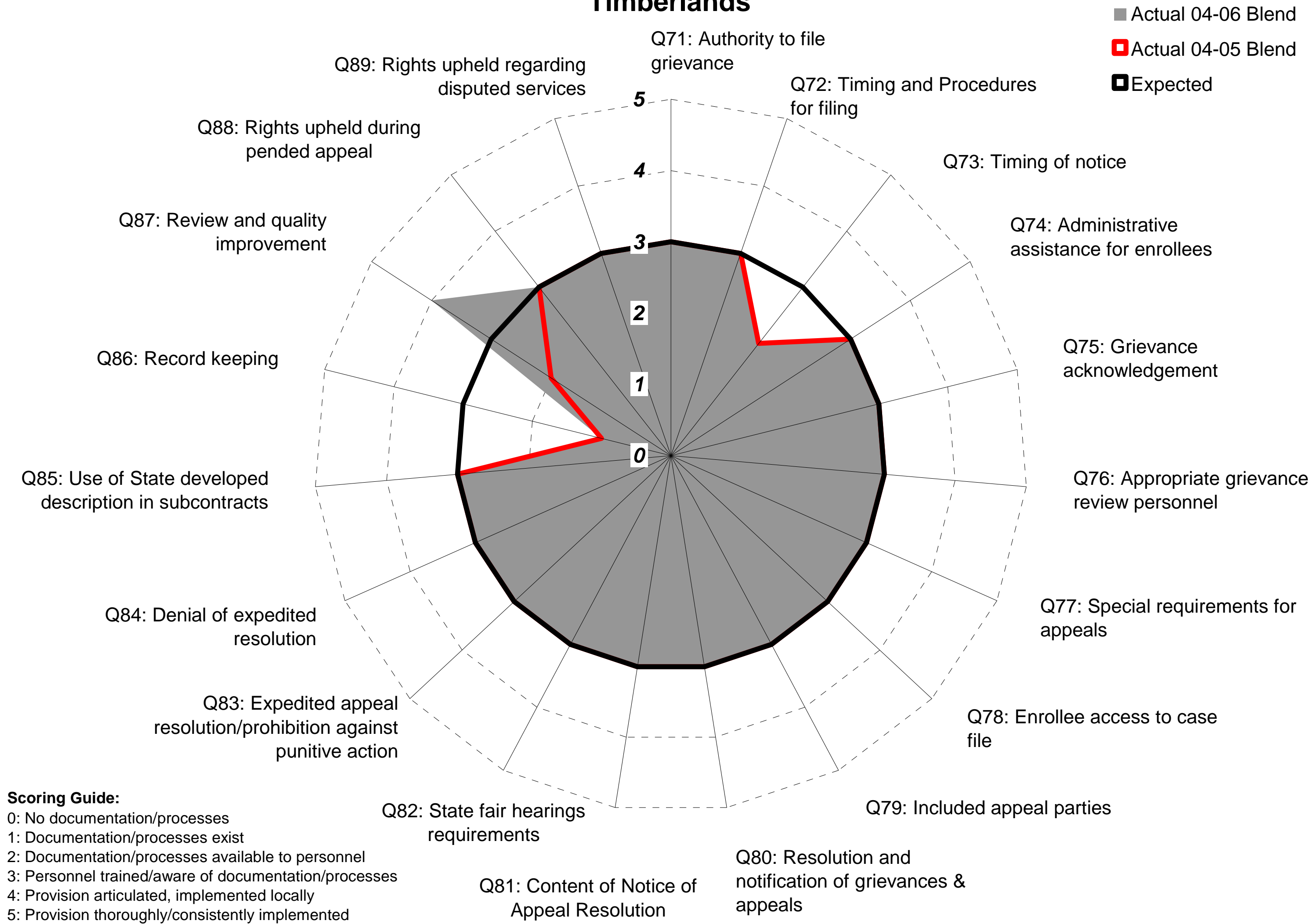
CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	health diagnosis. • Inpatient Peer Review conducted by Medical Director. • Second opinion requests and results. • No tracking logs to show adherence to timeframes were submitted for review. • Provider management and direct service staff accurately described purpose and procedures related to NOAs. • Score remains the same as 2005 EQR due to incomplete policy and procedures as described above. (Partial Compliance)	2
438.210(d)	**Timeframe for decisions**	
[Q43]	**Procedures for standard authorization decisions** Evidence: • Timely Access for Authorizations and Coverage and Authorization of Services policies and procedures jointly contain procedures for standard authorization decisions. • Resource Management Plan includes description of all authorization practices and procedures. • No copies of authorizations or authorization extension requests submitted for review. • PIHP Clinical Director reported that in the past their UM subcontractor (BHO) was not requesting extensions for authorizations occurring outside the 14-day requirement for standard authorizations. Since the PIHP's Delegation review of BHO, authorizations are more timely and BHO understands they must request an extension if authorization is going to be outside the standard timeframe. • Provider records of trainings related to client rights, second opinions and BBA policies and procedures are included in review materials. Training submissions are limited in scope and detail. • Provider management and direct service staff able to accurately articulate requirements of this provision. Staff explained recent discussions and training on meeting authorization timeframes. Providers have tightened the time for completing intakes and submitting authorization requests to BHO in order to meet the timeframe requirements. (Substantial Compliance)	4
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Timely Access for Authorizations and Coverage and Authorization of Services policies and procedures jointly contain procedures for expedited authorization decisions.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	• Resource Management Plan includes description of all authorization practices and procedures. • No copies of expedited authorizations submitted for review. • PIHP Clinical Director reported that expedited authorizations don't occur. When someone needs services immediately they enter through crisis services where no pre-authorization is required. • Provider records of trainings related to client rights, second opinions and BBA policies and procedures are included in review materials. Training submissions are limited in scope and detail. • Provider management and direct service staff able to accurately articulate requirements of this provision. (Substantial Compliance)	4
[Q45]	**Extension of expedited authorization request** Evidence: • Timely Access for Authorizations and Coverage and Authorization of Services policies and procedures jointly contain procedures for expedited authorization requests. • Resource Management Plan includes description of all authorization practices and procedures. • No copies of extensions of expedited authorizations submitted for review. • PIHP Clinical Director reported that expedited authorizations do not occur. When someone needs services immediately they enter through crisis services where no pre-authorization is required. Thus extensions of expedited authorization requests are not needed. • Provider records of trainings related to client rights, second opinions and BBA policies and procedures are included in review materials. Training submissions are limited in scope and detail. • Provider management and direct service able to accurately articulate requirements of this provision. (Substantial Compliance)	4
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • Delegated Functions policy and procedures contains detailed procedures for evaluating prospective network providers' ability to perform the activities to be delegated. These procedures	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	also may apply to any entity performing ASO functions for the PIHP, although this is not specifically addressed in policy. The policy does not reference subcontractors performing delegated functions such as MIS/IT and subcontractors who are not licensed mental health service agencies or direct service providers. • "Assessment of Delegated Entity" reports dated 8/11/05 (conducted in June and July '05) for all 3 network providers included overview of process; capacity regarding clinical functions including clinical capacity, staff training and support, documentation, coordination with other community providers; quality improvement process; and, organization capacity. • 2006 Annual Contract Review and Clinical Service Reviews for all 3 network providers. • Pre-Agreement Report, June 21, 2005, for BHO. Questions and report do not appear to follow required format outlined in Delegated Functions P&P. Reviewer unable to determine who conducted interview, where it occurred or who participated. • Unable to determine if Delegation and Sub-contractual Relations policy is implemented with PIHP's Netsmart Technologies (PIHP's MIS vendor), who houses PIHP's data and submits it to MHD. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q53]	**Written delegation agreement that specifies delegated functions, activities, and responsibilities** Evidence: • Delegated Functions policy and procedure contains the basic requirements of this provision without any detail of what the agreement should include or entail, other than provisions for revoking delegation or imposing sanctions if performance is inadequate. • Attachment for BHO Delegation Agreements for Utilization/Case Management has no name, date or identifier, unable to determine when it went into effect. This is significant in that the requirements of this provision are contained in the attachment. • Attachment for Provider Delegation Agreements has no name, date or identifier, unable to determine when it went into effect. • No written agreement between the PIHP and Netsmart Technology was submitted for review, therefore unable to determine if agreement meets requirements of this provision. • Score remains the same as 2004 EQR due to insufficient documentation and evidence to warrant an increase.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	(Partial Compliance)	2
[Q54]	**Annually monitor subcontractor performance related to delegated functions** Evidence: • Delegated Functions policy and procedures contains basic monitoring activities related to subcontractor performance of delegated functions. • 2006 Annual Contract Review and Clinical Service Reviews for all 3 network providers--review followed the responsibilities outlined in the PIHP-Network Provider Contracts in detail. • Review of Delegation for BHO, dated April 7,2006, addressed performance related to specific responsibilities outlined in the contract. • No annual performance review or other monitoring activities of Netsmart Technologies was submitted for review; unable to determine if PIHP is monitoring the performance of Netsmart on a regular basis. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q55]	**Identification of subcontractor deficiencies and corrective action associated with delegated functions** Evidence: • Delegated Functions policy and procedures specifies the PIHP will identify subcontractor deficiencies associated with delegated functions and institute corrective actions if warranted. • 2006 Annual Contract Review and Clinical Service Reviews for all 3 network providers--included recommendations and corrective actions (CA). Reviewer unable to determine what constituted a recommendation vs. a corrective action. No specific CA submission dates were identified in reports. All 3 providers submitted CA plans. Reviewer unable to determine if CA plans were approved. • BHO Review also specifically identified CAs. BHO responded with a modified CA plan. Reviewer unable to determine if approved by PIHP. • Clinical Director reported PIHP responds to CA plans via email acknowledging receipt and/or identifying CA plan is insufficient and the reasons why. No formal CA plan approval process has been established. • No annual performance review or other monitoring activities of Netsmart Technologies were submitted for review; unable to determine if PIHP is monitoring the performance of this subcontractor on a regular basis. Also unable to determine if	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	the PIHP has imposed any quality improvements or corrective actions. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2


Subpart F: Grievance System
Timberlands
Actual 04-06 Blend
Actual 04-05 Blend
Expected
Q71: Authority to file grievance
Q72: Timing and Procedures for filing
Q73: Timing of notice
Q74: Administrative assistance for enrollees
Q75: Grievance acknowledgement
Q76: Appropriate grievance review personnel
Q77: Special requirements for appeals
Q78: Enrollee access to case file
Q79: Included appeal parties
Q80: Resolution and notification of grievances & appeals
Q81: Content of Notice of Appeal Resolution
Q82: State fair hearings requirements
Q83: Expedited appeal resolution/prohibition against punitive action
Q84: Denial of expedited resolution
Q85: Use of State developed description in subcontracts
Q86: Record keeping
Q87: Review and quality improvement
Q88: Rights upheld during pended appeal
Q89: Rights upheld regarding disputed services
5
4
3
2
1
0
Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
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2004-2006 Subpart Scoring Trend and Detail for Timberlands

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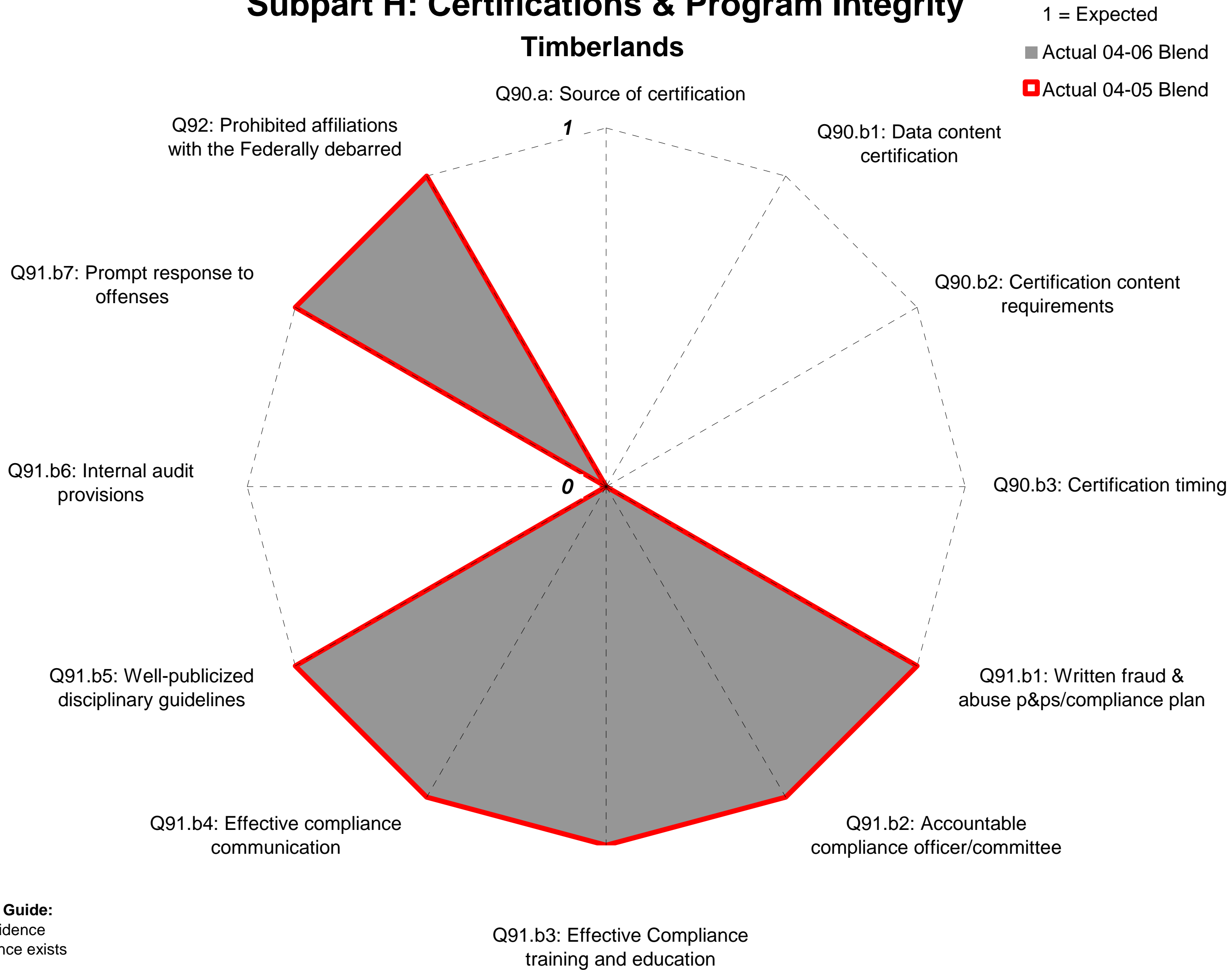
Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	3		3
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	2	2	2
Q74: Administrative assistance for enrollees	3		3
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	1	1	1
Q87: Review and quality improvement	2	4	4
Q88: Rights upheld during pended appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.404	**Notice of Action-Timing of Notice**	
[Q73]	**Timing of Notice of Adverse Action** Evidence: • Revised Notice of Action policy and procedures contains all requirements of this provision with the exception of 438.404(4)(i)(ii) which address extensions of timeframes. • Actual NOA letter to enrollee based on no covered mental health diagnosis. • Inpatient Peer Review conducted by Medical Director. • Second opinion requests and results. • No tracking logs to show adherence to timeframes were submitted for review. • Provider management and direct service staff accurately described purpose and procedures related to NOAs. • Score remains the same as 2005 EQR due to incomplete policy and procedures as described above. (Partial Compliance)	2
438.416	**Record Keeping and Reporting Requirements**	
[Q86]	**Mechanism to maintain records of grievances and appeals** Evidence: • Revised Grievances and Appeals Processes and Ombuds Contract and Amendment which partially address requirements of this provision by stating that documentation is maintained so as to assure security of protected health information and HIPAA regulations. • Above policy and contract make no reference to how and where records will be housed, or who has access to the documentation and records. In addition policy should explicitly include related contract and HIPAA requirements rather than just reference that they will be followed. Otherwise individuals have to look elsewhere (i.e. other policies, contract, and regulations) for procedures that pertain to this policy. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1
[Q87]	**Mechanisms for reviewing grievances and appeals and creating quality improvements** Evidence: • Revised Grievances and Appeals Processes, Grievances:	

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
	General Requirements incorporate mechanisms for reviewing grievances and appeals and creating quality improvements. "Issues reflected by complaints, grievances and appeals that are determined to be possible trends may be studied further by the QRT, QMC may work on possible interventions, or the issue may be directed back to a provider agency for additional investigation and problem solving, with a link back to QMC and/or the Ombuds. Issues identified through the grievance process are always reviewed with consideration of possible opportunities for quality improvement in the TRSN system. This review process may occur in either the Quality Management Committee or other forums which receive this information (e.g. Advisory and Governing Boards, Provider Network meetings, TRSN Clinical Committee)." • 11/16/05 QMC Minutes, which state, "[Ombuds] reviewed the six month Exhibit N report on complaints and grievances, indicating there were no clear trends. Some concerns about confidentiality turned out to be unfounded." • Provider records of trainings related to client rights, second opinions and BBA policies and procedures are included in review materials. Training submissions are limited in scope and detail. • Provider management articulated process of tracking complaints and grievances and review of aggregated results in QMC. • No evidence of aggregated results or analysis. (Substantial Compliance)	4



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for Timberlands

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	0	0	0
Q90.b1: Data content certification	0	0	0
Q90.b2: Certification content requirements	0	0	0
Q90.b3: Certification timing	0	0	0
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	1		1
Q91.b5: Well-publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	0	0	0
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. No evidence was provided by the PIHP. Due to staff changes, these certifications were not available for review. The PIHP reports that these certifications do exist, were signed and sent in to MHD. (No Compliance)	0
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification (1) To the accuracy, completeness and truthfulness of the data (No Compliance)	0
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State (No Compliance)	0
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (No Compliance)	0
438.608	**Program Integrity Requirements**	
[Q91.b6]	**Provisions for internal monitoring** Evidence: • Fraud and Abuse Compliance, MHD CIS Compliance, Provider Information Systems policies and procedures include provider and PIHP monitoring and auditing for potential fraud and abuse at the PIHP network providers and within the PIHP's and providers' MIS systems and practices. However, policies and procedures do not include monitoring mechanisms for internal PIHP procedures related to fiscal management, resource and utilization management, conduct, conflict of interests, and the like. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (No Compliance)	0

Scoring Frequency Overview

APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Timberlands

These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
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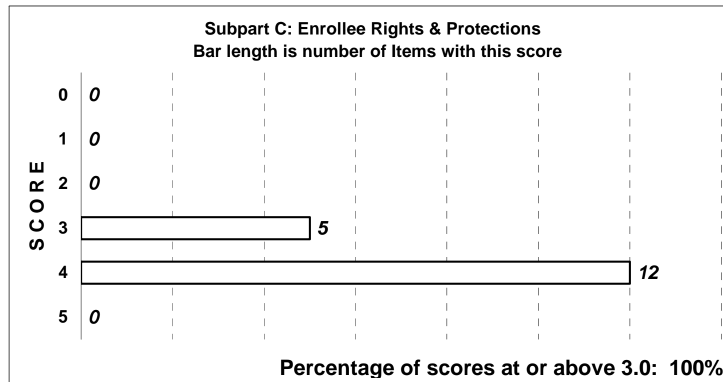
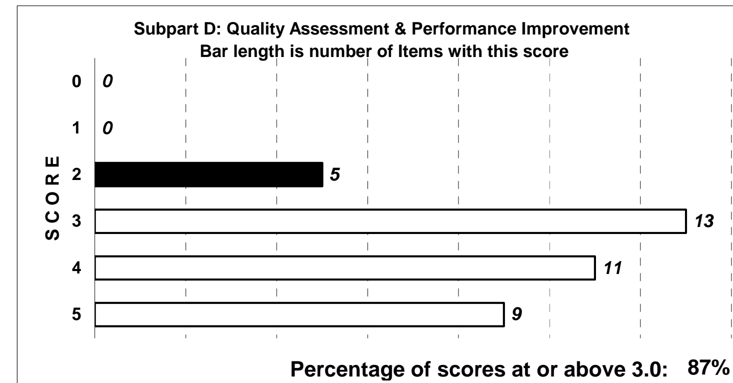
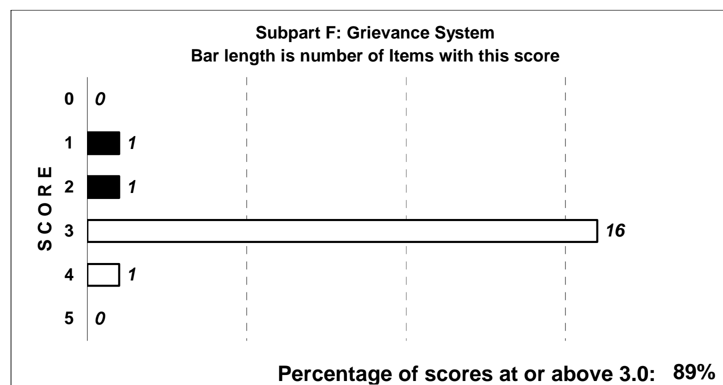
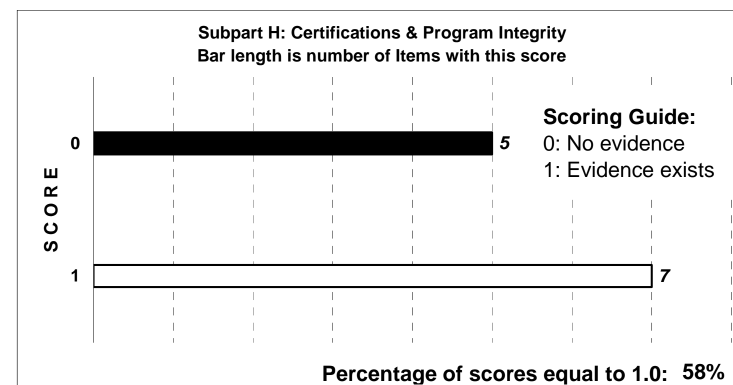








Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 100%
Subpart D: 87%
Subpart F: 89%
Subpart H: 58%

Timberlands PIHP meets the minimum standard for all the specific requirements in Subparts C-Enrollee Rights and Protections. The PIHP has prioritized Subpart C by ensuring that direct service staff are knowledgeable about rights and protections and provide this information to consumers. With respect to Subpart F, they have also met a large portion of the minimum standards. PIHP staff have prioritized continual grievance system training with their network providers. Direct service staff know where to access policies and procedures and are able to articulate many of the expected requirements and standards.

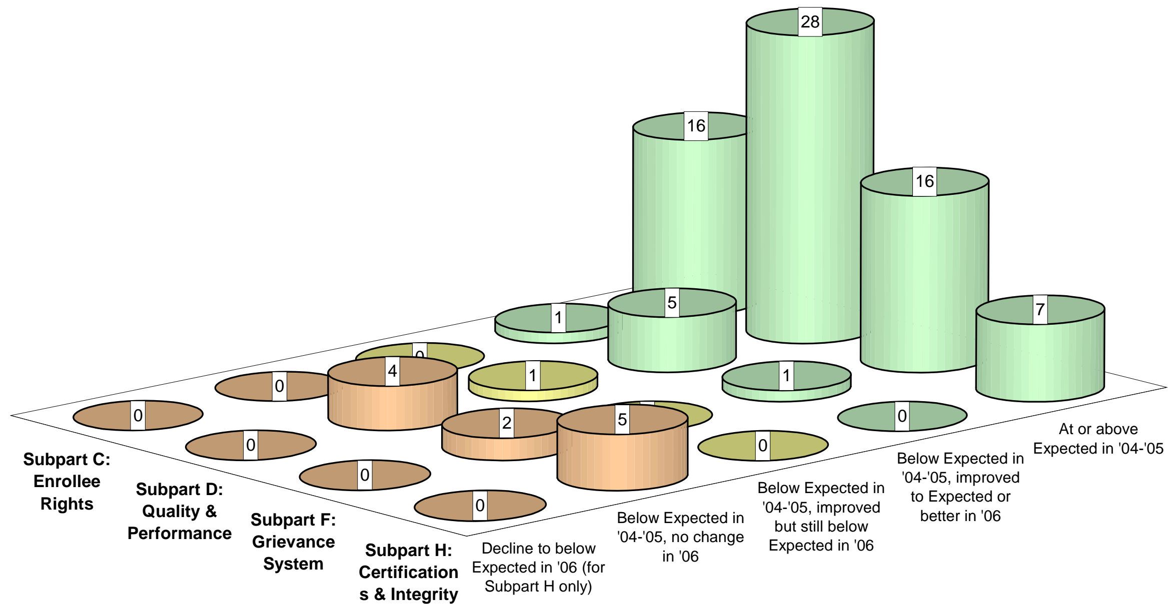
The PIHP continues to make progress with respect to Subpart D. Specific areas that remain a challenge include elements related to delegation of PIHP functions.

In Subpart, H-Certifications and Program Integrity, the Timberlands PIHP has met all but one of the requirements associated with Program Integrity. For the second year, certification of data submitted to the State fell far below acceptable levels.

Score Trend Summary for: Timberlands

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Subpart C: Percent	Subpart D: Quality & Performance Item Count	Subpart D: Percent	Subpart F: Grievance System Item Count	Subpart F: Percent	Subpart H: Certifications & Integrity Item Count	Subpart H: Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	4	10.5%	2	10.5%	5	41.7%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	1	2.6%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	1	5.9%	5	13.2%	1	5.3%	0	0.0%
At or above Expected in '04-'05	16	94.1%	28	73.7%	16	84.2%	7	58.3%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, Timberlands PIHP performance relative to Subpart C (*Enrollee Rights*) showed 16 out of 17 items (94.1%) already at or above the Expected level of performance. After the 2006 review, 17 items (100%) are at the Expected level, reflecting improvement in all elements that scored below Expected in 2005.

For Subpart F (*Grievance System*), Timberlands PIHP entered the 2006 review with 16 out of 19 items (84.2%) already at or above Expected. After the 2006 review, 17 items (89.5%) meet that level of performance, indicating minimal improvement. However, 2 (10.5%) items remain below Expected.

The improvement Timberlands PIHP has made in 3 of the 4 Subparts reflects focused efforts on continuous quality improvement during 2006. There was no improvement in Subpart H scores in 2006, thus indicating where management priorities can be focused to gain improvement in the coming year.

Subpart Strengths

- Creative service options, based on fundamental values of recovery and normalization, have been developed to meet diverse enrollee needs.
- The PIHP and provider network are committed to integrating consumer voice and participation in decision making throughout the service delivery system. This is evidenced by training and hiring of 3 Certified Peer Counselors, re-establishing a Club House in Lewis County, and quarterly Individualized and Tailored Care training and consultation for provider direct service staff.
- The PIHP has maintained a steady level of continuous quality improvement while recruiting for a PIHP Administrator and other positions during the review period.

Subpart Challenges

- Insufficient number of staff available to perform all required PIHP functions: additional state requirements continue to pose challenges.
- PIHP staff are unclear as to which PIHP functions require the application of subcontractor delegation conditions.
- PIHP and provider network tracking and documentation for training is limited and disorganized.

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Incorporate all required BBA requirements for Notice of Actions in policy and procedures. In addition, explicitly stipulate in policy requirements and procedures for maintaining grievances, appeals, and State fair hearings.

3. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, and effective date of the policy.

4. Elucidate procedures related to translation of client materials into all prevalent languages and alternative formats, and reiterate to providers the particular client materials expected to be made regularly available.

5. Include monitoring of client access to second opinions and clinical records as part of annual clinical reviews.

6. Clarify delegated PIHP functions and develop processes related to sub-delegation:
    - Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
    - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
    - Review their related performance on an annual basis.

7. Create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance, to provide a reliable record of

activities.

8. Continue to provide organized trainings for PIHP and Provider Network staff to ensure awareness, understanding, skill development, and consistent implementation of new policies, procedures, and mechanisms.

9. Develop a policy and procedure for the generation and maintenance of data certifications and batch logs to ensure full compliance with this requirement. Although these certifications were reported to have been generated, signed and sent in to MHD, the PIHP was unable to provide this evidence.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the EQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

These items remain unchanged from the 2005 review.

1. Mapping non-standard codes
   The new IT system employed by the PIHP uses a crosswalk to define codes that will be accepted, as well as the codes to which these will translate prior to transmission to the State's system. There is no documented process or procedure describing how to coordinate modification of these mappings.

2. Unique member ID
   The new system uses a data query to search for duplicate member IDs. Once potential duplicates are flagged, the IT manager checks the data to determine whether flagged IDs are indeed duplicates. If so, the information is merged into the original member ID.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   The PIHP can track members, regardless of changes in status, periods of enrollment and disenrollment, and changes across product lines.

4. Calculating member months
   The PIHP was unable to define their member month calculation process prior to April, 2005.

5. Member database
   The PIHP was unable to define their member database calculation process prior to April, 2005.

6. Provider Database
   The PIHP does have provider data that is complete at the individual practitioner

level.

7. Data easily under-reported
   The PIHP does not have a documented process or procedure to account for data that is easily under-reported.

Performance Measurement Summary

The Timberlands PIHP has made efforts to improve its data accuracy and consistency. Their encounter validation efforts did not meet the state contract requirements, but did provide valuable information and served as catalyst for process improvement. Unfortunately, data measures did not improve over time. Steps taken to raise data quality have yet to reflect any improvements, leading to questions regarding accuracy of the data. For this reason, the general state of the PIHP's data is evaluated as "poor" (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

Performance Measurement Strengths

- None noted

Performance Measurement Challenges

- The PIHP has struggled to secure and maintain adequate staffing levels to accomplish needed improvement.

Performance Measurement Recommendations

1. Formalize a written policy and procedure for mapping non-standard codes to ensure consistent implementation. Not following a predefined process could result in underreporting of encounters.

2. Develop and implement a written policy and procedure that ensures encounter data is not lost due to unique circumstances (e.g., out-of-network services), thus minimizing the risk of under reporting data.

3. Continue efforts to improve audit results through quality improvements

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two PIPs submitted by Timberlands PIHP: “Social Support Enhancement”, identified by the PIHP as clinical. Included in the document request were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of steps in the process and evaluate their performance. Site visit interviews focused on increasing the WAEQRO’s understanding of the basis and plan for the PIP, and strategies for improving it or developing new ones based on training provided by MHD in September, 2006. (See, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

The PIHP submitted a well-developed PIP that demonstrated increasing understanding of the PIP protocol. The outline submitted reflects their Year 1 submission; the study is intended to cover the periods January 2006 to June 2007. Based on clinical chart reviews in 2004 and general interest in improving their ability to include enhancement of client social networks, PIHP staff engaged in a study of literature related to this topic.

They discovered several studies and protocols for assessing and increasing client involvement in a social network wider than that comprised primarily of therapists and other helpers, which results in improvement in key areas of functioning, such as symptom management. The PIHP designed a pilot study to assess outcomes resulting from their implementation of the Social Network Mapping process, one of the protocols described in the literature. If they generate positive results, they will implement the protocol system-wide and continue to study results. While the PIP was generally structured according to CMS protocol, there are some critical design problems which they recognize in their self-validation. These problems include a lack of clear definition of the study population, a sampling process that will not yield reliable outcome information, and an underdeveloped data analysis plan. These difficulties are described in detail below and were discussed at the site visit; PIHP staff understand the limitations. They will pursue course-corrections as they are able over the period of the study.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				Focus is on clients with severe and persistent mental illness, who have the least adaptive community adjustment and the most difficulty managing symptoms.
1.2. Is selected following collection and analysis of data (or was selected by the State).		X			• Annual clinical audit in 2004 (and others previously) reflected significant lack of attention to, and/or interventions to address social support aspects of clients' lives. • "Data" said to be qualitative.
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	This refers to accumulation of multiple PIPs over time.
1.4 Includes all eligible populations that meet the study criteria.			X		Eligible population not clearly defined (see below).
1.5. Does not exclude members with				X	All PIHP consumers are considered to have

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
special health care needs.					special health care needs.
1.6 Has the potential to affect member health, functional status, or satisfaction.	X				• Research review found "benefits relative to no treatment or active controls." • No mention of data-based indicators; however, description of positive outcomes includes increased symptom control, improved treatment compliance, and increase in social skills that leads to improved role activities.
Totals for Step 1:	**2**	**1**	**1**	**2**	
Number of shaded critical evaluation elements met for Step 1: 1/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.	X				"Will an increased focus on assessment of clients' social support, including assessment and one or more related social support interventions, lead to improvement in client-reported social support?"
2.2 Is answerable/provable.	X				Data can be gathered pre-and post intervention that would assess client-reported improvement in social support.
Totals for Step 2:	**2**	**0**	**0**	**0**	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Number of shaded critical evaluation elements met for Step 2: 2/2					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.		X			Plan description implies that there are specifics attached to each of the indicators, per design of the Map and tools for use; however, the PIHP did not provide that information.
3.2. Are based on practice guidelines, with sources identified.	X				Based on multiple studies published.
3.3 Allow for the study question/hypothesis to be answered or proven.		X			Measurement of indicators is through self-report; no objective data is used.
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.		X			Measure client perception of increase in social support as defined by tool; no objective data is used.
3.5 Have available data that can be collected on each indicator.	X				Will do a pre-and post test using the Network Map.
3.6 Include the basis on which each indicator was adopted, if internally developed.	X				Based on Social Network Map protocols.
Totals for Step 3:	**3**	**3**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 3: N/A					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 4: Accurately Identify Study Population *The method for identifying the study population:*					
4.1. Is accurately and completely defined.		X			• Criteria for selection of total population not well defined: "Persons to be included in this PIP include a subgroup of Level 2 clients identified by their clinician as experiencing difficulties in the area of social support"; • The plan describes these difficulties in some detail, but lacks necessary specificity for population identification.
4.2. Includes requirements for the length of a member's enrollment in the MCP.			X		Not addressed, although will be tracking length of time in current episode of treatment.
4.3 Captures all members to whom the study question applies.			X		Lack of specificity makes it difficult to assess this.
Totals for Step 4:	**0**	**1**	**2**	**0**	
Number of shaded critical evaluation elements met for Step 4: 0/2					
Step 5: Valid Sampling Methods *Sampling methods:*					
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).			X		Plan identified specific number of Level 2 clients; however, it did not specify the time frame to which that number applies.
5.2. Identify the sample size (or use the		X			Developed the number of clients that would be

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
entire population).					included; however, criteria for selection were not well-defined.
5.3. Specify the confidence interval to be used (or use the entire population).		X			The plan states a "confidence level" of 95%; however, it does not identify the sampling methodology this level would be based on and how the level relates to the methodology used by the PIHP.
5.4 Specify the acceptable margin of error (or use the entire population).			X		Use the term confidence interval, pegged at "11".
5.5 Ensure a representative sample of the eligible population.			X		The sample selection process is unclear (each clinician picks two of all who qualify on their caseload), as is the relationship of sample size to method of selection.
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.			X		Sampling process has some problems that raise questions as to its validity.
Totals for Step 5:	**0**	**2**	**4**	**0**	
Number of shaded critical evaluation elements met for Step 5: 0/1					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.	X				Will be capturing a combination of demographic and indicator data.
6.2. Identification of specified sources of	X				Will use Network Map, Clinical Record

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
data.					(Individual Recovery Plan), and RSN MIS.
6.3. A defined and systematic process for collecting baseline and remeasurement data.		X			Plan describes process for gathering information from clients, including provision of a script to clinicians; no timeframes defined for consistent data collection.
6.4. A timeline for collection of baseline and remeasurement data.		X			Remeasurement "at least" 6 months after initial measurement; specific dates not identified for data collection.
6.5. Qualified staff and personnel to abstract manual data.	X				RSN Administrator and Quality Specialist.
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	X				• Network Grid specifies possible scores and descriptions for each indicator being tracked. • Because data collection is largely through client self-report, precision cannot be guaranteed.
6.7 A manual data collection tool that supports inter-rater reliability.		X			Data collection will be conducted by client case managers, which may bias the responses.
6.8 Clear and concise written instructions for completing the manual data collection tool.		X			Script provided along with training by supervisors for completion of pre-and post data gathering.
6.9 An overview of the study in written instructions.			X		Not evident in PIP submission.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
6.10 Automated data collection algorithms that show steps in the production of indicators.			X		Automated data used only for demographic information, none of which has been designated as an indicator.
6.11 An estimated degree of automated data completeness.			X		Not addressed.
Totals for Step 6:	**4**	**4**	**3**	**0**	
Number of shaded critical evaluation elements met for Step 6: 1/1					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.	X				• Interventions selected based on models that have been previously studied in the literature; also reviewed clinical charts and documented lack of attention to social network issues. • Concepts for this PIP have been discussed in Quality Management and Clinical Committee meetings that included supervisory staff from each network provider.
7.2 System changes that are likely to induce permanent change.	X				Intensive training and monitoring of staff fidelity to interventions and mapping process could permanently change the Recovery Plan development and implementation.
7.3 Revised if original interventions are not	X				Plan indicates intention to review results and

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
successful.					modify their plan, if indicated.
7.4 Standardized and monitored if interventions are successful.		X			The plan is currently missing a detailed method for standardizing interventions.
Totals for Step 7:	**3**	**1**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 7: 1/1					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					
8.1. Is conducted according to the data analysis plan in the study design.			X		The data analysis plan requires additional specificity with respect to the amount of change required for success.
8.2. Allows for generalization of the results to the study population if a sample was selected.			X		
8.3. Identified factors that threaten internal or external validity of findings.		X			Plan addresses intent to analyze this.
8.4. Includes an interpretation of findings.				NA	Has not progressed that far.
8.5 Is presented in a way that provides accurate, clear, and easily understood information.				NA	
8.6 Identifies initial measurement and remeasurement of study indicators.				NA	

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
8.7 Identifies statistical differences between initial measurement and remeasurement.				**NA**	
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.				**NA**	
8.9 Includes the interpretation of the extent to which the study was successful.				**NA**	
Totals for Step 8:	**0**	**1**	**2**	**6**	
Number of shaded critical evaluation elements met for Step 8: 0/2					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.					Project has not progressed this far.
9.2. There is documented improvement in processes or outcomes of care.					
9.3. The improvement appears to be the result of planned intervention(s).					
9.4. There is statistical evidence that observed improvement is true improvement.					
Totals for Step 9:					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.					Project has not progressed this far.
Totals for Step 10:					
Number of shaded critical evaluation elements met for Step 10:					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS
Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported** * Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported** ***** Not Met = Reported PIHP PIP results or plan/activities not credible**
Summary of Aggregate Validation Findings * ☐ **Met**   ** ☒ **Partially Met**   *** ☐ **Not Met**
Summary of Performance Improvement Project validation findings: Timberlands PIHP has done a reasonable job of conceptualizing and documenting an important area of clinical need for their clients. Staff have completed research to validate their clinical intuition and find established protocols to address deficits, and have designed a process to test the impact of implementing a change in their recovery planning and interventions. Unfortunately, their sampling methodology and data analysis plans lack sufficient detail and scientific basis to provide reliable results. Because they have involved their Quality Management Committee and provider clinical supervisors and directors, as they pursue this study, they likely will see areas that need to be improved in order to feel confident in their results.

PIP Strengths

- The PIHP developed the PIP from "data" they had accumulated conducting clinical chart reviews and in discussion with the Quality Management Committee.
- The study topic is an important element of client care and could result in significant improvement in clinical outcomes.
- The PIHP demonstrates significant progress in their understanding of the PIP protocol.

PIP Challenges

- Despite the pilot nature of this initial project, problems with their definition of the study population (including their sampling methodology) and with their data analysis plan will impact result reliability.

PIP Recommendations

1. Develop the necessary detail to define the study population and ensure a valid sampling method with reasonable levels of confidence and margin of error.

2. Select some objective outcome measures as additional indicators to balance the self-report of clients.

3. Determine the degree of change needed to feel confident in moving ahead with this project.

4. Consider an alternate method of obtaining information from subjects to avoid possible influence of their case managers.

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentations was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff, and in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide reviewers responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with the all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	Rating	Comments
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Not Met	Information to support this requirement was not submitted.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Not Met	
2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Partially Met	The PIHP worked with provider agencies on process improvements to aid in more accurately capturing data. The improvements recommended were documented. The PIHP completed these assessments and improvements based on negative audit outcomes during baseline audits of their agencies' clinical records.
3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that	Not Met	The PIHP did not conduct an analysis of the entire data set.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.		
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Not Met	
Data is evaluated in a frozen state and archived for future possible use.	Not Met	

4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Not Met	The process defined by the PIHP did not meet contract requirements. The audits did sample the correct number of records (1% of the first six months of encounters or 250, whichever is least). Other items specified in the contract were missed. The PIHP did not check the clinical record against the PIHP encounter data for agreement in: • type of service, • date of service, and; • service provider. The review should also verify that the service reported actually occurred.

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		The review conducted by the PIHP primarily emphasized establishing congruence between the PIHP's data and the clinical records. Three items were checked: • If there is an encounter in the data, is there a progress note in the record? • If there is a progress note in the record, is there data in the system? • In addition, congruence between time durations was checked and noted.
PIHP includes additional data elements in matching exercise.	Not Met	
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Not Met	The PIHP submitted a tool designed for the process undertaken by the PIHP. No filled-in tools were submitted.

5. Submission of findings

Item	Rating	Comments
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report to the State lists numbers of encounters audited, numbers of encounters matching, numbers of encounters missing, and the percentages. The report also contained a listing of audited charts, including consumer names. This list would not be considered minimally necessary information under HIPAA laws.

PIHP Encounter Validation Process Review

Item	Rating	Comments
		Ideally, the report should contain the information requested by this tool. At a minimum, documentation should contain: • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	The PIHP provided evidence with respect to the practice of sharing results of these review exercises with their providers.
PIHP regularly reports internally for quality improvement activities.	Met	Reports from the Quality Management Committee meetings indicate regular discussions about this subject.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of	Not Met	The PIHP did not submit a policy with respect to the required documentation and oversight or corrective actions required of provider agencies based on the findings of a review activity.

PIHP Encounter Validation Process Review

Item	Rating	Comments
provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.		
If warranted, evidence of follow-up activity was presented.	Partially Met	The PIHP did provide evidence of follow-up activities and detailed changes being specified when process flaws were uncovered that put data accuracy at risk. The PIHP also provided written instructions specifying corrective actions when specific data conditions were present; however, these instructions included specific actions that were complex and potentially flawed. It was unclear whether the instructions were created in a group setting or had wider circulation and review prior to implementation.

Summary of Encounter Validation Findings

Score **Met _15_%**

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ **Met** ☐ **Partially Met** ☒ **Not Met**

Summary of Encounter Validation findings:

The encounter validation efforts made by this PIHP did not meet requirements set forth in the contract between the MHD and the PIHP. The encounter validation review did not include items specified in the contract. The PIHP did make efforts to reconcile data accuracy issues identified in previous reviews. The effort undertaken by the PIHP was defined as a PIP which did not meet specific EV requirements set forth in the contract between the PIHP and MHD. The PIPs re-measurement from the baseline yielded results that were worse than the baseline measures. These results may not be an indication of PIP failure, but of more serious problems with data congruence in the PIHP's data systems and the charts maintained by its provider agencies.

The overall finding of Not Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. Had the entire tool been used in computing the score, the PIHP would have fared the same, with 15% of all items meeting a score of Met, 69% at Not Met, and the remaining 16% at Partially Met.

Encounter Validation Strengths

- The PIHP made a concerted effort to conduct an encounter validation as they understood was required.

Encounter Validation Challenges

- These are the same challenges as apply to the Performance Measures.

Encounter Validation Recommendations

1. Develop an encounter validation process using this evaluation tool as guidance. Be certain to specifically meet minimum requirements specified in the PIHP contract with MHD.

2. Document data requirement to include completeness standards.

3. Conduct a data analysis, using a frozen data set, for purposes of an encounter validation.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. Each standard was then scored separately and the number of Met/Partial/Not Met summed for each. Total percentages are calculated by dividing the number in each category of Met/Partial/Not Met by the total number of items scored. Scores greater than 80% are considered an overall Met score; 65% to 79% is Partially Met, and those below 65% are considered overall as Not Met.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		3		• Plan is comprehensive; however, it is also redundant, which makes it difficult for the reader to clearly understand the structure and activities. • The structure lacks some clarity and accountability, particularly with respect to the chair position of the Quality Management Committee and the degree of informality of some subcommittees.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.	4			• The Clinical Director ensures completion of the annual QM Plan and the annual review.

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PIHP: Timberlands RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
C. Plan includes annual work plan and process for review of associated activities and progress.		**2**		• The 2006 work plan includes all indicators to be monitored during the year, as well as QAI activities planned for the year. • No documentation was submitted that describes the rationale for selection or detail of QAI activities • No evidence was submitted of specific, focused quality improvement activities other than PIPs.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.	**4**			• In addition to an annual clinical review, the Clinical Services Review Team (CSRT) conducts ad hoc focused reviews. • Scope of reviews described in Plan; follow-up on Corrective Actions included; describes reporting and use of information in quality improvement.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	**4**			• QMC membership includes Advisory Board and QRT members, Special Populations representative, family and client advocates and OMBUDS. • QMC membership includes

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PIHP: Timberlands RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				representatives from each provider. They participate in the integrated complaint process and annual survey. • Direct service representatives from providers staff the Clinical Services Review Team and client and family members assist in the review process. • The Provider Network meets monthly and gives input to the QMC.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.	**4**			Evidence provided included the following. • Site visits were conducted at all providers and reported in April (letters with results for each were provided). • QMC has met monthly all year. • Chart reviews for clinical quality are identified in QM Plan. PIHP submitted reports to agencies with results and request for CA, with due date for submission. • Quality Management Committee minutes reflect regular reports from QRT, Ombuds, and data reports with

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PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
				some trending; they reflect a clear indication of specific indicator tracking with comparison to history or state requirements. • Table tracking complaints including type and resolution for 1st 6 mo 2006. • List of Governing Board actions for 2006 indicates approval of annual QI plan update. • Access performance graphed by provider and total system for January through June 2006; QMC minutes reflect reporting of this data. • Providers report involvement in QMC and CSRT; in addition, they conduct chart reviews for each other. • Network providers confirm that agency managers participate in an annual review of QM Plan, and that agency staff was trained on PIPs.
Standard 1 Count (Target 6 Met):	**4**	**2**	**0**	**Target Points: 24 Actual: 21**

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PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
Standard **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			Evidence includes the following. • CSRT chart review reports were submitted for each provider, from April 2006. o These include detailed results of reviews, by topic, and corrective action requests with due dates. • RSN states that they conduct ad hoc reviews based on data and other information. • Providers state that clinical chart audits were conducted this past spring, along with spot audits. • They receive written feedback on audit results; evidence reflects a focus on care plans; progress notes reflect client voice and perception of satisfaction.

PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**2**		• The review tool is comprehensive and includes all aspects of care provision. • Scoring of chart review results is tabulated in Excel and reflects simple averages of all elements scored; this methodology waters down any outliers that might be present and require attention. • Review tool does not include criteria for applying scores, which may result in significant variation in results across reviewers.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.			**0**	• Clinical Director conducts an annual review; the Clinical Services Review Team, comprised of staff from network providers, conducts ad hoc chart reviews. • Inter-rater reliability training and testing was not conducted.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**3**		• RSN reports not having a system for tracking and follow-up on CAs; PIHP usually waits until the next contract monitoring.

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PIHP: Timberlands RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				• Dates of monitoring reports and responses from providers are several months apart, raising a question of timeliness with respect to identifying and addressing problems related to client service delivery. • Per the RSN, no additional documentation was provided to the agency for completed CA; review of problem and results are included in next contract monitoring report. • Providers report either a written or verbal confirmation of RSN receipt and approval of CA plan. • Provider completion of tasks is included in data reports, biennial quarterly reports, and subsequent site reviews. • Providers report that ad hoc review feedback is provided at the time of review.
Standard 2 Count (Target 4 Met):	**1**	**2**	**1**	**Target Points: 16 Actual: 9**

PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
<u>Standard</u> **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.			**0**	• Contract monitoring and CRT reports with recommendations and corrective actions were submitted. Discussion of these reports was not mentioned in QMC minutes. • Brief mention appears in 1 set of QMC minutes of an agency making progress on CAs. • No evidence was submitted indicating that results of clinical oversight activities are reviewed or analyzed by a committee (CSRT minutes not provided).
B. PIHP analyzes and trends individual provider performance.			**0**	• Reports to providers include detailed descriptions of results of individual reviews. • No evidence of aggregated/longitudinal trending for individual providers.

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PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
C. PIHP analyzes and trends system-wide performance.			0	• No evidence of trending for system.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		2		• QMC minutes reflect attendance and reporting across systems • QMC minutes contain information on key indicators (from reports not included) across system. These minutes contain limited analysis; e.g., little discussion with respect to follow-up.
Standard 3 **Count (Target 4 Met):**	**0**	**1**	**3**	**Target Points: 16 Actual: 2**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		2		• PIHP reports that they submit data monthly to the Ombuds, who reports to the QMC.

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PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
				• Exhibit N reported to QMC. • Submitted Complaints and Grievances Log by quarter: documents number of complaints, grievances and fair hearings by type and by provider and RSN totals. • No evidence of RSN tracking compliance with requirements for Grievances, NOAs and appeals.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.		**2**		• PIHP policy, "Performance Improvement Program" specifies quarterly review of complaints and grievances presented by Ombuds, with discussion and trending and recommendations for quality improvements. • Multiple sets of QMC minutes submitted contain brief mention of quarterly complaints/grievance reports; no evidence was submitted reflecting analysis of content of reports. • Evidence of activity related to complaints: QMC recommended a

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PIHP: Timberlands RSN

Requirement	Met	PM	Not Met	Findings Comments
				policy for staff leaving agencies, based on a complaint reported to the Ombuds.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	**4**			• RSN reports that providers are required to conduct annual training and orient new staff; Ombuds also provide training on these matters and other client rights issues (advance directives). • Clinical Director communicates frequently with Ombuds and keeps her up to date on changes; Wahkiakum. • Provider agency direct service staff confirm that they are trained annually and oriented at time of hire; they are able to describe their roles in the appeal process. • Ombuds is able to describe role in appeal, complaint, grievance, and fair hearing processes. • This Ombuds has been working in the mental health system for many years and knows the material; has attended trainings conducted by WIMRT and spent time initially with the previous

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PIHP: Timberlands RSN				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				Ombuds. She confirmed close communication with the RSN Clinical Director.
Standard 4 Count (Target 3 Met):	**1**	**2**	**0**	**Target Points: 12 Actual: 8**
Grand Totals Count (Target 17 Met): 6				**Target Points: 68 Actual: 40**

Summary Quality Assurance and Improvement Findings
Summary of QAI review findings: Timberlands RSN's QAI structure and operations demonstrate most requirements of a well-functioning system; however, 64% of the standards are not met or partially met, and the RSN indicated that they understand the specifics of their challenges.

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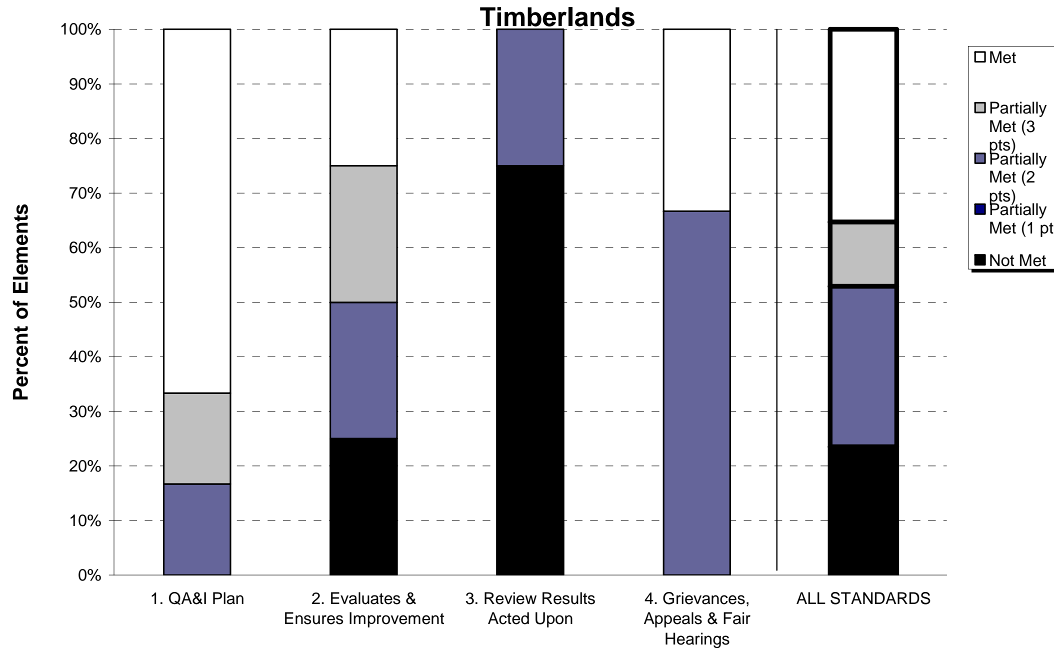


I. Frequency of Scores

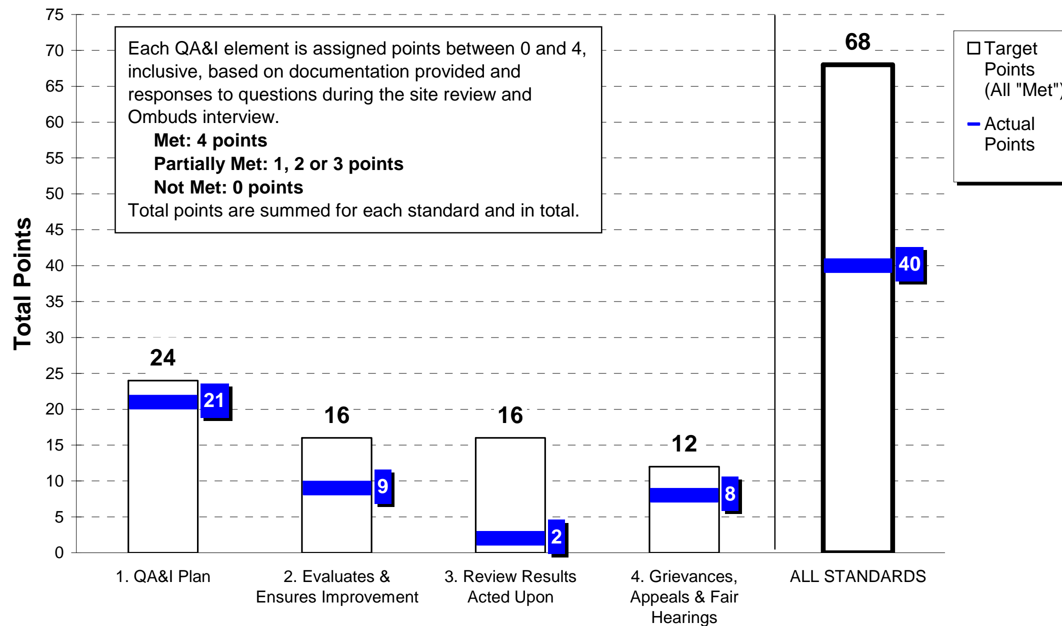
Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	4	1	1	0	0
2. Evaluates & Ensures Improvement	4	1	1	1	0	1
3. Review Results Acted Upon	4	0	0	1	0	3
4. Grievances, Appeals & Fair Hearings	3	1	0	2	0	0
ALL STANDARDS	**17**	**6**	**2**	**5**	**0**	**4**

QAI Strengths

- The PIHP gathers a great deal of information on a regular basis.
- The information is reported monthly to the Quality Management Committee, per the QAI Plan.
- There is ample involvement of network providers, consumers, advocates, and other stakeholders in the QAI process.
- The use of provider agency staff to conduct clinical reviews, if managed well, is a creative strategy to accomplish both a labor-intensive task and improve provider knowledge and adherence to clinical care requirements.

QAI Challenges

- The QAI Plan as written does not provide an effective road map to accomplish the required oversight and improvement activities.
- Limited staffing, including IT turnover, in the last few years, presents challenges regarding reliability of the reported information and timely and consistent analysis of system performance.
- Clinical reviews yield a great deal



II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	21
2. Evaluates & Ensures Improvement	16	9
3. Review Results Acted Upon	16	2
4. Grievances, Appeals & Fair Hearings	12	8
ALL STANDARDS	**68**	**40**

of information that could direct the PIHP toward valuable improvement efforts; however, the scoring and analysis of the chart reviews is not designed to provide that view.

QAI Recommendations

1. Revise the QAI Plan to eliminate redundancy and increase the clarity of structure and process; consider change in leadership design of Quality Improvement Committee to ensure that decision-making and oversight authority is appropriately in place.

2. Develop a matrix of indicators that specifies definition, method of measurement, targets for achievement, threshold for considering/taking action, and reporting responsibilities.

3. Devise an annual work plan that consists of 2-4 focused projects generated from results of the previous year's indicator performance.

4. Revise the chart review scoring method to ensure capture of high

quality performance areas as well as agency and system problems that should be addressed. Develop longitudinal trending of performance to aid in the analysis.

5. Reflect more detail of analysis or discussion of reports presented in the QIC to allow readers better understanding of outcomes and plans to address problems.

Recommendations

Subpart Recommendations

1. Design and implement formal procedures to prevent and detect internal fraud and abuse within the PIHP; conduct internal monitoring activities on a regular basis.

2. Incorporate all required BBA requirements for Notice of Actions in policy and procedures. In addition, explicitly stipulate in policy requirements and procedures for maintaining grievances, appeals, and State fair hearings.

3. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, and effective date of the policy.

4. Elucidate procedures related to translation of client materials into all prevalent languages and alternative formats, and reiterate to providers the particular client materials expected to be made regularly available.

5. Include monitoring of client access to second opinions and clinical records as part of annual clinical reviews.

6. Clarify delegated PIHP functions and develop processes related to sub-delegation:
   - Conduct a formal evaluation of subcontractor ability to perform PIHP- delegated functions prior to their delegation;
   - Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
   - Review their related performance on an annual basis.

7. Create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance, to provide a reliable record of activities.

8. Continue to provide organized trainings for PIHP and Provider Network staff to ensure awareness, understanding, skill development, and consistent implementation of new policies, procedures, and mechanisms.

9. Develop a policy and procedure for the generation and maintenance of data certifications and batch logs to ensure full compliance with this requirement. Although these certifications were reported to have been generated, signed and sent in to MHD, the PIHP was unable to provide this evidence.

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Performance Measurement Recommendations

1. Formalize a written policy and procedure for mapping non-standard codes to ensure consistent implementation. Not following a predefined process could result in underreporting of encounters.

2. Develop and implement a written policy and procedure that ensures encounter data is not lost due to unique circumstances (e.g., out-of-network services), thus minimizing the risk of under reporting data.

Performance Improvement Project Recommendations

1. Develop the necessary detail to define the study population and ensure a valid sampling method with reasonable levels of confidence and margin of error.

2. Select some objective outcome measures as additional indicators to balance the self-report of clients.

3. Determine the degree of change needed to feel confident in moving ahead with this project.

4. Consider an alternate method of obtaining information from subjects to avoid possible influence of their case managers.

Encounter Validation Recommendations

1. Develop an encounter validation process using this evaluation tool as guidance. Be certain to specifically meet minimum requirements specified in the PIHP contract with MHD.

2. Document data requirement to include completeness standards.

3. Conduct a data analysis, using a frozen data set, for purposes of an encounter validation.

Quality Assurance & Improvement Recommendations

1. Revise QAI Plan to eliminate redundancy and increase clarity of structure and process; consider change in leadership design of Quality Improvement Committee to ensure decision-making and oversight authority is appropriately place.

2. Develop a matrix of indicators that specifies definition, method of measurement, targets for achievement, threshold for considering/taking action, and reporting responsibilities.

3. Devise an annual work plan that consists of 2-4 focused projects generated from the results of the previous year's indicator performance.

4. Revise the chart review scoring method to ensure capture of areas of high quality performance as well as agency and system problems that should be addressed. Develop longitudinal trending of performance to aid in the analysis.

5. Reflect more detail of analysis or discussion of reports presented in the QIC to enable readers to understand the outcomes of the discussions and the plans to address problems.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool – Not included (only in reports sent to PIHPs)

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees

***Grayed items – examples of these can be found in the main statewide reports' attachments**

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Attachments

Attachment B – PIHP Communications

- 2006 Review – Introductory Letter
- Document Submission General Instructions
- 2006 Review Process Dates
- PIHP Information Update Request
- Roadmap to a PIP
- PIP Review Information
- Instructions for Submission of PIP Materials
- Instructions for QAI Document Preparation
- Instructions for Submission of Encounter Validation Documentation
- Instructions for Submission of Subpart Materials
- QAI Scoring Criteria

August 1, 2006

Hello, RSN Administrators. It's that time of year again – preparation for the External Quality Review season. We hope you are enjoying your summer and that the information we provide in this general description of this year's review process will ease you into your preparations.

In this communication you will find information regarding:

- The review process, review period, and topics being reviewed
- Schedule of reviews for all PIHPs
- A list of future communications – what you can expect and when

We encourage you to read this carefully and request that one person, in addition to the RSN Administrator, be identified as an official EQR contact. Please email Joanne Jerabek, jjerabek@apshealthcare.com with the name, phone number, and email of that person.

If you have questions about this or future communications, please send them to Joanne via email. The EQRO will provide responses to all PIHP questions weekly, via email, to everyone.

2006-2007 Review Plan

1. **Review Period**: each PIHP will be on an individual review year, thereby establishing an annual review cycle that ensures that MHD gets the most up to date information about each PIHP. This process will also enable the PIHPs to receive feedback from the EQRO that is more current and relevant to their existing operation.
   - **Each PIHP's review period will begin 12 months prior to the date their 2006 review documents are due.**
     For example, if PIHP A's document due date this year is Sept 27, 2006, their review period will extend back to Sept 27, 2005. The EQRO would expect to receive all documents in place during that 12 month period that relate to the topics being reviewed.
2. **Review Topics**
   - Subpart Compliance Monitoring: all items scored below 3 in the 2005 review, using the same scoring mechanism that has been in place the last 2 years

- Performance Improvement Project Validation: 2 PIPs, one clinical and one non-clinical, of the PIHP's choosing, using the same validation tool enhanced with some helpful detail
- Performance Measure Validation:
  - Review and update of PIHP IT systems and the State's methods and systems for PM calculation
  - Specific State measures to be defined shortly
- Encounter Validation: Evaluation of PIHP's systems and process for conducting State-required encounter validation
- **Quality Management Review** – this is new this year and will include:
  - Review and evaluation of quality and completeness of PIHP Quality Management plans
  - Review and evaluation of PIHP Chart review process, results, and follow-up
  - Review of PIHP's use of results over time for network-wide quality improvement

2. **Review Process**
- **The EQRO will conduct a desk review of policies, procedures, and other primary documents related to all review topics, prior to a site visit to the PIHP and two network providers.**
- Document requests and specifics for site visit will be sent to each PIHP based on their site visit schedule
  - The EQRO will request all documents for review at the same time, for all review activities above
  - As was the case last year, there will be no opportunity to provide additional documents beyond the due date
  - The PIHPs will have 30 calendar days to submit the requested documents
  - Each PIHP will receive a list of recommended documents and specific instructions for organizing and submitting them
  - The EQRO is encouraging electronic document submission and requests that you prepare to submit as much as possible electronically
- Desk Review
  - Each PIHP's submitted documentation will be reviewed prior to their site visit.
  - PIHP and provider interview questions will be formulated based on the submitted documentation.
- Site Visit Schedule
  - The schedule for the 2006-2007 site visits is attached
  - The order and length of the visits will be essentially the same as last year – PIHP interviews for ½ day and 2 providers, for an hour and ½ each
  - The EQRO cannot entertain any requests for change in schedule
- The reporting schedule will be essentially the same as last year; specific dates for reports and the exit brief will be provided during the site visit.

4. **Future Communication**
   - **Document requests** will reach each PIHP 1 calendar month prior to their due date, and approximately 6 weeks before the site visit; all necessary documents for all desk reviews will be requested at the same time.
   - **Review tools** for each review activity will be sent in outline, draft or final form with the document requests.
   - **Site visit agenda and provider names** will be sent 30 days prior to the site visit.
   - **Pre-visit conference call** will take place about 2 weeks prior to the site visit and will include confirmation of provider visits as well as review of process and logistics for site visit.

APS Healthcare wishes you all a successful and informative review year!

Harriet Markell
Executive Director, WAEQRO

Cc: Judy Gosney, Mental Health Division

2006 External Quality Review

Document Submission Information

Clark PIHP

Greetings,

As was described in the first communication to the PIHPs for the 2006 EQR, APS will conduct a desk review of all documents pertaining to the review topics prior to the site visit. Your site visit is scheduled for **December 12th & 13th, 2006.** All documents are due to APS on **November 27th, 2006** by close of business. Documents reflecting activities/policies, etc., effective during the period from **November 28th 2005 through November 27th, 2006**, will be the primary focus of this year's review; the 12 months prior to the document due date is considered your individual PIHP review period. However, in order to ensure that we capture all activity since your last review, for this year only we will also accept documents reflecting activity back to September 1, 2005 (which was the end of the review period for everyone last year). We are particularly interested in training conducted during that interim as well as provider monitoring, reports generated, meeting minutes and other discreet activities that would be otherwise overlooked.

Enclosed you will find

1. Information Update form to be completed and returned

2. Description and Document submission instructions for:
    - Subparts
    - Performance Improvement Projects
    - Quality Assurance and Improvement Review (referred to as Quality Management review in APS' first communication)
    - Encounter Validation

3. Draft review tools for:
    - Subpart review
    - PIP validation
    - QAI review
    - Encounter Validation

4. Subpart Scoring Guides (they have not changed)

5. “Roadmap to a PIP” as technical assistance

APS is encouraging all PIHPs to send their documents electronically (via CD-ROM) to the extent possible; specific instructions regarding that process are included with each review instruction document attached. We hope to do a little to save the environment and minimize storage space requirements. We do include instructions for hard copy as well, and you can use a combination of the methods if that suits you.

A couple of reminders: 1) keep a copy of all document submissions for yourself, and 2) do not send original documents.

For hard copy submissions, APS will work with you to provide a FEDEX label for your shipment. Please contact Joanne Jerabek (jjerabek@apshealthcare.com) if you wish to arrange for that. You can also reach her by phone at (360) 570-2216.

All documents (electronic and hard copy) must be submitted to:

APS Healthcare
2405 Evergreen Park Dr. SW Suite B-3
Olympia, WA 98502

Please call or email Joanne with any questions you have pertaining to these documents. We will respond promptly.

Best regards,

APS Healthcare
(Harriet Markell, Executive Director)

2006 Review Process Dates

RSN	Visit Date	Document Due Date	Review Period
Thurston-Mason	September 25, 2006	September 8, 2006	9/09/05 – 9/08/06
Grays Harbor	September 26, 2006	September 8, 2006	9/09/05 – 9/08/06
Southwest	October 11, 2006	September 22, 2006	9/23/05 – 9/22/06
Timberlands	October 12 and 13, 2006	September 22, 2006	9/23/05 – 9/22/06
Peninsula	November 2 and 3, 2006	October 20, 2006	10/21/05 – 10/20/06
Pierce County	November 21, 2006	November 6, 2006	11/07/05 – 11/06/06
Clark County	December 12 and 13, 2006	November 27, 2006	11/28/05 – 11/27/06
North Sound	January 18 and 19, 2007	January 9, 2007	1/05/06 – 1/04/07
Greater Columbia	February 6 and 7, 2007	January 19, 2007	1/20/06 – 1/19/07
Spokane County	February 22, 2007	February 5, 2007	2/06/06 – 2/05/07
Chelan-Douglas	March 14, 2007	February 23, 2007	2/24/06 – 2/23/07
North Central WA	March 15 and 16, 2007	February 23, 2007	2/24/06 – 2/23/07
King County	April 10 and 11, 2007	March 26, 2007	3/27/06 – 3/26/07

2006 WAEQRO PIHP Information Request Update

The Information Request Update is a tool used by APS Healthcare to gather current information about your organization in order to conduct the highest quality and most efficient review possible. Please provide the following information:

Please note: Rows will automatically format to inserted content. In addition, rows can be added or subtracted electronically as needed.

PIHP Name:

Physical Address:

Mailing Address (if different than above)**:**

Phone Number:

Fax Number:

Email Address of Primary Contact:

Website Address:

PIHP Administrator Name and Email Address:

Additional EQRO Contact Names, Titles and Email Addresses:

A. Year began operating as a PIHP:

B. Number of Medicaid Enrollees, FY 2005:

C. Served Medicaid Population, FY 2005:

D. Provide an Organizational Chart with names and titles of staff

E. PIHP's History and Current Structure:

The description should address key historical events such as mergers and changes in organizational structure. Also describe any unique aspects of the structure history, or operation of the PIHP.

F. Description of all payment methodologies used to compensate providers and subcontractors performing delegated functions:

2006 WAEQRO PIHP Information Request Update

G. Describe your system for planning and conducting training for PIHP and network provider staff, including your process for ensuring full implementation and attendance.
Complete the table below, listing training offered or sponsored by the PIHP during the review year. Please indicate if training was provided for PIHP staff, provider staff (what level) or both, and include training dates.

Topic	Date	Trainer (PIHP/Provider /Consultant)	Audience

2006 WAEQRO PIHP Information Request Update

Governing Board

Member Name	Title	Organization/Employer

Advisory Board

Member Name	Title	Organization/Employer

Network Providers

Provider Name, Administrator and Contact Info	Served Medicaid Population FY 2005	Type of Services Provided	Delegated Functions

Subcontractor of Delegated Functions

Subcontractor Name, Administrator and Contact Info	Month and Year Initially Delegated	Delegated Functions

Road Map to a PIP

1. Assemble multi-functional team

A. Identify/list shortcomings, problems, weakness in services/delivery.
B. Review relevant data: routine QI monitoring, MHP data, DMH or APS data, complaints, rumors, or concerns.
C. Identify priority area(s) of concern.
D. Review each per steps 2-4.
E. Pick one for PIP.

2. "Is there really a problem?"
Validate the problem

A. Does the problem affect consumers' satisfaction, MH outcomes, or functional status? Is it within our scope of influence?
B. Use numbers – rates or frequency.
C. Use benchmark literature (MHP, CA, US, etc.) relating to goals.
D. Identify MHP's current baseline numbers or %.
E. What number or % would indicate "improvement"? Why?

3. Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

A. Investigate what is or is not happening. Process mapping can be helpful.
B. Accept/reject all possible reasons by examining data and processes.
C For each accepted reason, what is broken? These are the "barriers."

4. "How can we try to address the broken elements/barriers?"
Planned interventions

A. Identify interventions, then determine how and when to measure.
B. What measurements represent success?
C. Did we eliminate bias?
D. After a measurement cycle, review results, alter intervention(s) as necessary, remeasure or move on.
E. Document/account for outside influences.

5. Formulate the study question

"If we do____________________, then, can we __________________?"
(step 4.) (step 2E.)

Have study question **identify the problem** targeted for improvement, a the specific population, and a **general intervention(s)** approach.

6. Apply Interventions "What do we see?"
Data analysis:
apply intervention, measure, interpret

A. Specify and apply intervention(s) for each targeted barrier/element.
B. Make interventions as measurable as possible: frequency, time, etc.
C. Consider pilot, surveys, etc., to initially validate the intervention(s).

7. "Was the PIP successful?" What are the outcomes?

A. Were numerical goals achieved?
B. Has PIP demonstrated improvement for consumer MH outcomes, functional status, or satisfaction?
C. Were numerical goals sustained after a time period of re-measurement?
D. If successful, institutionalize changes and implement routine monitoring to maintain improvement.
E. Return to appropriate step if necessary.
F. Publicly celebrate your team's successes !!

CAEQRO
January 2006
V5.5

2006 External Quality Review

WA EQRO
Performance Improvement Project Review
Information and Instructions

As part of the 2006 External Quality Review, APS will be conducting a detailed review of two Performance Improvement Projects, of PIHP choosing, one clinical and one non-clinical. As with the Subpart Review, APS will conduct a desk review initially, followed by discussion with the PIHPs during the site visit.

For the review this year APS will be utilizing a somewhat modified version of the 2005 Validation Worksheet. This tool highlights those steps in the process that are critical for producing a valid PIP. While the scoring method is displayed on the tool and will be utilized by APS, it will be an "as if" process, without consequence for the PIHPs. APS will provide the PIHP with suggestions throughout the document for improving the process and ultimate validity of the PIP.

Because the CMS protocol clearly expects that a year's worth of activity should be reviewed each year, APS will be reviewing documents for a specific timeframe for each PIHP, again assuming that performance improvement is ongoing, and that each project will be developing at its own pace.

Attached here also is a "Roadmap to a PIP", created by the California EQRO – we hope this is helpful in thinking about your projects.

2006 External Quality Review

Instructions for Submission of PIP Materials

1. Documentation for two PIPs is required, one clinical and one non-clinical.

2. In order to support PIHPs' increasing understanding of the process of conducting PIPs, APS is requesting that PIHPs conduct their own validation this year. Please complete and submit a validation tool (attached) for each PIP being considered for review this year. APS will also complete a validation tool for each PIP.

3. Additional documentation should include (but is not limited to):
   - Performance Improvement Plan descriptions, as outlined in CMS protocol
   - Analyzed data and results (pre and post intervention), including any charts, graphs, etc. created for analysis purposes
   - Minutes from QI (or other relevant) Committee meetings discussing development or progress of a PIP
   - Copies of survey tools or other data collection instruments
   - Reports documenting progress or outcomes of performance improvement project activities

CD-ROM Submission

- Create folder labeled, "PIPs"
- Create a subfolder for each PIP, using title of PIP as name of folder
- In each PIP subfolder
  - Create a subfolder labeled, "Document List"
    - Use copy of tool, Comments column, to list name and date of documents being submitted as support – place in Document List folder
    - Complete 1st page of tool
  - Create additional subfolder labeled, "Self Validation" and place validated tool in that folder
  - Place remainder of all documents for each PIP in the relevant folder
    - Document titles should include name and date
    - Documents should have page numbers

- Highlight relevant sections of documents (if only part being used, as in meeting minutes) and insert comment with procedural step being supported (from PIP Validation tool)

Hard Copy

- Prepare and submit two packets of all documents for each PIP
    - 3-hole punched
    - Each PIP separated by dividers
- Remember to create an identical packet for yourself
- Use a copy of the validation tool to list documents submitted for each requirement (use Comments column); include document name/title and date
    - Include in relevant PIP section
    - Complete first page of tool
- Highlight relevant sections of each document and identify standard being supported
- Include copy of self-validation in each PIP packet

2006 External Quality Review

Quality Assurance and Improvement Review
Document Preparation

Please submit all documents that support PIHP compliance with standards outlined in draft review tool as follows.

C-D ROM

- Create folder labeled QAI
- Create subfolders for each major standard heading (far left column on tool)
- Create subfolder labeled Document List
- Place all documents in relevant subfolders
  - Documents titles should include name and date
  - Documents should have page numbers
- Highlight relevant sections of documents and insert comment with standard number being supported
- Use copy of tool, Comments column, to list name and date of documents being submitted as support – place in Document List folder

Hard Copy

- Prepare and submit two packets of all documents, 3-hole punched, and indexed (separated) by Standard number
- Remember to create an identical packet for yourself
- Use a copy of the tool to list documents submitted for each requirement (use Comments column); include document name/title and date
- Highlight relevant sections of each document and identify standard being supported

Documents supporting compliance with this section would include (but not necessarily be limited to):

- * Most recent PIHP Quality Improvement/Assurance Plan
- Quality Management Oversight committee structure and roster

- Policies and procedures related to standards of care and provider oversight
- Provider contract sections addressing standards of care requirements and oversight procedures
- Provider manual
- Completed monitoring tools
- Results of provider reviews, including corrective action requests
- Documentation of follow-up on CA activities of providers
- Reports presented to QI and other committees re: network performance on standards of care, including analyses of results (includes long term trending as well as annual review results)
- Minutes of meetings demonstrating discussion of reports and recommendations for follow-up
- * Policies and procedures related to grievance and appeals
- * Copy of Grievance and Appeal report for Period April through September, 2006
- * Copies of all grievance and appeal files resolved or in process during reporting period above
- * Grievance and appeal tracking logs

*** Required documents**

2006 External Quality Review

Instructions for the Submission of Encounter Validation Documentation

Below you will find specific document submission information for the 2006 encounter validation activities being conducted by APS Healthcare. To help the PIHPs understand the direction of this year's review process, the following excerpt from the CMS protocol is relevant:

"Development of accurate and complete encounter data is an iterative process. Because encounter data are an outgrowth of MCO/PIHP IS and data policies, it is often not possible for MCOs and PIHPs to overcome all limitations in their IS and data policies in one year. As a result, in the first year that a State requires the submission of encounter data from its MCOs and PIHPs, the data may be significantly incomplete and contain errors. Improving the completeness and accuracy will take place through continuous quality improvement (CQI) processes implemented year after year. Because of this, States will need to develop a "phased-in" approach for using standards for encounter data accuracy and completeness. "Phased-in" standards acknowledge the start-up issues affecting both MCO/PIHPs and State Medicaid information systems receiving the encounter data."

This year's External Quality Review is geared towards looking at the first iteration of the PIHPs' encounter validation processes.

The protocol to evaluate the PIHPs will follow the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment.

1. Review the State's and the PIHP's requirements for collection and submission of encounter data.
2. Review of PIHP's Provider Agency network's capability to produce accurate and complete encounter data.
3. Analysis of PIHP's Provider Agencies' electronic encounter data for accuracy and completeness.
4. Review of medical records, as appropriate, for additional confirmation of findings (the encounter validation/matching exercise).
5. Submission of findings (and follow-up activities).

The 2006 Encounter Validation (EV) compliance review will include a desk-review of the processes used by the PIHP to meet the Encounter Validation requirements in the

PIHP's contract with MHD. The EQRO will also evaluate the results of the process, including any follow-up with the individual provider agencies that were evaluated.

Please organize and submit the EV Documents as described below.

1. **Suggested documents include**:
    - Descriptive documentation of EV process (include any policy and procedures, contract language, trading partner agreements that help define this process)
    - Data standards used (PIHP contracts with provider agencies, Trading Partner Agreements, PIHP Data Dictionary and/or any policies and procedures that define data standards)
    - Documentation of IT evaluation efforts (any information collected by the PIHP to understand their network's capability to produce accurate and complete encounter data – a mini ISCA done by the PIHP on their provider network)
    - Results from reviews (internal working documents and external reports)
    - Corrective actions issued (if any)
    - Re-evaluation results (if any)

2. **<u>Electronic Submission</u>**
    - Submit materials on CD-ROM
    - Create a **folder for Encounter Validations**
    - Place EV related documentation in this folder
    - In order for evidence to be easily located and referenced in each document, please include the following on the document:
        - ♦ Document title
        - ♦ Document, Revision or Version Date
        - ♦ Page numbers
    - Please prepare a **Table of Contents** and/or a **Guide** to understanding the layout of your electronic submission, including a list of all documents and the requirement each is intended to support and include as a separate file on the C-D ROM.

3. **<u>Hard Copy submission</u>**
    - Create two (2) separate binder-ready packets
    - Place EV related documentation in these packets
    - In order for evidence to be easily located and referenced in each document, please include the following on each document:
        - ♦ Document title
        - ♦ Document, Revision or Version Date

2006 External Quality Review

Instructions for Submission of Subpart Materials

The 2006 Subpart compliance review will include all elements scored below a 3 in the 2005 review using the same scoring mechanism that has been in place the last 2 years. Elements scored as a zero (0) on a two (0-1) point scale will also be reviewed. Please organize and submit the **Subpart Review Documents** as described herein.

1. Please utilize the **Subpart Scoring Tools** and the **Scoring Guidelines** attached, along with your **PIHP's 2005 External Quality Review Report** as guides to assist you in preparing and organizing evidence of compliance for your Subpart review document submission.

2. Please submit:
   - Board approved policies and procedures
   - Signed and dated subcontracts
   - Training logs, agendas, Power Points, and attendance sheets
   - Actual NOAs, grievances and appeals
   - Completed contract and clinical monitoring tools, including results and reports and corrective actions
   - Provider corrective action plans and PIHP follow-up
   - Evidence of other quality assurance and improvement activities
   - Current and relevant data
   - Etc.

3. **Draft policies and procedures, outdated contracts, blank forms, incomplete monitoring tools and the like will not be accepted as evidence of how practice is implemented as required in the Scoring Guides.**

4. **2004 MHD EQR Corrective Actions** will be a focus in this year's review. For any 2004 corrective action elements not meeting a score of 3 or above, please submit your corrective action plans and implementation update.

5. **Electronic Document Submission via CD-ROM**:

   - Create a **folder for each Subpart** (i.e. Subpart C-Enrollee Rights and Protections).

   - In each Subpart folder create a **folder for each CFR** in which you scored below a 3 during the 2005 EQR.

- Example: **Subpart C-Enrollee Rights and Protections** would potentially have folders with the following names:

    - ♦ **438.10**
    - ♦ **438.100(b)**
    - ♦ **438.100(c)**
    - ♦ **438.100(d)**
    - ♦ **438.102,** and so on.

- In each CFR folder create a **folder for each Review Element Number** (i.e. [Q1], [Q2], etc.) in which you scored below a 3 during the 2005 EQR.

- In each Review Element Number folder place **all documents containing relevant evidence**.

- In order for evidence to be easily located, each document should contain:

    - ♦ Title and date
    - ♦ Page numbers
    - ♦ Highlighted subject matter pertaining to each review element

- Please prepare a **Table of Contents** and/or a **Guide** to understanding the layout of your electronic Subpart Review submission. Documents may be duplicated throughout the Subpart folders, or may be included once, with the Table of Contents or Guide providing a roadmap to reference the pages and paragraphs to be reviewed for each CFR and review element. One acceptable strategy would be listing, on a copy of the Subpart Scoring Tools, each document submitted as evidence for each of the Review Element Numbers.

6. **Hard Copy Document Submission:**

- Create two (2) separate binder-ready (whole punched, indexed, etc.) packets for each Subpart and title the binder packets accordingly (Subpart C, D, F, or H):

    - ♦ Example: Packets 1 and 2 would each be titled **Subpart C-Enrollee Rights and Protections,** packets 2 and 3 would each be titled **Subpart D-Quality Assessment and Performance Improvement** and so on.

- In each Subpart label a section for each CFR reference in which you scored below a 3 during the 2005 EQR.

- Example: **Subpart C-Enrollee Rights and Protections** would potentially have sections with tabs labeled:

    - ♦ **438.10**
    - ♦ **438.100(b)**

- **438.100(c)**
- **438.100(d)**
- **438.102,** and so on.

- Under each labeled section place the supporting documents pertaining to that CFR.

- In order for evidence to be easily located, each document should contain:

    - Title and date
    - Page numbers
    - Review element numbers (i.e. [Q1], [Q2], etc.)
    - Highlighted subject matter pertaining to each review element

- Please prepare a **Table of Contents** and/or a **Guide** to understanding the layout of your packet for each Subpart. Documents may be duplicated throughout the Subpart packets, or may be included once, with the Table of Contents or Guide providing a roadmap to reference the pages and paragraphs to be reviewed for each CFR and review element. One acceptable strategy would be listing, on a copy of the Subpart Scoring Tools, each document submitted as evidence for each of the Review Element Numbers.

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review
Scoring Criteria

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.				• See Requirements of QA&I Process (in separate document)
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.				• Review plan includes timing, process, plan to incorporate results into following year plan and reports to stakeholders
C. Plan includes annual work plan and process for review of associated activities and progress.				• Based on previous year's QA results; • Is not the PIPs

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.				• At least semi-annual review of clinical charts • At least bi-annual review of provider staff training
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.				• Specifies committee involvement and avenues for input
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.				• Annual summary of activities/findings/etc. • Evidence of consumer involvement in committees and QI activities • Evidence of progress on work plan (e.g. committee minutes) and inclusion of year-end status in report
Standard 1 **Count (Target 6 Met):**				**Target Points: 24** **Actual:**
<u>Standard</u> **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.				• Has Policy & procedure defining review process • Review schedule follows plan • Results for each provider produced in timely fashion and communicated to agency

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.				• Tool includes items related to all categories mentioned • Review questions structured for easy and clear evaluation of compliance and quality; e.g. evidence of positive outcomes, use of best practices, etc. • Scoring or evaluation system clearly spelled out in policy and procedure • Thresholds/definitions of scores clearly defined • Scoring system is amenable to aggregation of results on various parameters
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.				• Plan clearly identified/documented • Specification of frequency and/or incorporation of new staff • Evidence of implementation
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.				• Policy/procedure or In QAI plan: ➢ Who responsible; ➢ Ensures timely follow-up and documentation of progress; ➢ Documentation for PIHP and provider of satisfactory completion of required activities • Evidence that process implemented reliably and consistently
Standard 2 **Count (Target 4 Met):**				**Target Points: 16** **Actual:**

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
Standard **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.				• Minutes of committee reflect discussion of reports as scheduled in plan • Discussions include corrective action oversight activities
B. PIHP analyzes and trends individual provider performance.				• Reports include longer term analysis of individual provider performance • Discussion re: trends and needed remediation reflected in minutes
C. PIHP analyzes and trends system-wide performance.				• System-wide trends on key indicators reviewed regularly and analyzed for necessary remediation, training, etc
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.				• Minutes of meetings with providers, advisory boards, QRT, etc. reflect provision of information about QAI results and activities
Standard 3 Count (Target 4 Met):				**Target Points: 16 Actual:**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.				• Identifies specific positions responsible for all aspects of implementation and tracking • Maintains documentation of each case in manner that ensures timelines and requirements met • Maintains logs documentation over-all compliance with requirements
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.				• Provider reviews include grievance and appeal requirements • Minutes of QI committee reflect reporting of results for individual providers and system-wide • Need and plan for improvements identified and acted upon when indicated
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.				• Evidence of training on regular basis and for all new employees • Staff and Ombuds can articulate basic requirements and role of agency staff/PIHP • Ombuds understands level of detail required to provide effective support to consumers • Ombuds and/or agency staff describe actual situation and outcome demonstrating familiarity with process and detail for which they would be accountable.

Standard 4 **Count (Target 3 Met):** **Target Points: 12** **Actual:**

PIHP:				
Requirement	Met	PM	Not Met	Findings Comments
Grand Totals Count (Target 17 Met):				Target Points: 68 Actual:

Summary Quality Assurance and Improvement Findings

QAI Strengths
-

QAI Challenges
-

QAI Recommendations

1.

  - ♦ Page numbers
- Please prepare a **Table of Contents** and/or a **Guide** to understanding the layout of your submission

APS HEALTHCARE
Healthy Together

Attachments

Attachment C – Site Visit Documentation

- **Sample Site Visit Schedule**
- **Sample Site Visit Agenda**
- **Sample Agenda Letter**
- **Sample List of Attendees**

WA EQRO Site Visit Schedule 2006-2007

Thurston-Mason	September 25th, 2006
Grays Harbor	September 26th, 2006
Southwest	October 11th, 2006
Timberlands	October 12th & 13th, 2006
Peninsula	November 2nd & 3rd, 2006
Pierce	November 21st, 2006
Clark	December 12th & 13th, 2006
North Sound	January 18th & 19th, 2007
Greater Columbia	February 6th & 7th, 2007
Spokane	February 22nd, 2007
Chelan-Douglas	March 14th, 2007
North Central	March 15th & 16th, 2007
King	April 10th & 11th, 2007

North Sound PIHP
117 N. 1st Street, Suite #8
Mount Vernon, WA 98273
360-416-7013 x 239
Administrator: Chuck Benjamin

*****January 18th, 2007*****

I	**Introductions/Review Agenda**	**9:00 - 9:15**
II	**Updates from PIHPs**	**9:15 – 9:45**
III	**Quality Management**	**9:45 – 10:30**
	Break	***10:30 - 10:45***
IV	**Performance Improvement Projects (Review of 1)**	**10:45 - 11:15**
V	**Subparts**	**11:15 - 12:00**
VI	**Encounter Validation/Performance Measurement**	**11:15 - 12:00**
VII	**Wrap-up**	**12:00 - 12:10**

Catholic Community Services — **2:30 – 4:00**
1133 Railroad Avenue
Bellingham, WA 98225
Kathy McNaughton, Clinical Director
360-676-2164

*****January 19th, 2007*****

Compass Health — **9:00 - 10:30**
4526 Federal Ave
Everett, WA 98213
Jess Jamieson, Executive Director
425-349-6200

WA EQRO
2405 Evergreen Park Dr SW
Olympia, WA 98502

December 18, 2006

Chuck Benjamin, PIHP Administrator
North Sound RSN
117 N. 1st Street, Suite #8
Mount Vernon, WA 98273

Dear Mr. Administrator:

APS Healthcare is looking forward to the third year External Quality Review site visit with North Sound PIHP on 01/18/07, from 9:00 am – 12:10 am.

<u>The designated review team will include the following APS staff members:</u>

- Harriet Markell, EQRO Executive Director
- Brad Babayan, IT Analyst
- Marty Driggs, Clinical/Administrative Reviewer
- Irene Finley, Clinical/Administrative Reviewer

This year the review will incorporate an update of your overall service delivery system as well as a discussion about those Subpart items from last year's review that were re-reviewed. Included also will be a review of your PIPs, using one specifically as the vehicle for identifying strengths and opportunities for improvement, and an in depth discussion about your quality management program.

<u>Representatives from the following PIHP operations should plan on participating</u>:

- Executive Leadership
- Information Systems
- Utilization Management
- Quality Management
- Ombuds – either at site visit, on phone at site visit, or phone call at some later date

The list of planned participants will be discussed in detail with Harriet Markell, prior to the site review, in order to ensure that the appropriate staff members are included in each component of the review.

Please ensure that one conference room and one office-type space is available that can accommodate the PIHP and APS staff conducting simultaneous reviews. We will begin promptly at 9:00 am.

In addition to the EQRO visit to the PIHP, we will be visiting the following network providers on January 18th, 2007:

Catholic Community Services 1133 Railroad Avenue Bellingham, WA 98225	2:30 – 4:00

And January 19th, 2007:

Compass Health 4526 Federal Ave Everett, WA 98213	9:00 – 10:30

Please notify your providers about the date and time. These visits will cover implementation of policies and procedures addressed in your Subpart review and provider involvement in PIHP QM/QI activities, so we would like to meet with staff responsible for carrying those out. Included may be clinical service staff as well as relevant administrative and executive staff.

Attached is a detailed agenda for the PIHP visit. Please arrange for a telephone call between yourself and Ms. Markell to discuss this agenda by calling or emailing me at (360) 570-2216 or jjerabek@apshealthcare.com. We would like to schedule this call within the next 2 weeks.

Sincerely,

Joanne Jerabek
Administrative Manager

Attachments:
PIHP Site Visit Agenda

CC: Harriet Markell, Executive Director
Marty Driggs, Clinical/Administrative Reviewer
Brad Babayan, IT Analyst
Irene Finley, Clinical/Administrative Reviewer
Judy Gosney, Mental Health Division Operations

Chelan-Douglas PIHP
2006 External Quality Review
March 14, 2007

Site Visit Participants

Name	Position/Title
Chelan-Douglas RSN	
Jim Colvin	RSN Administrator
Rick Lewellyn	Clinical Director
Kathy Latimer	IS
Catholic Family & Child Services	
Susie Tryon	Agency Director
Michael Stride	Clinical Director
Trinidad Medina	IS Coordinator
Jennifer Dulmaine	Counselor – QA Coordinator
Manoah Winter	Counselor
Columbia Valley Community Health	
Jan Clay	BH Director
Kathleen Miner	Operations
Tessa Timmons	Children's Program Manager
Vicki Bringman	Director/Manager Outpatient Services
Diega Cabrera	Clinical Services Director
Alana Kay	Intake/Therapist
Jennifer Latimer	Case Manager
Brett McDonald	Mental Health Therapist
Jeff Corcoran	DMHP

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Attachments

Attachment D – Subpart Scoring Guidelines

- **Scoring Guide 1**
- **Scoring Guide 2**

Scoring Guide 1

(This guideline is used for scoring most policy, procedures, and contract language based on Balanced Budget Act (BBA) requirements and provisions)

0 = No evidence of written policies and procedures, or contract language to ensure that the specific provision is implemented in the PIHP.

1 = Policies and procedures and/or contract language can be located that is relevant to the scope and intent of the BBA provision.

2 = The written policies and procedures and/or contract language are readily available to all PIHP and Provider staff that might need access and, if required, is adequately displayed for staff or, where applicable, enrollees.

3 = Evidence is found that staff and, where applicable, Providers are trained and aware of the policies and procedures and/or contract language.

4 = PIHP staff and, where applicable, Providers can articulate the purpose of the provision and describe how it is implemented in the local setting.

5 = All of the following exist:

- Written policies and procedures for the specific provision are in place and readily accessible and/or prominently displayed.

- There is evidence that PIHP staff and Providers have been trained regarding the requirements of the provision and are aware of written policies and procedures.

- PIHP staff and Providers can articulate purpose of provision, how practice is implemented in local setting and understand why the specific provision is needed.

- There is evidence that the provision has been thoroughly and consistently implemented through documented signatures, certificates, training logs, or other documentation satisfactory to the State.

Scoring Guide 2

(This guideline is used for scoring Balanced Budget Act (BBA) provisions that require specific mechanisms, processes, and/or analyses to be in place)

0 = No evidence that mechanisms, processes, and/or analyses are written or otherwise documented.

1 = Written descriptions of the mechanisms, processes, and/or analyses are in place and in sufficient detail to permit implementation.

2 = Written descriptions of the mechanisms, processes, and/or analyses are readily available to PIHP staff responsible for implementation and, where applicable, Providers.

3 = Evidence exists that indicates PIHP staff and Providers are trained and aware of written descriptions of the mechanisms, processes, and/or analyses.

4 = PIHP staff and, where applicable, Providers can articulate purpose of the mechanisms, processes, and/or analyses and describe how they are implemented in local setting.

5 = The presence of all of the following:

- Written descriptions of the mechanisms, processes, and/or analyses are in place and readily accessible to appropriate PIHP staff and where applicable, Providers.

- There is evidence that the responsible staff has been trained regarding the implementation of the mechanisms, processes, and/or analyses required by the provision and are aware of written policy and procedures.

- PIHP staff and Providers can articulate purpose of the mechanisms, processes, and/or analyses, how the practice is implemented in local setting, and understand why the specific provision is needed.

- There is documented evidence that the descriptions of the mechanisms, processes, and/or analyses have been thoroughly and consistently implemented through documented signatures, products, or transmittals to the appropriate target (usually the State MHD). The State may approve other forms of documentation that the mechanisms, processes, and/or analyses have been thoroughly and consistently implemented.

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Attachments

Attachment E – Subpart Scoring Tool

438.10	**Information Requirements** **(a) <u>Terminology</u>:** As used in this section, the following terms have the indicated meanings: enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but are not yet an enrollee of a specific in a PIHP,... Enrollee means a Medicaid recipient who is currently enrolled in a PIHP... in a given managed care program. **(b) <u>Basic Rule</u>:** Each…PIHP,…must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and enrollees in a manner and format that may be easily understood. **(c) <u>Language</u>:** The State must: (1) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and enrollees throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of enrollees and enrollees in the State. (2) [This paragraph contains a requirement for the State, not the PIHP.] (3) Require each PIHP,... to make its written information available in the prevalent, non-English languages in its particular service area. (4).Require each PIHP, to make those services [i.e., oral and sensory interpretation services] available free of charge to each enrollee. This applies to all non-English languages, not just those the State identifies as prevalent. (5).Require each PIHP,... to notify its enrollees: (i) That oral interpretation is available for any language and written information is available in prevalent languages; & (ii) How to access those services. **(d) <u>Format</u>:** (1) Written material must: (i) Use easily understood language and format; (fourth grade reading level, easy-to-read 14 point font) (ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. (Large print, Braille, recorded cassettes) (2) All enrollees and enrollees must be informed that information is available in alternative formats and how to access those formats. **(e) <u>Information for Enrollees</u>:** [The requirements of this paragraph pertain to the State Medicaid agency or its contracted representative, not to PIHPs.] **(f) <u>General Information for all Enrollees of PIHPs</u>:**...Information must be made available to PIHP,... enrollees as follows: (1) [Requirement pertains to State, not to PIHPs.] (2) The State, its contracted representative, or the PIHP,... must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section, (and (g)* of this section if applicable) at least once a year. (3) The State, its contracted representative, or the PIHP,... must furnish to each of its enrollees the information listed in paragraph (f)(6) of this section, (and (g) of this section if applicable) within a reasonable time after the PIHP,… receives, from the State or its contracted representative, notice of the recipient's enrollment. (Within 30 Days of enrollment and annually)

	(4) The PIHP, must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraph (f)(6) of this section, (and section (g) of this section if applicable) at least 30 days before the intended effective date of the change. (5) The PIHP,... must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. (6) The following information must also be provide to all enrollees: (i) Names, locations, telephone numbers of, and non-English languages spoken by current network providers in the enrollee's service area, including information at least on primary care physicians, specialists, and hospitals, and identification of providers that are not accepting new patients. (ii) Any restrictions on the enrollee's freedom of choice among network providers. ***(g) referenced in number (2) above is the grievance, appeal and fair hearing information.**							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q1]	• PIHP has written policies and procedures addressing the information requirements the PIHP is responsible for in 438.10. • PIHP has the most recent DSHS Public Mental Health System Benefits Booklet in seven languages (Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese, English) available at the PIHP and contracted providers for distribution to enrollees at first request for services **[MHD-PIHP '05-'06 Contract 1.4.5.1 / 1.4.5.4] [MHD-PIHP '06-'07 Contract 3.1.1.1 / 3.1.1.2 / 8.3.13]**							

Comments/Observations:

42 CFR REFERENCE AND APPLICATION	Subpart C-Enrollee Rights and Protections	8-07-06

438.100	**ENROLLEE RIGHTS** **General rule.-State requirement**							
438.100(b)	**(b) Specific Rights:** (1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section. (2) An enrollee of an PIHP has the following rights to: i. Receive information in accordance with Sec. 438.10 (right to a State fair hearing). ii. Be treated with respect and with due consideration for his or her dignity and privacy. iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in Sec. 438.10(f)(6)(ix)] iv. Participate in decisions regarding his or her health care, including the right to refuse treatment. v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. vi. If the privacy rule as set forth in 45 CFR parts 160 and 164 subparts A and E applies, request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45 CFR 164.524 and 164.526. vii. The right to request and receive a copy of enrollees medical record under 45 CFR parts 160 and 164 and a right for the medical record to be amended or corrected as specified in 45 CFR 45 Section 164.524 and 164.526. (3) An enrollee of a PIHP (consistent with the scope of the PIHP's contracted services) has the right to be furnished health care services in accordance with Secs. 438.206 through 438.210.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 **[Q2]**	The PIHP has a written policy that guarantees the rights of the enrollee as specified in paragraphs (b)(2) and (b)(3) above. **[MHD-PIHP '05-'06 Contract 1.4.5.4(a)]** **[MHD-PIHP '06-'07 Contract 9.1]**							
[Q3]	The PIHP has written contracts with subcontractors that include advising enrollees of their rights (as above) in their primary language as needed.							
[Q4]	The PIHP has provider contract language that holds subcontractors to posting the rights of enrollees in public places in all prevalent languages. **[MHD-PIHP '05-'06 Contract 1.4.5.3]** **[MHD-PIHP '06-'07 Contract 3.1.3. / 3.1.4]**							
[Q5]	The PIHP has contract language that requires subcontractors to ensure that clients understand their rights.							

42 CFR REFERENCE AND APPLICATION	Subpart C-Enrollee Rights and Protections	8-07-06

Comments/Observations:								
438.100(c)	**(c) Free Exercise of Rights**: Each enrollee is free to exercise his or her rights, and the exercise of those rights does not adversely affect the way that the PIHP or its community mental health agencies or the State agency treats the enrollee.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q6]	The PIHP has provider contract language that requires subcontractors to protect an enrollee's right to exercise his or her rights, and when enrollees exercise these rights, assurance that their treatment will not be adversely affected. **[MHD-PIHP '05-'06 Contract 4.11.9] [MHD-PIHP '06-'07 Contract 9.2.9]**							
Comments/Observations:								
438.100(d)	**(d) Compliance with Other Federal and State Laws**: Each PIHP must comply with any other applicable Federal and State laws (such as Title VI or the Civil rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1965 as implemented by regulations at 45CFRpart 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality). • Right to a second opinion from a qualified health care professional within the network, at no cost to the enrollee (438.206) (b)(3). • Client involvement in decisions about their mental health treatment • Client access to clinical records							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q7]	Compliance with other Federal and State Laws is reflected in the PIHP's policies. **[MHD-PIHP '05-'06 Contract 1.4.10.2, 1.4.21] [MHD-PIHP '06-'07 Contract 16.5 / 17.2 / 17.8.2 / 9.1]**							
[Q8]	Compliance with other Federal and State Laws is required of subcontractors as evidenced by their contract with the PIHP. **[MHD-PIHP '05-'06 Contract 1.4.10.2 / 1.4.21] [MHD-PIHP '06-'07 Contract 16.5 / 17.2 / 17.8.2 / 9.1]**							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q9]	PIHP has policies to ensure compliance with the three client rights noted in the above section. **[MHD-PIHP '05-'06 Contract 3.1.6 / 4.11.5 / 4.11.8 / 4.13] [MHD-PIHP '06-'07 Contract 13.2 / 9.3.1 / 9.2.8]**							
[Q10]	Provider contracts have references that hold them to compliance with a client's right to a second opinion, involvement in their mental health treatment and access to clinical records. **[MHD-PIHP '05-'06 Contract 3.1.6 / 4.11.5 / 4.11.8 / 4.13] [MHD-PIHP '06-'07 Contract 13.2 / 9.3.1 / 9.2.8]**							
[Q11]	PIHP has policies and procedures on how they monitor their subcontractors to ensure compliance with these regulations. **[MHD-PIHP '05-'06 Contract 3.1.6 / 5.2 / 5.2.1] [MHD-PIHP '06-'07 Contract 8.3.12]**							

Comments/Observations:								
438.102	**PROVIDER – ENROLLEE COMMUNICATIONS** **General Rules** (1) A PIHP may not prohibit, or otherwise restrict, a mental health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered (ii) Any information the enrollee needs in order to decide among all relevant treatment options (iii) The risks, benefits, and consequences of treatment or non-treatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q12]	The PIHP has policies and procedures that ensures against prohibiting or otherwise restricting any subcontractor from advising or advocating on behalf of an enrollee who is his or her patient (with respect to any of the conditions cited above). **[MHD-PIHP '05-'06 Contract 4.11-4.11.5]** **[MHD-PIHP '06-'07 Contract 9.2-9.2.11]**							
Comments/Observations:								
 438.102 **438.104** **438.108** **438.114** **438.116**	**ACCORDING TO MHD CMS HAS WAIVED THESE REQUIREMENTS FOR WA STATE MENTAL HEALTH SERVICES** **438.102 (a)(2); (b)(1`) – enrollee communications** **438.104 – marketing activities** **438.108 – cost sharing** **438.114 – emergency and post-stabilization services** **438.116 – solvency standards**							
438.106	**LIABILITY FOR PAYMENT** Each PIHP must provide that its Medicaid enrollees are not held liable for any of the following: (a) The PIHP's debts, in the event of the entity's insolvency (b) Covered services provided to the enrollee for which – (1) The state does not pay the PIHP; or (2) The State or the PIHP does not pay the individual or health care provider that furnishes the services under a contractual, referral or other arrangement. (c) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the PIHP provided the services directly.							

Scoring		0	1	2	3	4	5	05
Scoring Guide 1 **[Q13]**	The PIHP subcontracts ensure that Medicaid enrollees are not held liable for payment if the PIHP does not pay its subcontractors or for : • payment of PIHP debt in the event of the entity's insolvency, (RSNs are exempt from this requirement per the CFR) • covered services provided to the enrollee for which the state does not pay the PIHP; or • any service provided on referral that exceeds what the PIHP would cover if provided within the network • community psychiatric hospitals in the event of insolvency **[MHD-PIHP '05-'06 Contract 1.4.9-1.4.9.3 / 1.4.20(c)] [MHD-PIHP '06-'07 Contract 9.4-9.4.5]**							
Comments/Observations:								
438.10 (g) **438.6(h)(2)(i)**	**ADVANCE DIRECTIVES** **Note: Section 438.10(g)(2) requires PIHP enrollees receive information on advance directives. Because of the relationship of advance directives to decisions regarding health care, these provisions are discussed in this section.** 438.10(g) states that, "…PIHPs must provide to their enrollees, information on (2) Advance Directives, as set forth in 438.6(i)(2). (1) All PIHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives. **(Note: Section 422.128(a) requires that each organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 48889 of the chapter. Section 489.102(d) requires adherence to 417.436 requirements that are stated below.** (2) The PIHP must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law. (3) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 **[Q14]**	The PIHP has written policies and procedures for Mental Health Advance Directives (see endnotes for required provisions). **[MHD-PIHP '05-'06 Contract 1.4.3] [MHD-PIHP '06-'07 Contract 9.6.1]**							
[Q15]	The PIHP's policy clearly reflects changes in State law as soon as possible but no later than 90 days after the effective date of the change and the PIHP is able to show evidence of a procedure that supports this. **[MHD-PIHP '05-'06 Contract 1.4.3] [MHD-PIHP '06-'07 Contract 9.6.1]**							
[Q16]	The PIHP specifies in its subcontracts that providers must have policies and procedures for Mental Health Advance Directives. **[MHD-PIHP '05-'06 Contract 1.4.3] [MHD-PIHP '06-'07 Contract 8.3.4]**							

[Q17]	The PIHP subcontracts clearly reinforce the requirement that all adult enrollees must be informed in writing about their right to be advised of Mental Health Advance Directives and the policies as evidenced in their clinical record by a signed statement indicating their choice for a Mental Health Advance Directive or not. (provide example of signed statement) **[MHD-PIHP ’06-’07 Contract 9.6.1]**							
Comments/Observations:								

END NOTES TO FOLLOW

The PIHP policy and procedures for advance directives contain the following provisions:

- Require documentation in each adult enrollee's medical record whether or not the individual has executed an advance directive;
- Protect against the provision of care conditioned upon execution of an advance directive or discrimination against an individual based on whether or not the individual has executed an advance directive.
- Address situations in which an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive.
- Giving advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law.
- Follow-up procedures to ensure that the information is given to the individual directly at the appropriate time; i.e., once he or she is no longer incapacitated or unable to receive such information.
- Policy that informs individuals that complaints concerning non-compliance with the advance directive may be filed with the State survey and certification agency.

42 CFR REFERENCE AND APPLICATION	Subpart D-Quality Assessment and Performance Improvement	8-07-06

ACCESS AND AVAILABILITY STANDARDS

438.204	**ACCESS STANDARDS – State Requirement**
438.206(b)(1)	**AVAILABILITY OF SERVICES** **(a) <u>Basic Rule</u>:** Each State must ensure that all services covered under the State Plan are available and accessible to enrollees of PIHPs. **(b) <u>Delivery Network</u>:** The State must ensure, through its contracts, that each PIHP consistent with the scope of the PIHP's contracted services, meets the following requirements: (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each PIHP must consider the following: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services, considering Medicaid enrollee characteristics and health care needs. (iii) The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services. (iv) The number of network providers who are not accepting new Medicaid patients. (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities. ("Network" refers to the Regional Support Networks subcontracted providers, Community Mental Health Agencies (CMHAs) and their affiliated staff/providers.)

Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q18]	PIHP has a process that monitors the provider network on a reasonable basis to ensure adequate access to all medically necessary services based on b (1)(i) through (v) above. The process entails the following : **[MHD-PIHP '05-'06 Contract 1.3-1.3.3.4 / 4.1 / 4.4] [MHD-PIHP '06-'07 Contract 6.1]**							
Scoring Guide 2 [Q19]	PIHP has a mechanism to monitor change in network sufficiency and to provide reports to the state in a timely fashion. **[MHD-PIHP '05-'06 Contract 4.1-4.3 / 5.5] [MHD-PIHP '06-'07 Contract 6.1.2 / 8.4-8.4.2 / 10.1.2-10.1.3.2]**							
Scoring Guide 2 [Q20]	PIHP manages network adequacy by responding to changes in population served or network providers appropriately and monitors their network to insure that it remains adequate to provide all services including gaps in service capabilities. **[MHD-PIHP '05-'06 Contract 4.2 / 4.3] [MHD-PIHP '06-'07 Contract 6.1 / 10.1.2-10.1.3.2]**							
<u>Comments/Observations</u>:								

		0	1	2	3	4	5	05
438.206(b)(2)	**ACCORDING TO MHD CMS HAS WAIVED THIS REQUIREMENT FOR WA STATE MENTAL HEALTH SERVICES**							
438.206(b)(3)	**DELIVERY NETWORK** **Second Opinion:** The contract must require that the entity provide for a second opinion from a qualified health care professional within the network or arranges for the enrollee to obtain one outside the network at no cost to the enrollee.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 2 [Q21]	The PIHP guarantees enrollees a second opinion and has a mechanism to ensure that this is accomplished in a systematic way and that the PIHP subcontracts clearly pass this requirement on to the providers as part of their service delivery requirements. **[MHD-PIHP '05-'06 Contract 4.13] [MHD-PIHP '06-'07 Contract 13.2]**							
Comments/Observations:								
438.206(b)(4)	**DELIVERY NETWORK CONT'D.** **Out of Network Providers:** If the PIHP is unable to provide covered services, to a particular enrollee, the PIHP must pay for these services to be delivered by non-contracted providers for as long as the PIHP is unable to provide them							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q22]	The PIHP has a policy that lists the above requirement and has developed a system to ensure that subcontractors are aware of the PIHP policy and procedure so that they make out-of-network referrals when necessary. **[MHD-PIHP '05-'06 Contract 1.4 / 4.13] [MHD-PIHP '06-'07 Contract 13.2 / 13.4.23]**							
Comments/Observations:								
438.206(b)(5)	**DELIVERY NETWORK CONT'D.** **Out of Network Providers:** Requires out-of-network providers to coordinate with the PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q23]	The PIHP has policies regarding the use of out of network providers and procedures to support coordination with respect to payment. **[MHD-PIHP '05-'06 Contract 1.4 / 4.13] [MHD-PIHP '06-'07 Contract 13.2 / 13.4.23]**							
Scoring Guide 2 [Q24]	The PIHP has a mechanism to ensure that cost to enrollees when an out of network provider is used is no greater than it would be if the services were furnished within the network. **[MHD-PIHP '05-'06 Contract 1.4 / 4.13] [MHD-PIHP '06-'07 Contract 13.2 / 13.4.23]**							
Comments/Observations:								

438.206(b)(6)	ACCORDING TO MHD CMS HAS WAIVED THIS REQUIREMENT FOR WA STATE MENTAL HEALTH SERVICES							
438.206(c)(1)	**FURNISHING OF SERVICES** **Timely Access:** (i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services; (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for service, if the provider serves only Medicaid enrollees (iii) Makes services available 24 hours a day, 7 days a week when medically necessary (iv) Establish mechanisms to ensure compliance (v) Monitor providers regularly to determine compliance (vi) Take corrective action if there is a failure to comply							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q25]	PIHP ensures compliance with standards regarding timely access (See Access Standards Below). **[MHD-PIHP '05-'06 Contract 1.3.3.5 / 1.3.3.6 / 1.3.4 / 1.3.4.2 / 1.4.20(b)] [MHD-PIHP '06-'07 Contract 6.2-6.2.1.4]**							
Scoring Guide 1 [Q26]	PIHP contracts require network providers to meet the standards for timely access and specify each standard. **[MHD-PIHP '05-'06 Contract 1.3.3.5 / 1.3.3.6 / 1.3.4 / 1.3.4.2 / 1**.4.20(b)] **[MHD-PIHP '06-'07 Contract 6.2-6.2.1.4]**							
Scoring Guide 2 [Q27]	PIHP has mechanisms for oversight of subcontractor compliance with standards for timely access. **[MHD-PIHP '05-'06 Contract 1.4.20(b)] [MHD-PIHP '06-'07 Contract 6.2-6.2.1.4]**							

Review the following Access Standards:

- Intake is initiated within 10 working days, of the request for MH services.
- Routine mental health services are offered to occur within 14 calendar days of determination of eligibility.
- An extension is possible upon request by the enrollee a total of 28 calendar days from request for services to first routine apt. will be the normal time period expected.
- Emergent Care occurs within 2 hours;
- Urgent Care occurs within 24 hours from the request for services.

Comments/Observations:

438.206(c)(2)	**FURNISHING OF SERVICES CONT'D** Each PIHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.							
	PIHP ensures the delivery of culturally competent services regarding :							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 **[Q28]**	Mental Health Specialists as defined in WAC 388-865-0150 and 0415.							
[Q29]	Translation of materials into languages in covered population per contract: oral interpretation in any language, written interpretation in 7 languages (Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese). **[MHD-PIHP '05-'06 Contract 1.4.5.2 / 1.4.5.3]** **[MHD-PIHP '06-'07 Contract 3.1.2-3.1.5]**							
[Q30]	Availability of interpreters in 7 languages (Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese) when needed (including sign language for sensory impairments). **[MHD-PIHP '05-'06 Contract 1.4.5.2 / 1.4.5.3 / 1.4.5.4(b) / 4.10]** **[MHD-PIHP '06-'07 Contract 3.1.2-3.1.5]**							
Comments/Observations:								
	PIHP subcontract has requirements that ensure access to culturally competent service practices utilizing:							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 **[Q31]**	Mental Health Specialists according to WAC 388-865-015.							
[Q32]	Materials translated according to WAC 388-865-0330 requirements related to language thresholds (most commonly used languages).							
Scoring Guide 2 **[Q33]**	PIHP has mechanism for oversight of culturally competent service standards. **[MHD-PIHP '05-'06 Contract 5.2.2 / 1.4.5.2(b)]** **[MHD-PIHP '06-'07 Contract 7.2.2 / 9.2.10 / 9.2.11]**							
Comments/Observations:								
438.207	**ASSURANCES OF ADEQUATE CAPACITY AND SERVICES** **(a) Basic rule:** The State must ensure through its contracts that each PIHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this subpart **(b) Nature of supporting documentation:** Each PIHP must submit documentation to the State in a format specified by the state to demonstrate that it complies with the following requirements: (1) Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area.							

Scoring		0	1	2	3	4	5	05
Scoring Guide 2 [Q34]	Maintains a network of Community Mental Health Agencies (CMHAs) that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. **[MHD-PIHP '05-'06 Contract 1.3.1 / 1.3.3 / 4.1 / 4.4]** **[MHD-PIHP '06-'07 Contract 6.1 / 10.1.2-10.1.3.2]**							
Scoring Guide 2 [Q35]	**(c) Timing of documentation:** Each PIHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following: (1) Current contract requires waiver renewal or when the changes are substantial. (2) At any time there has been a significant change (as defined by the State) in the PIHP's operations that would affect adequate capacity and services including: (i) changes in PIHP services, benefits, geographic service area or payments or (ii) enrollment of a new population in the PIHP. **[MHD-PIHP '05-'06 Contract 1.3.2 / 1.3.2.1 / 5.5]** **[MHD-PIHP '06-'07 Contract 6.1.2 / 8.4-8.4.2 / 11.1.7]**							
438.207(d)(e)	**State Requirements**							
Comments/Observations:								
438.208(a)	**State Requirement**							
438.208(b)(1)-(4)	**ACCORDING TO MHD CMS HAS WAIVED THIS REQUIREMENT FOR WA STATE MENTAL HEALTH SERVICES**							
438.208(c)	**ACCORDING TO MHD CMS HAS WAIVED THIS REQUIREMENT FOR WA STATE MENTAL HEALTH SERVICES** (Therefore questions 36, 37 and 38 have been removed)							
438.210	**State Requirement**							
438.210(b)	**(b) Authorization of Services:** For the processing of requests for initial and continuing authorizations of services, each contract must require: (1) That the PIHP and its subcontractors have in place, and follow, written policies and procedures (Note: subcontractors are typically CMHAs unless there is a contracted ASO organization). (2) Have contracts, written policies and procedures and mechanisms to ensure: (i) Consistent application of review criteria for authorization decisions (ii) Consultation with the requesting provider (3) Require that decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollees condition or disease.							

Scoring		0	1	2	3	4	5	05
Scoring Guide 1 [Q39]	The PIHP ensures that authorization of services occurs within the consistent application of Access to Care Standards published by the MHD throughout the provider network and in consultation with the requesting provider. **[MHD-PIHP '05-'06 Contract 4.6] [MHD-PIHP '06-'07 Contract 6.2.2.3 / 10.1.1.5]**							
Scoring Guide 1 [Q40]	The PIHP ensures that authorization decisions are made by health care professionals with appropriate clinical expertise. (Mental Health Professionals-MHP) **[MHD-PIHP '05-'06 Contract 4.8] [MHD-PIHP '06-'07 Contract 6.2.2.7 / 10.0]**							
Scoring Guide 2 [Q41]	PIHP conducts audits of providers that insure compliance as evidenced by clear policy at the agency level and consistent authorization practices. **[MHD-PIHP '05-'06 Contract 1.4.18 / 1.4.20] [MHD-PIHP '06-'07 Contract 8.2.1 / 8.4.3]**							
Comments/Observations:								
438.210(c)	**(c) Notice of Adverse Action:** Each contract must provide for the PIHP to notify the requesting provider, and give the enrollee written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing. (See 438.404)							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q42]	PIHP ensures that notices of adverse action meet the above requirements. **[MHD-PIHP '05-'06 Contract 3.1.2 / 3.5.4.1] [MHD-PIHP '06-'07 Contract 10.2.7/ 10.2.8.1]**							
Comments/Observations:								
438.210(d)	**(d) Timeframe for Decisions:** Each PIHP contract must provide for the following decisions and notices:							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q43]	**(1) Standard Authorization Decisions:** For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if: (i) The enrollee, of the provider, requests extension: Authorization shall not take more than fourteen calendar days, unless the enrollee or the CMHA requests an extension. An extension of up to 14 additional calendar days is possible upon request by the enrollee or the CMHA. The Contractor must have written policy and procedure to ensure consistent application of requests within the service area. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary. **[MHD-PIHP '05-'06 Contract 1.3.4.1 / 1.3.4.1(a) / 4.6 / 4.8] [MHD-PIHP '06-'07 Contract 6.2.2.3 / 12.2.3.3]**							

Scoring		0	1	2	3	4	5	05
Scoring Guide 1 [Q44]	**(2) Expedited Authorization Decisions**: (i) For cases in which a provider indicates, or PIHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. **[MHD-PIHP '05-'06 Contract 1.3.3.6(a)(b)] [MHD-PIHP '06-'07 Contract 6.2.1.2 / 6.2.1.3 / 6.2.1.3.1]**							
Scoring Guide 1 [Q45]	(ii) The PIHP may extend the 3 working days time period by up to 14 calendar days if the enrollee or the MHCP requests an extension or if the PIHP justifies to the State agency upon request, a need for additional information and how the extension is in the enrollee's interest.							
438.210(e)	**e) Compensation for Utilization Management Activities**: Each contract must provide that, consistent with §438.6(h), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.							
Scoring		0	1	2	3	4	5	05
Scoring Guide 2 [Q46]	If the PIHP contracts with an entity to perform ASO activities the PIHP has mechanisms in place that protect against financial incentives to authorize care in such a way as to minimize financial risk (or maximize financial gain). **[MHD-PIHP '05-'06 Contract 4.12] [MHD-PIHP '06-'07 Contract 10.1.1.4]**							
Comments/Observations:								
438.114	**ACCORDING TO MHD CMS HAS WAIVED THIS REQUIREMENT FOR WA STATE MENTAL HEALTH SERVICES**							
STRUCTURE AND OPERATION STANDARDS								
438.214 (a)(1)-(2) and (b)	**ACCORDING TO MHD CMS HAS WAIVED THIS REQUIREMENT FOR WA STATE MENTAL HEALTH SERVICES**							
438.214 (c)	**Nondiscrimination**: PIHP provider selection policies and procedures, consistent with 438.12 do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.							
Scoring		0	1	2	3	4	5	05
Scoring Guide 1 [Q47]	PIHP guards against discrimination of providers. **[MHD-PIHP '05-'06 Contract 1.4.13 / 1.4.14 / 1.4.15] [MHD-PIHP '06-'07 Contract 8.1.1]**							

Comments/Observations:								
438.12	**Excluded Providers:** PIHPs may not employ or contract with providers excluded from participation in Federal Health Care Programs under either section 1128 or section 1128A of the Act.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q48]	PIHP's provider network policies specify that PIHP may not employ or contract with providers excluded from participation in Federal Health Care Programs under either section 1128 or section 1128 A of the Act. **[MHD-PIHP '05-'06 Contract-Special Terms and Conditions-General Requirements #10]** **[MHD-PIHP '06-'07 Contract 8.5.2]**							
Comments/Observations:								
438.218	**State Requirements**							
438.224	**CONFIDENTIALITY** The State must ensure, through its contracts, that (consistent with Subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a particular enrollee, each PIHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q49]	PIHP has policies regarding compliance with 45 CFR parts 160 and 164, Subparts A and E (HIPPA). **[MHD-PIHP '05-'06 Contract-General Terms and Conditions-General Requirements #5-Confidentiality]** **[MHD-PIHP '06-'07 Contract 11.3.1-11.3.2 / 16.6 / 17.3.1 / 17.3.2]**							
[Q50]	PIHP ensures that subcontractors comply with privacy requirements. **[MHD-PIHP '05-'06 Contract-General Terms and Conditions-General Req #5-Confidentiality / 1.5.3]** **[MHD-PIHP '06-'07 Contract 8.3.10 / 16.6 / 17.3.1 / 17.3.2]**							
[Q51]	PIHP ensures through audits of their subcontractors that procedures are in place that protects privacy according to the provisions of 45 CFR. **[MHD-PIHP '06-'07 Contract 8.4.3]**							
Comments/Observations:								
438.226	**ACCORDING TO MHD CMS HAS WAIVED THIS REQUIREMENT FOR WA STATE MENTAL HEALTH SERVICES**							
438.228	**State Requirement**							

438.230	**SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION** (a) General Rule. The State must ensure, through its contracts, that each PIHP: (1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor, and (2) Meets the conditions of paragraph (b) of this section.							
438.230(b)	**(b) Specific Conditions:** (1) Before any delegation, each PIHP evaluates the prospective subcontractor's ability to perform the activities to be delegated. (2) There is a written agreement that- (i) Specifies the activities and report responsibilities delegated to the subcontractor; and (ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. (3) The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. (4) If the PIHP identifies deficiencies or areas for improvement, the MCO or PIHP and the subcontractor take corrective action. PIHP has policies that state the following conditions:							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q52]	(1) Before any delegation, each PIHP evaluates the prospective subcontractor's ability to perform the activities to be delegated. **[MHD-PIHP '05-'06 Contract 1.4.19 / 1.4.19.1] [MHD-PIHP '06-'07 Contract 8.2.2 / 8.2.2.1]**							
[Q53]	(2) There is a written agreement that-(i) Specifies the activities and reports responsibilities delegated to the subcontractor; and (ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. **[MHD-PIHP '05-'06 Contract 1.4.19 / 1.4.19.2] [MHD-PIHP '06-'07 Contract 8.2.2 / 8.2.2.3]**							
[Q54]	(3) The MCO or PIHP monitors the subcontractor's performance on an annual basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. **[MHD-PIHP '05-'06 Contract 1.4.20] [MHD-PIHP '06-'07 Contract 8.2.1 / 8.2.2]**							
[Q55]	(5) If any MCO or PIHP identifies deficiencies or areas for improvement, the MCO or PIHP and the subcontractor take corrective action. **[MHD-PIHP '05-'06 Contract 1.4.19 / 1.4.19.2 / 1.5.4 / 1.5.5] [MHD-PIHP '06-'07 Contract 8.3.12]**							

Comments/Observations:

MEASUREMENT AND IMPROVEMENT STANDARDS

		0	1	2	3	4	5	05
438.236	**PRACTICE GUIDELINES** **(a) Basic Rule:** The State must ensure, through its contracts, that each PIHP meets the requirements of this section. **(b) Adoption of Practice Guidelines:** Each PIHP adopts practice guidelines that meet the following requirements:							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q56]	(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. (2) Consider the needs of the PIHP's enrollees. (3) Are adopted in consultation with contracting health care professionals. (4) Are reviewed and updated periodically as appropriate. **[MHD-PIHP '05-'06 Contract 3.1.7-3.1.7.4] [MHD-PIHP '06-'07 Contract 7.12-7.12.1.3]**							
Scoring Guide 1 [Q57]	**(c) Dissemination of Guidelines:** Each PIHP disseminates the guidelines to all affected providers and, upon request to enrollees. **[MHD-PIHP '05-'06 Contract 3.1.7.5] [MHD-PIHP '06-'07 Contract 7.12.1.4]**							
Scoring Guide 2 [Q58]	**(d) Application of Guidelines:** Decisions for utilization management, enrollee education coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. **[MHD-PIHP '05-'06 Contract 3.1.7.6] [MHD-PIHP '06-'07 Contract 7.12.1.5 / 8.4.3 / 10.1.1.3]**							
Comments/Observations:								
438.240	**QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM** **(a) General Rules:** (1) The State must require, through its contracts that each PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. (2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with PIHPs. **(b) Basic Elements of PIHP Quality Assessment and Performance Improvement Programs:** At a minimum, the State must require that each PIHP comply with the following requirements:							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 2 [Q59]	**Omitted as there is a separate scoring mechanism for PIPs**							
[Q60]	**Omitted, not being scored**							
[Q61]	(3) Have in effect mechanisms to detect both under utilization and over utilization of services. **[MHD-PIHP '05-'06 Contract 4.1 / 4.5] [MHD-PIHP '06-'07 Contract 10.1.1.4]**							
[Q62]	**Omitted as there is a separate scoring mechanism**							

Scoring Guide 2	**(c) <u>Performance Measurement</u>:** Annually, each PIHP must:							
[Q63]	**Omitted, not being scored**							
[Q64]	**Omitted, not being scored**							
[Q65]	**Omitted, not being scored**							
	(d) <u>Performance Improvement Projects</u>: (1) PIHPs must have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**<u>05</u>**
[Q66]	**Omitted as there is a separate scoring mechanism for PIPs**							
[Q67]	**Omitted as there is a separate scoring mechanism for PIPs**							
[Q67A]	**Omitted as there is a separate scoring mechanism for PIPs**							
[Q67B]	**Omitted as there is a separate scoring mechanism for PIPs**							
[Q67C]	**Omitted as there is a separate scoring mechanism for PIPs**							
<u>Comments/Observations</u>:								

<u>Contract Deliverables</u>:

1. Report the number of individual staff by geographic locations, specialty or type employed or contracted by community mental health agencies to meet access, age, cultural , quality of care and travel standards within 60 days of execution of (this) agreement (42CFR 438-206…)

2. Report changes in the number, mix and/or geographic distribution of CMHAs and qualified personnel to meet:
   a) An appropriate range of services;
   b) The needs of the anticipated number of enrollees;
   c) Access and travel standards, in a CMS approved format to MHD when required by the Waiver renewal or when the changes are substantial 42CFR 438.207(c).

3. Access standards include the following:
   - Routine Care is offered to occur within 10 working days, but not to exceed 14 calendar days;
   - Emergent Care occurs within 2 hours;
   - Urgent Care occurs within 24 hours from the request for services.

4. Time and distance standards in:
   - Rural areas, service sites are within a 30-minute commute time.
   - Large rural geographic areas, service sites are accessible within a 90-minute commute time;
   - Urban areas sites area accessible by public transportation with the total trip not to exceed 90 minutes each way.

42 CFR REFERENCE AND APPLICATION	Subpart F-Grievance System	8-07-06

438.400 **438.402**	**STATUTORY BASIS AND DEFINITIONS** (See CFR text for definitions) **GENERAL REQUIREMENTS** **(a) <u>Grievance System</u>:** The PIHP must have a system in place for enrollees that include a grievance process, an appeal process and access to the State's fair hearing system. **(b) <u>Filing Requirements</u>:** **(1) Authority to file:** (i) An enrollee may file a grievance and a PIHP level appeal and may request a State fair hearing (ii) A community mental health agency, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A community mental health community mental health agency may file a grievance or request a State fair hearing on behalf of an enrollee if the State permits the community mental health agency to act as the enrollee's authorized representative in doing so. **(2) Timing:** The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the PIHP's notice of action Within that timeframe: (i) The enrollee or the community mental health agency may file an appeal; (ii) In a state that does not require prior exhaustion of PIHP level appeals; the enrollee may request a State fair hearing. **(3) Procedures:** (i) The enrollee may file a grievance either orally or in writing and as determined by the State either with the State or with the PIHP. (ii) The enrollee or the community mental health agency may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal.

Scoring		0	1	2	3	4	5	05
Scoring Guide 1 [Q71]	(a) Grievance System: The PIHP must have a system in place for enrollees that includes a grievance process, an appeal process and access to the State's fair hearing system that includes the following: [MHD-PIHP '05-'06 Contract 1.4.6 / Exhibit N] [MHD-PIHP '06-'07 Contract 12] (b) Filing Requirements: (1) Authority to file: (i) An enrollee may file a grievance and a PIHP level appeal and may request a State fair hearing (ii) A community mental health agency, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A community mental health agency may file a grievance or request a State fair hearing on behalf of an enrollee if the State permits the community mental health agency to act as the enrollee's authorized representative in doing so.							
Scoring		0	1	2	3	4	5	05
Scoring Guide 1 [Q72]	(2) Timing: Within the timeframe established by the State – (i) The enrollee or the community mental health agency may file an appeal; (ii)In a state that does not require prior exhaustion of PIHP level appeals; the enrollee may request a State fair hearing. (3) Procedures: (i) The enrollee may file a grievance either orally or in writing and as determined by the State either with the State or with the PIHP. (ii)The enrollee or the community mental health agency may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal. [MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.1.1-12.1.4]							

Comments/Observations:

438.404	NOTICE OF ACTION (a) Language and format requirements as in 438.10(c) and (d). (b) Content of Notice.

Scoring		0	1	2	3	4	5	05
Scoring Guide 2 [Q73]	**(c) Timing of Notice:** The PIHP must mail the notice within the following timeframes: (1) For termination, suspension or reduction of previously authorized Medicaid covered services, within the timeframes specified in 431.211, 431.213 and 431.214 of this chapter. (2) For denial of payment, at the time of any action affecting the claim. (3) For standard service authorization decisions that deny or limit services within the timeframe specified in 438.210(d)(1) and (2). (4) If the PIHP extends the timeframe in accordance with 438.210(d)(1) it must – (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (5) For service authorization decisions not reached within the timeframes specified in 438.210(d) (which constitutes a denial and thus an adverse action), on the date that the timeframes expire. (6) For expedited service authorization decisions, within the timeframes specified in 438.210(d). **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.2]**							

Comments/Observations:

438.406	**HANDLING OF GRIEVANCES AND APPEALS**
	(a) General Requirements: In handling grievances and appeals, each PIHP must meet the following requirements: (1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (2) Acknowledge receipt of each grievance and appeal. (3) Ensure that the individuals who make decisions on grievance and appeals are individuals: (i) Who were not involved in any previous level of review or decision-making; and (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves clinical issues. **(b) Special Requirements for Appeals**: The process for appeals must: (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or community mental health agency requests expedited resolution (2) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PIHP must inform the enrollee of the limited time available for this in case of expedited resolution.) (3) Provide the enrollee and his or her representative opportunity, before and during the appeals process to examine the enrollee's case file, including medical records and any other documents and records considered during the appeals process. (4) Include, as parties to the appeal: (i) The enrollee and his or her representative; or (ii) The legal representative of a deceased enrollee's estate. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.3]**

Scoring		0	1	2	3	4	5	05
Scoring Guide 1 [Q74]	(1) PIHP ensures that enrollees are provided reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD interpreter capability. (PIHP should have Policy and Procedure, Specific Language Requirements (e.g. handbooks, postings) and system of oversight [QA]). **[MHD-PIHP '06-'07 Contract 12.1.5]**							
Scoring Guide 2 [Q75]	(2) Acknowledgement of receipt of each grievance and appeal (What is PIHP Process?) **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.3.1.2]**							
Scoring Guide 1 [Q76]	(3) The PIHP ensures that the individuals who make decisions on grievance and appeals are individuals: (i) Who were not involved in any previous level of review or decision-making; and (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves clinical issues. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.3.1.3 / 12.3.1.4]**							
Scoring Guide 1 [Q77]	**b) <u>Special Requirements for Appeals</u>:** The process for appeals must: (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or community mental health agency requests expedited resolution. (2) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PIHP must inform the enrollee of the limited time available for this in case of expedited resolution.) **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.3.2.1 / 12.3.2.2]**							
Scoring Guide 1 [Q78]	(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process to examine the enrollee's case file, including medical records and any other documents and records considered during the appeals process. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.3.2.3]**							
Scoring Guide 1 [Q79]	(4) Include, as parties to the appeal: (i) The enrollee and his or her representative; or (ii)The legal representative of a deceased enrollee's estate.							
<u>Comments/Observations</u>:								

438.408	RESOLUTION AND NOTIFICATION: Grievances and Appeals							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [80] (Receives one total score)	**(a) Basic Rule:** The PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established time frames that may not exceed time frames specified in this section. **(b) Specific Timeframes:** See Endnotes **(c) Extension of Timeframes:** See Endnotes (1) The PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if: (i) The enrollee requests the extension; or (ii) The PIHP shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest. (2) Requirements following extension. If the PIHP extends the timeframes, it must--for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay. **(d) Format of Notice:** (1) Grievances. The State must establish the method the PIHPs will use to notify an enrollee of the disposition of a grievance. (2) Appeals. (i) For all appeals, the PIHP must provide written notice of disposition. (ii) For notice of expedited resolution, the PIHP must also make reasonable efforts to provide oral notice. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.4-12.4.1.5]**							
Scoring Guide 1 [Q81]	**(e) Content of Notice of Appeal Resolution:** The written notice of the resolution must include the following: (1) The results of the resolution process and the date it was completed. (2) For appeals not resolved wholly in favor of the enrollees- (i) The right to request a State fair hearing, and how to do so; (ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and (iii) The enrollee may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.4.2]**							

Scoring		0	1	2	3	4	5	05
Scoring Guide 1 [Q82]	**(f) Requirements for State Fair Hearings:** **(1) Availability:** The State must permit the enrollee to request a state fair hearing within a reasonable time period specified by the State but not less than 20 or in excess of 90 days from whichever of the following dates applies: (i) If the State requires exhaustion of the PIHP level appeal procedures from the date of the PIHP's notice of resolution; or (ii) If the State does not require exhaustion of the PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing from the date on the PIHP's Notice of Action **(2) Parties:** The parties to the State fair hearing include the PIHP as well as the enrollee and his/or her representative or the representative of a deceased enrollee's estate. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.4.1.6]**							
Comments/Observations:								
438.410	**EXPEDITED RESOLUTION OF APPEALS**							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 2 [Q83]	**(a) General Rule:** Each PIHP must establish and maintain an expedited review process for appeals, when the PIHP determines (a request from the enrollee) or the community mental health agency indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. **(b) Punitive Action:** The PIHP must ensure that punitive action is neither taken against a community mental health agency that requests an expedited resolution or supports an enrollee's appeal. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.1.4 / 12.3.1.5]**							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 2 [Q84]	**(c) Action following denial of a request for expedited resolution:** If the PIHP denies a request for expedited resolution of an appeal, it must: (1) Transfer the appeal to the timeframe for standard resolution in accordance with 438.408(b)(2); (2) Give the enrollee prompt oral notice of the denial, and follow up within 2 calendar days with a written notice.							

Comments/Observations:

438.414	INFORMATION ABOUT THE GRIEVANCE SYSTEM TO COMMUNITY MENTAL HEALTH AGENCIES AND AGENTS OF THE PIHP							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 1 [Q85]	The PIHP must provide the information specified at 438.10(g)(1) about the grievance system to all community mental health agencies and subcontractors at the time they enter into a contract, using a State developed description that must include: (i) The right to file grievances; (ii)The requirements and timeframes for filing a grievance; and (iii)The availability of assistance in the filing process; and (iv)Toll free numbers that the enrollee can use to file a grievance. **[MHD-PIHP '05-'06 Contract 1.5.8] [MHD-PIHP '06-'07 Contract 8.3.15 / 12.5.4-12.5.4.1]**							

Comments/Observations:

438.416	**RECORDKEEPING AND REPORTING REQUIREMENTS** The State must require PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 2 [Q86]	PIHP has a mechanism to maintain records of grievances and appeals. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.6]**							
Scoring Guide 2 [Q87]	PIHP has a mechanism for reviewing grievances and appeals and creating quality improvements. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.6.2.4]**							

Comments/Observations:

438.420	**CONTINUATION OF BENEFITS WHILE THE PIHP APPEAL AND THE STATE FAIR HEARING ARE PENDING** **(a) Terminology:** As used in this section, "timely" filing means filing on or before the later of the following: (1) Within 10 days of the PIHP mailing the notice of action (2) The intended effective date of the PIHP's proposed action **(b) Continuation of Benefits:** The PIHP must continue the enrollee's benefits if: (1) The enrollee or the provider files the appeal timely; (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment ; (3) The services were ordered by an authorized provider; (4) The original period covered by the original authorization has not expired; and (5) The enrollee requests extension of benefits **(c) Duration of Continued or Reinstated Benefits:** If, at the enrollee's request, the PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: (1) The enrollee withdraws the appeal. (2) Ten days pass after the PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. (3) A State fair hearing Office issues a hearing decision adverse to the enrollee (4) The time period or service limits of a previously authorized service has been met. **Enrollee Responsibility for Services Furnished While the Appeal is Pending:** If the final resolution of the appeal is adverse to the enrollee, that is, upholds the PIHP's action, the PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 431.230(b) of this chapter.							
Scoring		**0**	**1**	**2**	**3**	**4**	**5**	**05**
Scoring Guide 2 [Q88]	PIHP ensures that the rights of enrollees as delineated above are upheld during the time period during which an appeal or State fair hearing is pending. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.5]**							
Comments/Observations:								
438.424	**EFFECTUATION OF REVERSED APPEAL RESOLUTIONS** **(a) Services not Furnished While the Appeal is Pending:** If the PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires. **(b) Services Furnished While the Appeal is Pending:** If the PIHP , or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.							

42 CFR REFERENCE AND APPLICATION	Subpart F-Grievance System	8-07-06

Scoring		0	1	2	3	4	5	05
Scoring guideline 2 [Q89]	PIHP has mechanism to ensure that enrollees' rights are upheld regarding the authorization / provision of disputed services. **[MHD-PIHP '05-'06 Contract Exhibit N] [MHD-PIHP '06-'07 Contract 12.5.3]**							
Comments/Observations:								

End Notes

Resolution and notification of grievances and appeals:

- Completion of a grievance disposition – within 90 calendar days of receipt
  PIHP – has 30 calendar days unless there is mutual written agreement to extend in that case can be extended up to another 60 calendar days
- State specified timeframes for a standard disposition of a grievance -not more **than 30 days** from statement of grievance
- State specified timeframes for a standard resolution of an appeal - not more than **45 calendar days** from receipt of notice of appeal
- State specified timeframes for extensions on disposition of grievances up to **14 calendar days** if the enrollee requests extension, or MHD provides written approval
- State specified timeframes for extensions on disposition of appeals - up to **14 calendar** days if the enrollee requests extension, or MHD provides written approval
- State specified timeframes for expedited resolution of appeal – can not exceed more than **3 working days** after the PIHP receives the appeal

State Fair Hearings:

- State specified timeframes for request for an enrollee State Fair Hearing:
  Standard service authorization decisions –not less than **20 days** and not more than **90 days** from date of the PIHP's notice of resolution of an appeal.
  Appeals regarding termination, suspension or reduction of services – within **10 days** from date of the PIHP's notice of resolution of an appeal.

Note: State requires exhaustion of all PIHP level "appeal" procedures prior to request for State Fair Hearing. If the PIHP fails to adhere to notification timeframes the enrollee can exercise his or her rights to a State Fair Hearing.

CFR REFERENCE AND APPLICATION	SUBPART H – CERTIFICATIONS AND PROGRAM INTEGRITY	8-07-06

NOTE: FOR SUBPART H SCORING GUIDELINES 1 AND 2 DO NOT APPLY. USE THE SCORING GUIDE INDICATED IN THE LEFT HAND COLUMN.

438.600	**STATUTORY BASIS AND DEFINITIONS – State Requirement**			
438.602	**Basic Rule** As a condition for receiving payment under the Medicaid managed care program, a PIHP must have a mechanism to ensure compliance with the applicable certification, program integrity and prohibited affiliation requirements of this subpart.			
438.604	**Data that Must be Certified** (a) Data Certifications. When State payments to a PIHP are based on data submitted by the PIHP, the State must require certification of the data as provided in 438.606. The data that must be certified include, but are not limited to: enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents. (b) Additional certifications. Certification is required as provided in 438.606 for all documents specified by the State.			
438.606 [Q90]	**Source, Content and Timing of Certification**			
Scoring		**0**	**1**	**05**
0 = No Evidence **1 = Evidence Exists**	**(a) Source of Certification:** For the data specified in 438.604, the data the PIHP submits to the State must be certified by one of the following: (1) The PIHP's Chief Executive Officer; (2) The PIHP's Chief Financial Officer ; or (3) An individual who has delegated authority to sign for, and who reports directly to the PIHP's CEO or CFO. **[MHD-PIHP '05-'06 Contract 6.5] [MHD-PIHP '06-'07 Contract 11.5]**			
0 = No Evidence **1 = Evidence Exists**	**(b) Content Certification:** The certification must attest, based on best knowledge, information and belief as follows:	**0**	**1**	**05**
	(1) To the accuracy, completeness and truthfulness of the data. **[MHD-PIHP '05-'06 Contract 6.5] [MHD-PIHP '06-'07 Contract 11.5]**			
	(2) To the accuracy completeness and truthfulness of the documents specified by the State. **[MHD-PIHP '05-'06 Contract 6.5] [MHD-PIHP '06-'07 Contract 11.5]**			
	(3) Timing of certification. The PIHP must submit the certification concurrently with the certified data. **[MHD-PIHP '05-'06 Contract 6.5] [MHD-PIHP '06-'07 Contract 11.5]**			

Comments/Observations:

CFR REFERENCE AND APPLICATION	SUBPART H – CERTIFICATIONS AND PROGRAM INTEGRITY	8-07-06

438.608 [91]	**PROGRAM INTEGRITY REQUIREMENTS** **(a) General requirement:** The PIHP must have administrative and management arrangements or procedures including a mandatory compliance plan that are designed to guard against fraud and abuse. **[MHD-PIHP '05-'06 Contract 1.4.10 / 1.4.10.1]** **[MHD-PIHP '06-'07 Contract 17.8]**			
Scoring		**0**	**1**	**05**
0 = No Evidence **1 = Evidence Exists**	**(b) Specific requirements:** The arrangements or procedures must include the following:			
	(1) Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards. **[MHD-PIHP '05-'06 Contract 1.4.10.2] [MHD-PIHP '06-'07 Contract 17.8-17.8.2]**			
	(2) The designation a compliance officer and a compliance committee that are accountable to senior management. **[MHD-PIHP '05-'06 Contract 1.4.10.3] [MHD-PIHP '06-'07 Contract 17.8.3]**			
	(3) Effective training and education for the compliance officer and the organization's employees. **[MHD-PIHP '05-'06 Contract 1.4.10.4] [MHD-PIHP '06-'07 Contract 17.8.4]**			
	(4) Effective lines of communication between the compliance officer and the organization's. employees. **[MHD-PIHP '05-'06 Contract 1.4.10.5] [MHD-PIHP '06-'07 Contract 17.8.5]**			
	(5) Enforcement of standards through well-publicized disciplinary guidelines. **[MHD-PIHP '05-'06 Contract 1.4.10.6] [MHD-PIHP '06-'07 Contract 17.8.6]**			
	(6) Provision for internal monitoring and auditing. **[MHD-PIHP '05-'06 Contract 1.4.10.7] [MHD-PIHP '06-'07 Contract 17.8.7]**			
	(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the PIHP's contract. **[MHD-PIHP '05-'06 Contract 1.4.10.8] [MHD-PIHP '06-'07 Contract 17.8.8-17.8.9]**			
Comments/Observations:				

CFR REFERENCE AND APPLICATION	SUBPART H – CERTIFICATIONS AND PROGRAM INTEGRITY	8-07-06

438.610	**Prohibited affiliations with individuals debarred by Federal agencies**			
Scoring		**0**	**1**	**05**
Scoring Guide 2 [92]	**(a) General Requirement:** A PIHP may not knowingly have a relationship of the type described in paragraph (b) of this section with the following: (1) An individual who is debarred suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issues under Executive Order No. 12549 or under guidelines implementing Executive Order No 12549. . (2) An individual who is an affiliate as defined in the Federal Acquisition paragraph (a)(1) of this section. **(b) Specific requirements:** The relationships described in this paragraph are as follows: (1) A director, officer, or partner of the PIHP (2) A person with beneficial ownership of five percent or more of the PIHP's equity (3) A person with an employment consulting or other arrangement with the PIHP for the provision of items and services that are significant and material to the PIHP's obligations under its contract with the State. **[MHD-PIHP '05-'06 Contract-General Terms and Conditions-Definitions #7 / Special Terms and Conditions-General Requirements-#11]] [MHD-PIHP '06-'07 Contract 8.5 and 16.8]**			
438.610	**(c) Effect of Noncompliance-State Requirement**			
Comments/Observations:				