2008 External Quality Review Annual Report

Washington State Healthy Options

State Children's Health Insurance Program

Mental Health Division Program

Washington Medicaid Integration Partnership

Medicare/Medicaid Integration Project

December 2008

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Presented to Washington State Department of Social & Health Services,
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Table of contents

Executive Summary 1
Introduction 5
Washington's Medicaid managed care programs 6
State quality improvement activities 8
Methods 13
Mental health care delivered by RSNs 15
Access to mental health care 18
Timeliness of mental health care 20
Quality of mental health care 22
Clinical record review 23
Mental health regulatory and contractual standards 30
Mental health PIP validation 37
Mental health performance measure validation 47
Mental health encounter data validation 51
Physical health care delivered by MCOs 57
Access to physical health care 59
Timeliness of physical health care 62
Quality of physical health care 64
Physical health regulatory and contractual standards 67
Physical health PIP validation 73
Washington Medicaid Integration Partnership Evaluation 81
Washington Medicare/Medicaid Integration Project Evaluation 87
Discussion and Recommendations 92
References 101
Appendix A. RSN Profiles A-1
Appendix B. MCO Profiles B-1
Appendix C. Elements of Regulatory and Contractual Standards C-1
Appendix D. Performance Improvement Project Review Steps D-1

Index of tables and figures

Tables

Table 1. Required and optional Medicaid managed care EQR activities 12
Table 2. Mental health Regional Support Networks and enrollees served, December 2007....15
Table 3. Responses to clinical record review questions....24
Table 4. Coordination of care for mental health enrollees by agency type 28
Table 5. Proportion of issues addressed and not addressed in mental health treatment plans...29
Table 6. Resolution of deferred, rule-out, or provisional diagnoses....29
Table 7. Issues in RSN corrective action plans....36
Table 8. Standards for RSN PIP validation....38
Table 9. PIP scoring ranges on 80-point scale 38
Table 10. PIP topics by RSN 39
Table 11. Performance measure validation ratings....48
Table 12. Results of electronic data checks 54
Table 13. Results of encounter data validation....55
Table 14. Healthy Options MCOs and enrollees served, December 2007 57
Table 15. Washington scores and national averages for physical health access measures....60
Table 16. MCO and state scores on access measures 61
Table 17. Washington scores and national averages for physical health timeliness measure 62
Table 18. MCO and state scores on timeliness measure....63
Table 19. Washington scores and national averages for physical health quality measures....65
Table 20. MCO and state scores on quality measures 66
Table 21. MCO compliance scores for physical health regulatory and contractual standards ...69
Table 22. Disposition of MCOs' corrective action plans....72
Table 23. PIP topics and scores by MCO 74
Table 24. Community Health Plan PIP topics and scores, 2006–2008 75
Table 25. Columbia United Providers PIP topics and scores, 2006–2008 76
Table 26. Group Health Cooperative PIP topics and scores, 2006–2008....77
Table 27. Kaiser Permanente Northwest PIP topics and scores, 2006–2008 78
Table 28. Molina Healthcare of Washington PIP topics and scores, 2006–2008....79
Table 29. Regence BlueShield/Asuris Northwest Health PIP topics and scores, 2006–2008....80
Table 30. WMIP comprehensive diabetes care measures, 2006–2008....82
Table 31. WMIP inpatient utilization, general hospital/acute care measures, 2006–2008....82
Table 32. WMIP inpatient utilization, nonacute care measures, 2007–2008 83
Table 33. WMIP ambulatory care measures, 2006–2008....83
Table 34. WMIP antidepressant medication management measures, 2008....83
Table 35. WMIP follow-up after hospitalization for mental illness measures, 2008 83
Table 36. WMIP use of high-risk medications for the elderly measures, 2007–2008....84
Table 37. WMIP compliance scores 85
Table 38. WMIP PIP topics and scores....86
Table 39. Washington MMIP falls risk screening measure....88
Table 40. Washington MMIP dementia screening measure 88
Table 41. Washington MMIP depression screening measure....88
Table 42. Washington MMIP compliance scores 89
Table 43. Washington MMIP PIP topics and scores 90

Figures

Figure 1. Organizational chart for DSHS, HRSA, MCOs, and RSNs 5
Figure 2. Components in measuring the quality of health care....14
Figure 3. Geographical coverage of RSNs....16
Figure 4. RSN compliance scores: Enrollee Rights 31
Figure 5. RSN compliance scores: Grievance Systems 34
Figure 6. Average scores by validation standard for clinical and nonclinical PIPs....40
Figure 7. RSN scores on clinical PIPs....41
Figure 8. RSN scores on nonclinical PIPs....41
Figure 9. Geographical coverage of Healthy Options MCOs 57
Figure 10. Percentiles and star ratings used for this report 58
Figure 11. Changes in compliance scores for selected physical health regulatory standards by MCO, 2007–2008 70

Acronyms used in this report

ADSA	Aging and Disability Services Administration
ALOS	average length of stay
BBA	Balanced Budget Act of 1997
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIS	Children’s Healthcare Improvement System
CMS	Centers for Medicare & Medicaid Services
DHS	Division of Healthcare Services (HRSA)
DOH	Department of Health
DSHS	Department of Social and Health Services
E&T	evaluation and treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	emergency room
FFS	fee for service
GAF	Global Assessment of Functioning
HEDIS®	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act of 1996
HRSA	Health and Recovery Services Administration
ISCA	Information Systems Capabilities Assessment
MCO	managed care organization
MMIP	Medicare/Medicaid Integration Project
NCQA	National Committee for Quality Assurance
NOA	notice of action
NOD	notice of determination
PACT	Program of Assertive Community Treatment
PCP	primary care provider
PIP	performance improvement project
QAPI	quality assurance and performance improvement
QI	quality improvement
QRT	Quality Review Team
RSN	Regional Support Network
S-CHIP	State Children’s Health Insurance Program
SHCN	special healthcare needs
WCC	well-child care
WMIP	Washington Medicaid Integration Partnership
WSC	Washington State Collaborative to Improve Health

Acronyms for individual RSNs and MCOs are listed on pages 15 and 57, respectively.

Executive Summary

The federal Balanced Budget Act (BBA) of 1997 requires each state to implement a strategy for assessing and improving the quality of health care delivered to Medicaid enrollees through managed care. The BBA also requires an annual, independent external quality review (EQR) of enrollees' access to services and of the quality and timeliness of those services. Acumentra Health produced this EQR annual report on behalf of the Washington Department of Social and Health Services (DSHS), Health and Recovery Services Administration (HRSA).

This report builds on the findings of previous annual reports from 2005 through 2007, which focused on physical health services provided through the Healthy Options managed care organizations (MCOs) and overseen by HRSA's Division of Healthcare Services (DHS). In addition, Medicaid mental health services have been capitated since 1994. For the first time, this report incorporates a review of mental health services provided through the state's 12 Regional Support Networks (RSNs) and overseen by HRSA's Mental Health Division (MHD).

Separately, this report presents quality measurements for

- the Washington Medicaid Integration Partnership, aimed at improving health care for adult enrollees in Snohomish County who are eligible for both Medicaid and Medicare and who have complex healthcare needs
- the Medicare/Medicaid Integration Project, serving Medicare- and Medicaid-eligible clients age 65 and older in King and Pierce counties (discontinued in June 2008)

To evaluate the services delivered to Medicaid enrollees by the MCOs and RSNs, Acumentra Health analyzed data on a variety of performance indicators and compliance criteria. The data elements analyzed for this annual report came from individual reports produced for HRSA during 2008, and reflect MCO and RSN performance in contract year 2007.

State-level highlights

Acumentra Health identified high-level strengths of the Medicaid managed care program.

- Recent state legislation and policy initiatives have focused on improving health care and providing medical homes for children, the predominant segment of the population served by Washington's Medicaid program.
- The MCOs are fully complying with most requirements for coverage, authorization, and availability of services.
- The RSNs typically provide timely access to outpatient care and telephone access to crisis services 24 hours a day, 7 days a week. All RSNs can dispatch designated mental health professionals for emergency evaluations around the clock.
- Pilot projects are underway through the MCOs and RSNs to improve access to care for Medicaid enrollees in minority communities, those with severe and persistent mental illnesses and co-occurring disorders, and children who need mental health services.
- The MCOs generally ensure their enrollees an ongoing source of appropriate primary care and coordination of healthcare services. All MCOs use evidence-based practice guidelines for utilization management, enrollee education, and service coverage.

- RSNs across the state are implementing the Recovery Model of care, with emphasis on increasing enrollees' dignity, respect, and involvement in the design and delivery of mental health services. Increased consumer involvement in care has resulted in greater awareness of system issues, improvements in quality of care, and support for innovative program strategies, such as supported employment.
- HRSA's efforts to align provider payments with quality improvements through contract incentives for MCO performance have led to gains in standard measures of preventive care, including childhood immunizations and well-child care (WCC) visits.
- The Healthy Options MCOs continue to perform above the national average Medicaid performance in providing diabetes testing for adults and timely postpartum care for female enrollees. Two-thirds of Medicaid children are receiving the Combo 2 package of immunizations, and the Combo 2 rate has risen steadily since 2002.
- The Washington State Collaborative to Improve Health, funded primarily by HRSA, the Department of Health, and MCOs, combines the quality improvement (QI) efforts of local clinics, tribal organizations, and MCOs to improve preventive care for children and adults with chronic conditions.

Recommendations

Mental health care delivered by RSNs

Recommendations for improving the system of managed mental health care emerged from the baseline results of RSN site visits conducted by Acumentra Health during 2008. The Washington RSNs are still in transition to the BBA regulatory environment. Many are still updating policies and procedures, enrollee information materials, and other operations in response to EQR requirements. The RSNs generally are dedicated to serving Medicaid enrollees and have made commendable efforts to maintain their effectiveness in the face of resource limitations.

Care coordination. Although Washington has established the goal of integrating primary care and mental health services, most RSNs have not progressed beyond initial steps toward that goal.

- ***MHD needs to work with RSNs to establish standards and priorities for coordinating mental health and primary care services.***
- ***MHD needs to takes steps to ensure exchange of information between the mental health clinician and the primary care provider (PCP), and between the mental health clinician and ancillary agencies.***

Managing care. Many RSNs have not yet implemented level-of-care guidelines for outpatient services. The majority of service authorizations are based solely on qualifying diagnoses. Services are authorized for six months or a year, with limited attempts to manage resources for ongoing mental health care. Only limited information from clinical assessments is considered during the authorization process. Assessments often do not fully address functional impairment and the services needed to support progress toward the enrollee's recovery.

- ***MHD needs to increase efforts to clarify the criteria for initial and continuing care, to assist RSNs in effectively managing outpatient mental health services in line with the Recovery Model.***

- ***MHD needs to require RSNs to ensure that providers***
  - ***document psychiatric symptoms that establish medical necessity and meet access-to-care standards for authorization of ongoing services***
  - ***clarify deferred, rule-out, or provisional diagnoses within 180 days***
  - ***assess and address sensitive cultural issues when developing treatment plans***

Mental health assessments. Reviewers found many cases in which comprehensive assessments occurred only at intake and were more than 10 years old. Although the enrollee's clinical status is updated with each service reauthorization, reassessments tend to be very brief and generally focus on only the primary diagnosis.

- ***MHD needs to establish a policy regarding the frequency of comprehensive reassessment of the enrollee's treatment needs.***

Provider oversight. RSNs delegate many responsibilities associated with meeting federal standards to provider agencies as part of the contracting process. While each RSN has a process for monitoring the delivery of services, the RSNs do not always fully monitor other responsibilities delegated to provider agencies, such as handling of grievances and appeals. In addition, most RSNs use a review protocol aligned with the Washington Administrative Code and statutes, which does not cover all federal regulatory requirements.

- ***MHD needs to clarify the requirements for RSNs to monitor their provider networks versus the state's licensing of community mental health agencies. The RSNs need to ensure that they monitor all delegated functions as required by federal regulations, and take corrective action as needed.***

Data improvements. Because MHD's data system does not distinguish Medicaid enrollees at state hospitals and evaluation and treatment (E&T) facilities, the state cannot calculate statewide performance measures that apply only to Medicaid enrollees. Currently, MHD calculates only one of four contractual performance measures, and that measure describes the general population, not the Medicaid population. Although MHD has devoted some staff resources to calculating the statewide PIP indicators, the state has yet to produce timely and accurate calculations.

- ***MHD needs to upgrade the data system used to calculate performance measures in order to identify Medicaid patients receiving state hospital or E&T services, to enable accurate calculation of the measure of timely follow-up care.***
- ***MHD needs to calculate all four of its statewide performance measures for the RSNs serving Medicaid enrollees.***

Physical health care delivered by MCOs

Recommendations for improving the system of managed physical health care build on the observations presented in previous EQR annual reports.

Value-based purchasing. Contractual pay-for-performance incentives have focused the MCOs on working to improve immunization and preventive care rates for children. Early results have been positive, and moving the incentives downstream may lead to further improvement.

- ***HRSA should redirect a significant portion of MCO incentive funds to the provider level.***

Improving preventive care. While most children in Healthy Options have access to primary care, the majority of children still are not receiving preventive care regularly when they visit their PCPs. MCOs may be able to improve preventive care for their Medicaid enrollees by participating in joint projects or by pooling resources.

- ***HRSA should consider organizing a statewide PIP targeting WCC visit rates.***

Compliance review. TEAMonitor, the interagency team that oversees the state's managed care contracts with MCOs, has refined its compliance review process over the past three years and could improve the process further.

- ***TEAMonitor should consider incorporating visits to provider clinic sites into its annual compliance review.***

Data improvements. The MCOs must devote considerable resources to medical chart reviews to collect some of the data they need to generate the required measures of clinical performance. Better administrative data would enable the MCOs to redirect some of the resources spent on data collection toward providing better care for enrollees.

- ***HRSA should continue to help the MCOs study and overcome barriers to collecting adequate administrative data for performance measures, such as through a study aimed at improving or validating encounter data.***

Washington Medicaid Integration Partnership

- ***WMIP program managers with Molina Healthcare of Washington should collaborate with RSNs to learn more about their use of the Recovery Model, including enrollee outcomes, barriers to care, outreach, and intervention practices.***
- ***WMIP program managers in DHS should meet with MHD to share program outcomes and explore ways to improve care processes to meet the common needs of their service populations.***
- ***Molina should discuss with the North Sound Mental Health Administration or other RSNs the feasibility of a collaborative project, the outcome of which could benefit the WMIP population. An example might be the development of a new nonclinical PIP to improve the delivery of noncritical services after psychiatric hospitalizations.***

EQR follow-up

Future improvements will result from the interplay of the DHS and MHD managed care quality strategies, QI activities, and annual reporting. The EQR results, reported annually, should inform the quality strategies, which are deployed through contract requirements.

- ***HRSA should implement contractual requirements for all MCOs and RSNs to address the specific recommendations in this report.***
- ***HRSA should merge and integrate the DHS and MHD Medicaid quality strategies to reflect a coordinated approach to managed care for physical and mental health.***

Introduction

Washington's Medicaid managed care program, administered by HRSA, provides medical benefits for more than 900,000 low-income residents, about half of whom are enrolled in Healthy Options. More than 700,000 residents are enrolled in managed mental health services, and about 3,000 clients are enrolled in the Washington Medicaid Integration Partnership. DHS and MHD meet the healthcare needs of these enrollees through contracts with medical MCOs and mental health RSNs, respectively. The MCOs and RSNs, in turn, contract with healthcare providers for service delivery. (See Figure 1.)

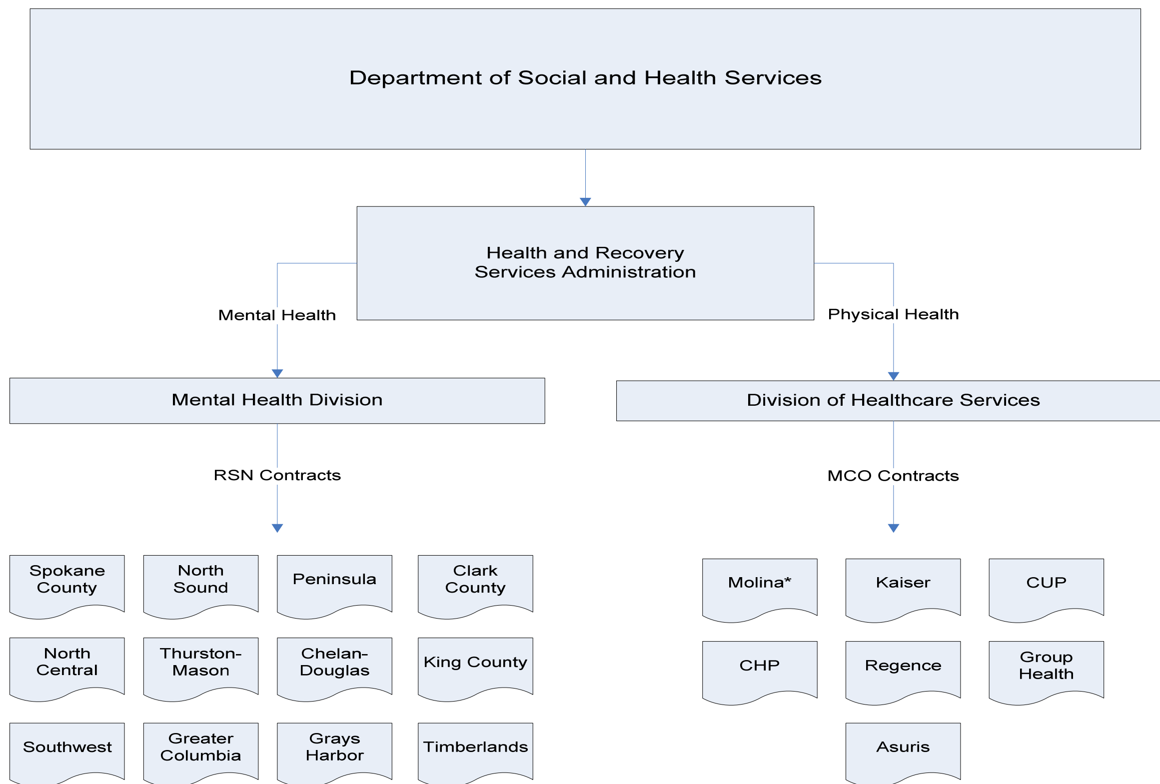

Figure 1. Organizational chart for DSHS, HRSA, MCOs, and RSNs.

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

This report contains information collected from MCOs and RSNs through the following activities, conducted according to protocols approved by the Centers for Medicare & Medicaid Services (CMS):

- **compliance monitoring**—site reviews of the Medicaid managed care plans to determine whether they meet federal and state standards for enrollee access to care, managed care structure and operation, and quality measurement and improvement
- **validation of performance improvement projects (PIPs)** to determine whether the health plans meet standards for conducting these required QI studies
- **validation of performance measures** reported by health plans or calculated by the state, including
  - Healthcare Effectiveness Data and Information Set (HEDIS®)* measures of clinical services provided by MCOs
  - statewide performance measures used to monitor the delivery of mental health services by RSNs

For the MCOs, HRSA monitors compliance and validates PIPs through TEAMonitor, a state interagency team responsible for reviewing physical health managed care. For the RSNs, Acumentra Health monitors compliance and validates PIPs on behalf of MHD.

EQR activities may encompass optional activities, such as studies that focus on the quality of clinical or nonclinical services. This annual report presents the results of two such activities that MHD has chosen to conduct in order to advance its QI goals:

- validation of the RSNs' mental health encounter data to ensure that the data meet standards of completeness and accuracy
- a review of clinical records to assess the quality of services provided by RSNs

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

Washington's Medicaid managed care programs

Medicaid eligibility is based on federal poverty guidelines issued annually by the U.S. Department of Health and Human Services. Historically, Washington has chosen to fund its Medicaid program above the federal minimum standard to cover additional low-income residents. State legislation in 2007 enacted the following changes in Medicaid eligibility and benefits:

- expanded Medicaid coverage to all children in families up to 250 percent of the Federal Poverty Level (FPL), or $51,635 for a family of four, and required premiums for families with incomes above 200 percent of the FPL, or $41,300 for a family of four
- appropriated $63 million to cover 38,500 new children

* HEDIS is a registered trademark of the National Committee for Quality Assurance.

Healthy Options

The Healthy Options program provides comprehensive medical benefits for low-income families, children younger than 19, and pregnant women who meet income requirements. Managed care programs also include Basic Health Plus, providing reduced-cost coverage to qualified residents, and the State Children's Health Insurance Program (S-CHIP), covering families who earn too much money to qualify for Medicaid, yet cannot afford private insurance.

Currently, Washington provides medical care for an average of about 500,000 Medicaid enrollees in managed care at an annual cost of $1 billion, and for a roughly equal number of clients in fee-for-service (FFS) programs, at a cost of $2.5 billion. More than 80 percent of Healthy Options enrollees are younger than 19 years old.

Managed mental health care

The state's RSNs provide mental health services to about 725,000 enrollees in managed care. Another 100,000 enrollees residing in Pierce County receive FFS mental health coverage administered by MHD.

Washington Medicaid Integration Partnership (WMIP)

This Medicaid pilot project, aimed at improving care for adult residents of Snohomish County who have complex healthcare needs, began in January 2005. WMIP seeks to coordinate Medicaid-funded medical, mental health, substance abuse, and long-term care within a patient-centered framework. Molina Healthcare of Washington (MHW) coordinates services for WMIP clients. As of October 2008, almost 3,000 clients were enrolled in WMIP.

Medicare/Medicaid Integration Project (MMIP)

This state demonstration project, launched in June 2005, targeted Medicare- and Medicaid-eligible clients age 65 and older in King and Pierce counties. The MMIP focused on preventive care and coordination to improve health outcomes and reduce expenditures for dual-eligible clients. Evercare Premier coordinated medical and long-term care services for these clients. This program ended in June 2008.

State quality improvement activities

DHS and MHD conduct and oversee a combination of mandatory and optional QI activities related to Medicaid managed care, as described below.

Managed Care Quality Strategy

DHS's *Managed Care Quality Strategy* incorporates elements of the managed care contract, state and federal regulations, and CMS protocols related to assessing and improving the quality of services for Medicaid enrollees. Acumentra Health evaluated the quality strategy in August 2005 and found that it complies with the majority of federal standards regarding enrollee access, managed care structure and operations, and quality measurement and improvement.

As recommended in the 2007 EQR annual report, DHS has dedicated resources to updating the Quality Strategy, last revised in 2003, and plans to issue a draft of the updated version for public comment in December 2008.

MHD's Quality Strategy, approved by CMS in December 2003 and updated in April 2007, incorporates quality assurance and performance improvement activities and expectations for the RSNs. The strategy also sets the framework for changes associated with the transition to an integrated system of medical, mental health, and chemical dependency care. Acumentra Health will evaluate the strategy as an EQR activity in 2010.

Performance improvement projects

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

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

Through repeated measurement of the quality indicators, a PIP is expected to show meaningful change in performance relative to the performance observed during baseline measurement.

The 2008–2009 Healthy Options contract requires each MCO to conduct at least one clinical and one nonclinical PIP. The previous contract called for each MCO to conduct five PIPs. An MCO must conduct a PIP to improve immunization and/or WCC rates if the MCO's reported rates fall below established benchmarks. DHS validates the PIPs' compliance with CMS standards through the TEAMonitor reviews, using the review protocol shown in Appendix D.

In addition to these required PIPs, each MCO must participate in the ongoing Washington State Collaborative to Improve Health. This group learning project, funded primarily by DHS, the Department of Health (DOH), and the MCOs, is part of a multi-year effort to improve health care for Washingtonians with chronic diseases such as asthma, diabetes, and heart disease.

For the WMIP program, MHW conducted five PIPs in 2008 targeting improvements in care and nonclinical services. All five projects were carried over from 2007, including two contractually required PIPs on chemical dependency topics.

MHD requires each RSN to conduct one clinical and one nonclinical PIP annually. Acumentra Health validates the PIPs using a review protocol approved by MHD. RSN representatives have worked with MHD to establish a topic for a statewide nonclinical PIP: improving the timeliness of outpatient appointments following a client's discharge from a psychiatric hospital. For 2008, 10 of the 12 RSNs submitted the statewide nonclinical PIP for validation.

Performance measurement

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

performance. The EQRO validates the measures annually through methods specified by CMS or the National Committee for Quality Assurance (NCQA).

Physical health performance measures

DHS takes steps to ensure that MCOs meet national performance benchmarks. The Healthy Options contract incorporates NCQA accreditation standards related to quality management and improvement, utilization management, and enrollee rights and responsibilities. The contract contains specific provisions regarding the performance measures described below.

HEDIS®: Since 1998, DHS has used the results of MCO performance in HEDIS measures for quality measurement. Valid and reliable, the HEDIS measures allow comparison of Washington MCOs' performance with national aggregated averages for the Medicaid population.

For reporting year 2008, DHS required each MCO to report HEDIS rates for

- childhood immunization status
- comprehensive diabetes care
- postpartum care
- WCC visits for infants, children, and adolescents
- utilization of inpatient and ambulatory care
- frequency of selected procedures (myringotomy/adenoidectomy, hysterectomy, mastectomy, and lumpectomy)
- race/ethnicity diversity of MCO membership

The latter two measures were a new requirement for reporting year 2008. At the same time, DHS dropped the requirement for MCOs to report rates for chlamydia screening, asthma medications, access to primary care practitioners for children, prenatal care, and newborn discharges.

MHW reported seven HEDIS measures for the WMIP population:

- comprehensive diabetes care
- inpatient utilization, general hospital/acute care
- inpatient utilization, nonacute care
- ambulatory care utilization
- anti-depression medication management
- follow-up after hospitalization for mental illness
- use of high-risk medications for the elderly

To ensure data integrity, NCQA requires certification of each health plan's data collection process by a certified HEDIS auditor. DHS funded the 2008 HEDIS audit for Washington health plans to fulfill the federal requirement for validation of performance measures. MHW (for the WMIP) and Evercare (for the MMIP) underwent a certified HEDIS audit that incorporated HEDIS validation of performance measures and CMS's Information Systems Capabilities Assessment (ISCA) tool.

CAHPS®: The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, developed and managed by the Agency for Healthcare Research and Quality, are designed to measure patients' experiences with the healthcare system. The survey includes questions for adults and for parents and guardians of children age 17 and younger. The results characterize patients' experiences in five domains:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making

Although the CAHPS survey is optional under BBA regulations, HRSA has elected to incorporate the annual CAHPS data into state QI activities to reflect the voice of the consumer in the evaluation of access, quality, and timeliness of care.

The 2008 CAHPS survey departed from previous surveys at the MCO level. As determined by HRSA, the survey collected responses from a statewide sample of S-CHIP enrollees, WMIP enrollees, and a comparison group of FFS clients for the WMIP program, rather than from a sample of each Healthy Options MCO's enrollees. The 2008 CAHPS results will be reported in early 2009 at *http://maa.dshs.wa.gov/healthyoptions*.

Mental health performance measures

By contract, MHD requires each RSN to show improvement on a set of performance measures that MHD calculates and reviews each quarter of the contract period. If the RSN does not meet defined improvement targets on any measure, the RSN must submit a performance improvement plan. The current contract incorporates four performance measures related to

- providing timely appointments for routine services
- providing timely follow-up care after an enrollee's discharge from inpatient treatment
- determining enrollee satisfaction at intake
- determining enrollee satisfaction at follow-up periods during a consumer's episode of care

RSNs also must participate with MHD in completing the nationally normed Mental Health Statistics Improvement Project consumer surveys each year, and must incorporate the results into RSN-specific QI activities.

Compliance monitoring

HRSA participates in TEAMonitor with DOH, the state Health Care Authority, and the Aging and Disability Services Administration to oversee the state's managed care contracts. TEAMonitor conducts an annual on-site review of each MCO's compliance with federal and state regulations and contract provisions. An MCO that does not meet standards must submit a corrective action plan. In 2008, TEAMonitor evaluated MCOs' compliance with more than 60 required elements of access, timeliness, and quality of care.

Acumentra Health monitors the RSNs' compliance with regulations and contract provisions during annual site visits, using a review protocol approved by MHD. The 2008 reviews addressed the portions of the protocol related to Enrollee Rights and Grievance Systems. Reviews in future years will address provisions for Quality Assessment/Performance Improvement (QAPI), Availability of Services, Provider Selection, and other compliance areas.

Value-based purchasing

Pay for performance is a leading strategy in state Medicaid agencies' efforts to improve the efficiency, timeliness, and quality of managed care.[1] Washington was one of the first states to incorporate value-based purchasing into its managed care contract. Since 2005, HRSA has provided incentive payments for improvement in WCC and childhood immunization rates, setting aside $1 million per year for each measure. The incentive system rewards health plans on the basis of their performance in the prior year on HEDIS rates relative to other health plans and on each plan's year-to-year improvement in its HEDIS rates relative to other plans. The plans receive pro-rated payments according to their rank in the performance scale.

In January 2008, the state paid $821,565 to MHW, $744,615 to Community Health Plan (CHP), and smaller amounts to other plans. MHW and CHP have received the highest performance bonuses since 2005. Of $6 million disbursed by HRSA since the onset of this program, MHW has received $2.8 million and CHP has received $1.8 million.

CMS audit

During 2004, CMS audited HRSA to gauge the managed care program's compliance with BBA regulations. The audit report, issued in mid-2006, cited shortcomings in the areas of policies and procedures, program oversight, reporting, monitoring, technical assistance, corrective actions and enforcement, training, and finance. The 2004 audit occurred before HRSA fully implemented the BBA standards in the TEAMonitor review; therefore, when CMS issued the audit report, HRSA already had responded to many of the findings.

CMS conducted a follow-up site visit with HRSA in August 2007. Results of this visit indicated that HRSA complied with federal requirements in 9 of the 11 areas reviewed: primary care case management, general administration, physician incentive plans, information requirements, advanced directives, assurances of adequate capacity and services, coordination of care for enrollees with special healthcare needs, subcontractual relationships and delegation, and QAPI programs. The report cited improvement opportunities in two areas: liability for payment and supplemental payments to Federally Qualified Health Centers and rural health centers.

Quality oversight

In response to the initial CMS audit, HRSA formed a quality oversight committee to review TEAMonitor results, recommend actions, and follow up on issues within the state's quality program. HRSA also created an Office of Quality and Care Management within DHS, three sections of which focus on quality monitoring, managed care, and care management. In 2008, HRSA began convening joint meetings on Medicaid quality management with Healthy Options MCOs and mental health RSNs from across the state.

EQR activities

Table 1 summarizes the mandatory and optional EQR activities that HRSA has pursued and indicates which tasks and/or reports addressed those activities.

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

Activity	How addressed for MCOs	How addressed for RSNs
Required		
Validation of PIPs	TEAMonitor audits	EQRO reviews
Validation of performance measures	HEDIS audit	Mental health performance measure validation by EQRO
Health plan compliance with regulatory and contractual standards	TEAMonitor audits	EQRO reviews
Optional		
Administration or validation of consumer or provider surveys of quality of care	CAHPS survey report by EQRO	
Encounter data validation		EQRO review
Clinical record quality study		EQRO review

Methods

BBA regulations provide a method for uniform oversight of Medicaid programs, based on each state's managed care quality strategy. This annual report combines results from HRSA's individual oversight activities to present a composite picture of care delivered to Washington Medicaid enrollees.

In aggregating and analyzing the data for this report, Acumentra Health used elements from the following reports produced for HRSA under the EQRO contract:

- 2008 HEDIS report of MCO performance in key clinical areas[2]
- TEAMonitor reports on MCOs' compliance with BBA regulations and state contractual requirements
- Acumentra Health reports on RSNs' compliance with regulatory and contractual provisions, PIP validation, encounter data validation, clinical record review, and ISCA follow-up results, submitted to MHD throughout 2008

Each source report presents its own methodology. The reports are available online at *http://maa.dshs.wa.gov/healthyoptions*.

Analytical framework

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

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

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

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

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

Figure 2 illustrates the relationship of these components for quality assessment purposes.

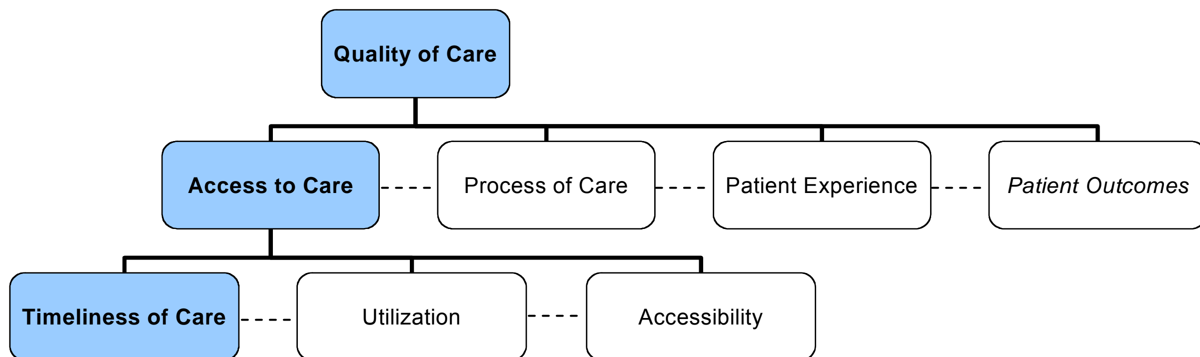

Figure 2. Components in measuring the quality of health care.

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

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

Mental health care delivered by RSNs

During 2008, MHD contracted with 12 RSNs to deliver mental health services for Medicaid enrollees through managed care. MHD assumed responsibility for administering FFS mental health services for Pierce County enrollees. The RSNs contract with provider groups, including community mental health agencies and private nonprofit agencies and hospitals, to deliver treatment services. The RSNs are responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory standards for effective care.

MHD requires all RSNs to contract with an independent Ombuds service to act as an advocate for enrollees by informing them about their rights and helping them to resolve complaints and grievances. A Quality Review Team (QRT) for each RSN represents consumers of mental health services and their family members. The QRT may monitor consumer satisfaction with services and work with consumers, service providers, the RSN, and MHD to improve services and resolve identified problems. In addition, many RSNs contract with a third-party administrator for utilization management services, including initial service authorization.

Table 2 shows the approximate number and percentage of enrollees assigned to each RSN as of December 2007.

Table 2. Mental health Regional Support Networks and enrollees served, December 2007.

Health plan	Acronym	Number of enrollees	% of all enrollees
Chelan-Douglas RSN	CDRSN	18,410	2
Clark County RSN	CCRSN	53,369	6
Grays Harbor RSN	GHRSN	13,823	2
Greater Columbia Behavioral Health	GCBH	135,476	16
King County RSN	KCRSN	178,307	21
North Central Washington RSN	NCWRSN	50,445	6
North Sound Mental Health Administration	NSMHA	119,656	14
Peninsula RSN	PRSN	38,796	5
Pierce County*	*	100,878	12
Southwest RSN	SWRSN	18,320	2
Spokane County RSN	SCRSN	75,665	9
Thurston-Mason RSN	TMRSN	35,471	4
Timberlands RSN	TRSN	17,672	2

*Services for Pierce County residents are now administered by MHD.

Figure 3 shows the counties served by each RSN. (Note: This report contains no analysis of Pierce County mental health services because EQR activities apply only to managed care.)

RSN Service Areas 2007

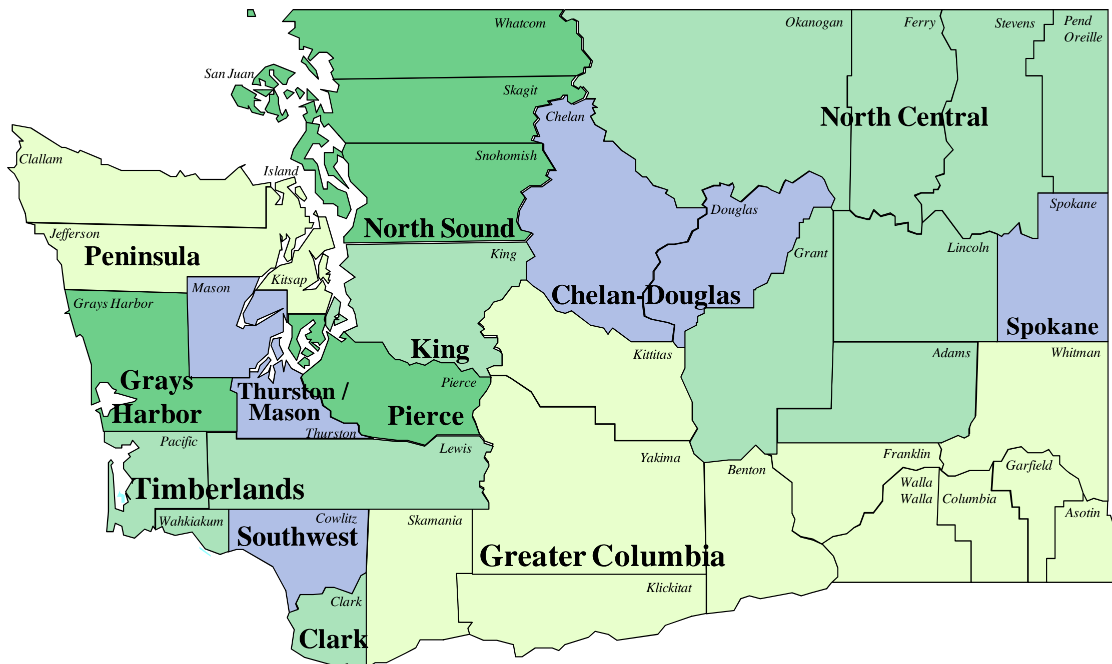

Figure 3. Geographical coverage of RSNs.

MHD is implementing the System Transformation Initiative, a package of initiatives for delivering public mental health services for adults with severe and persistent mental illness and for children with serious emotional disorders. Strategies include:

- statewide implementation of Program of Assertive Community Treatment (PACT) teams
- a study of the Medicaid benefits package and Medicaid managed care rates
- preparation of a plan for expanding housing options for people with mental illness
- a review of Washington’s involuntary commitment statute and system
- development of a utilization review system to ensure that people receive the appropriate level and duration of state hospital and community psychiatric inpatient care
- preparation of a plan for expanding employment options for people with mental illness

In 2008, Acumentra Health conducted a portion of the compliance review protocol for all RSNs, as well as the PIP validation and an encounter data validation for each RSN. Acumentra Health also reviewed each RSN’s response to the findings and recommendations of the ISCA performed in 2007 by MHD’s previous EQRO. Together, these activities addressed the following questions:

1. Does the RSN meet CMS regulatory requirements?
2. Does the RSN meet the requirements of its contract with MHD?

3. Does the RSN monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?
4. Does the RSN conduct the two required PIPs, and are they valid?
5. Is the state's encounter data set accurate and complete? Does the state's information match the information in providers' clinical records?

In conjunction with the encounter data validation, Acumentra Health conducted an additional "optional" activity: a review of clinical records at the RSN and at outpatient provider agencies to assess the quality of mental health care, as measured by indicators defined by MHD.

Review procedures for the individual activities were adapted from the following CMS protocols and approved by MHD:

- *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR parts 400, 430, et al.,* Final Protocol, Version 1.0, February 11, 2003
- *Validating Performance Improvement Projects,* Final Protocol, Version 1.0, May 1, 2002
- *Validating Encounter Data,* Final Protocol, Version 1.0, May 1, 2002
- *Appendix Z: Information Systems Capabilities Assessment for Managed Care Organizations and Prepaid Health Plans*, Final Protocol, Version 1.0, May 1, 2002

General procedures consisted of the following steps:

1. Prior to onsite interviews, the RSN received a written copy of all interview questions and documentation requirements, as well as the protocol and scoring guidelines for the compliance review and PIP validation.
2. The RSN provided the requested documentation to Acumentra Health for review.
3. Acumentra Health staff visited the RSN to conduct onsite interviews and provided each RSN with an exit interview summarizing the results of the review. Acumentra Health also interviewed mental health provider agencies and Ombuds representatives.
4. Acumentra Health weighted the oral and written responses to each question and compiled results.

The scoring system for each activity was adapted from CMS guidelines and approved by MHD.

The following sections summarize the results of individual EQR reports for the 12 RSNs completed during 2008. These results represent baseline measurements against which MHD will compare the results of future reviews to assess the RSNs' improvement. Each RSN report presents the specific review results in greater detail.

Access to mental health care

The following observations about access to mental health care arose from Acumentra Health's site reviews of the Washington RSNs during 2008.

Strengths

- **Timely access:** Each RSN has a system for authorizing services and notifying enrollees about approval or denial of initial services. Seven of the 12 RSNs delegate responsibility for managing authorizations and notices to third-party administrators, while five RSNs manage authorizations internally. Procedures are also in place to address requests for reauthorization of mental health services. Access to outpatient care through contact with a provider agency or a central access coordination point for the service region ensures that enrollees can receive initial assessments in a timely manner. The initial assessment of an enrollee requires no authorization. RSNs typically authorize requests for outpatient services within the required time frames—i.e., within 14 days for routine services and within 3 days for expedited requests.

  All RSNs provide telephone access to crisis services 24 hours a day, 7 days a week, through a combination of direct service provision and contracted after-hours services. All RSNs can dispatch designated mental health professionals for emergency evaluations around the clock.

- **Specialty care:** Washington's Medicaid waiver defines mental health services generically as specialty care. The state has responded further to the need for specialty care by mandating specialty consultations for children and for geriatric and minority populations. Geriatric and child specialists often carry caseloads. MHD has outlined training requirements for specialty designation and has defined a process to reflect cultural awareness in enrollees' ongoing treatment plans.

Opportunities for improvement

- **Access to specialists:** The implementation of specialty consultations across RSNs and their provider agencies has been inconsistent. The RSNs reported some difficulty in identifying appropriate staff to perform cultural and specialty assessments, noting that the requirements for designation as a specialist created a barrier to filling those positions at some RSNs. For example, a specialist must attend 100 hours of training for certification. Chart reviews showed that treatment plans often reflected minimal input from the cultural specialty evaluation, in part because the form and content of cultural evaluations were not well defined. ***MHD needs to review the current implementation of specialty evaluations and recommend modifications to improve practice in this area.***

  Care provided by specialists: Access to other types of specialty care, such as therapy for eating disorder, is inconsistent. Information distributed by MHD and the RSNs does not fully inform enrollees about how to obtain specialty care. ***MHD needs to expand its definition of access to specialty care to include specialized mental health services.***

- **Out-of-network services:** Although each RSN has a procedure for access to out-of-network providers, the RSNs often delegate to providers the responsibility for facilitating out-of-network services, or the RSN authorizes or facilitates these services in special

circumstances. ***MHD needs to help RSNs define access procedures and the criteria for approving out-of-network service requests more fully.***

- **Translation services:** Each RSN has means to provide translation services to facilitate access and ongoing services for enrollees through use of interpreters, including language line services. However, the RSNs do not consistently inform enrollees of their right to obtain translation services to help them understand written notices sent by the RSNs. ***MHD needs to clarify that the requirements to provide interpretation and translation apply to all types of communication with enrollees.***
- **Enrollment data:** The RSNs lack access to demographic information about their Medicaid-eligible population, including ethnicity and primary language. RSNs rely on their provider networks to identify enrollee needs for translation or materials in alternative formats, and service authorization requests from providers do not consistently identify these needs. As a result, the RSNs send relatively few notices to enrollees in non-English languages or alternative formats. ***MHD needs to provide RSNs with demographic data about all Medicaid-eligible people within their service areas.***

Timeliness of mental health care

The compliance review addressed several requirements for timeliness within the categories of Enrollee Rights and Grievance Systems. The following observations about timeliness arose from Acumentra Health's site reviews of RSNs during 2008.

Strengths

- **Timely access:** As noted in the previous section, the RSNs generally performed well in providing timely access to outpatient and crisis services.

Opportunities for improvement

- **Timeliness of enrollee information:** Federal regulations require RSNs to provide accurate information about current providers, including which providers are not accepting new enrollees. Because of the annual publication schedule for the state benefits booklet, enrollees who received the booklet at intake during 2007 sometimes received incomplete or inaccurate information. In particular, several RSNs had changed providers during the year, and the benefits booklet did not reflect those changes, although MHD updated the booklet on its website after receiving notice of the changes. ***MHD needs to develop a method to update provider listings in a timely manner.***
- **Timing of notices of action:** In mid-2007, MHD redefined a "denial" to apply only to suspension, termination, or reduction of previously authorized services, as opposed to a denial of an initial service authorization. MHD amended the RSN contract to require a notice of action (NOA) only when the RSN decides to terminate, reduce, or suspend previously authorized services. A decision to deny authorization for services due to lack of medical necessity or Medicaid eligibility is now termed an eligibility determination, rather than a denial. Since this change, the RSNs have issued very few NOAs and have sent notices of determination (NODs) for these types of service denials. An enrollee may not appeal an NOD but may request a second opinion or a fair hearing.

  Implementation of this process has been inconsistent. Some RSNs send NODs when services are authorized; others send notices only when services are denied. Some RSNs track the timeliness of NODs issued when an enrollee does not meet medical necessity or access-to-care standards, but do not track the timeliness of NODs sent when an enrollee is determined eligible for services.

  Federal regulations require enrollees to be notified as expeditiously as the enrollee's health condition requires and within state-established time frames that may not exceed 14 calendar days following receipt of a request for service, with a possible extension of up to 14 additional calendar days. ***The RSNs need to apply these time frames to all notices. MHD needs to provide guidance to the RSNs about timelines related to NODs.***
- **Timing of quality reviews:** In addition to annual administrative reviews of providers' policies and procedures, most RSNs conduct annual audits of the providers' clinical records. Most RSNs also conduct routine clinical audits on a monthly or quarterly basis. ***The RSNs needs to conduct annual site visits focusing on enrollee rights issues, e.g., privacy, advance directives, and enrollee access to records.***

Performance on timeliness measure

One of MHD's statewide performance measures for the RSNs focuses on the timeliness of outpatient appointments following discharge from psychiatric hospitalization. Good clinical care for people with serious mental illness depends on providing rapid follow-up care after discharge from an inpatient psychiatric facility. Ideally, a person with mental illness would receive outpatient follow-up care within seven days of discharge from inpatient care.

MHD's statewide benchmark calls for 80 percent of Medicaid patients released from psychiatric hospitals and evaluation and treatment (E&T) facilities to be offered non-crisis services within seven days of discharge. According to MHD's calculation, all RSNs performed below that benchmark during 2006–2007, as only about half of RSN enrollees across the state received non-crisis appointments within seven days. However, the current performance measure calculation does not distinguish between Medicaid and non-Medicaid patients (see pages 47–48).

A group of RSNs have adopted this topic as the focus of a statewide PIP. For 2008, 10 RSNs chose to submit the PIP aimed at improving the timeliness of outpatient follow-up appointments after psychiatric hospitalization. Intervention strategies are discussed on pages 42–46.

Quality of mental health care

In October 2005, Washington received a grant to support the Mental Health Transformation Project, a five-year initiative focusing on system reform. To date, reports generated through project activities have addressed mental health services; consumers, families, and youth; prevention; criminal justice; disparities in delivery of mental health services; and general financing and policy. Activities include a 2007 survey by the Washington Institute for Mental Illness Research and Training on the use of evidence-based practices (EBPs) by agencies statewide. EBPs identified for mental health agencies include Cognitive Behavior Therapy, Medication Management, Motivational Interviewing, Peer Support, Family Psychoeducation, and Dialectical Behavioral Therapy. Additional small-grant funding has been available for projects related to advancing recovery and resiliency.

The following assessment of the RSNs' compliance with quality standards emerged from on-site reviews and from a special clinical record review required by MHD.

Strengths

- **Recovery Model:** RSNs across the state are implementing the Recovery Model of care, with emphasis on increasing enrollees' dignity, respect, and involvement in the design and delivery of mental health services. Several RSNs have developed model practices based on the Recovery Model, including revisions of policies and procedures, support for consumer involvement in staffing and board membership, and QRT involvement in RSN activities. Consumers lead RSN-sponsored rights forums and group sessions related to the Wellness Recovery Action Plan. Surveys inform RSNs about consumer satisfaction with care delivery and about quality issues. Increased consumer involvement in care has resulted in greater awareness of systems issues, improvements in quality of care, and support for innovative program strategies (e.g., supported employment).
- **Ombuds:** The Ombuds system has strengthened RSNs' capacity to respond to consumer concerns, manage complaints and grievances fairly and equitably, and offer community training about issues related to enrollee rights (including use of the grievance system and advance directives).
- **Provider assistance:** During 2007, RSNs conducted many training and technical assistance activities for provider agencies. Topics included nondiscrimination, HIPAA, enrollee rights, and cultural competence. Several training activities were delivered by the Ombuds. In response to identified needs for increased expertise and specialization in treatment planning, several RSNs have sponsored system-wide training to build staff expertise (for example, in supported employment or treatment of eating disorders). Cross-agency training supports collaborative approaches to treatment.
- **Quality reviews:** Each RSN completes annual administrative reviews of provider agencies and periodic reviews of clinical records for compliance and quality.

Opportunities for improvement

- Opportunities for improvement emerged primarily from the findings of the clinical record review, described in the next section.

Clinical record review

Acumentra Health reviewed clinical records at the RSNs and at outpatient provider agencies to assess the quality of mental health care as measured by a series of indicators specified by MHD. This study focused on five standards related to enrollee rights and quality of care:

- **Standard 1:** Authorization or reauthorization of services reflects level-of-care guidelines and appropriate decision-making.
- **Standard 2:** The enrollee and his/her family, when appropriate, participate in ongoing treatment planning and service provision.
- **Standard 3:** Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.
- **Standard 4:** Treatment planning and progress notes are appropriate to the culture of the enrollee and his/her family.
- **Standard 5:** Treatment plan diagnosis and prescriber diagnosis are consistent. Where rule-out or provisional diagnoses are indicated, diagnosis is resolved through ongoing assessment.

Analysts reviewed a total of 1,251 charts for RSN enrollees served in calendar year 2007. Each enrollee in the sample had at least four service encounters (including at least one outpatient encounter and at least one non-crisis encounter) during the year before the review period. The charts reviewed for this activity were the same as those requested for the associated encounter data validation (see page 51).

To assess the degree to which each standard was met, reviewers completed a series of questions pertaining to each standard. After examining the chart documentation and progress notes, reviewers responded to each question by selecting “Present,” “Not present,” “Partial,” or “N/A.” For example, the second question for Standard 1 asked whether the chart documented that a mental health professional had authorized the service in question. If the reviewer found notes demonstrating such authorization, the reviewer chose a “Present” response for this question. Not all options were available in answering each question.

Table 3 shows the distribution of answers to the questions for each standard. Note that not all questions applied to every chart in the sample. Therefore, the percentage calculation occurred separately for each question, with inapplicable charts removed from the denominator.

Table 3. Responses to clinical record review questions (N, % of total).

Standard 1. Do authorizations reflect the RSN's level-of-care guidelines? Is clinical decision making appropriate?				
	Present	**Not Present**	**Partial**	**N/A**
1. Clinical intake/assessment is reviewed	284 (24.9%)	766 (75.1%)		
2. Authorization is conducted by mental health professional with appropriate specialization	758 (73.5%)	302 (26.5%)		
3. Diagnosis and psychiatric symptoms are described	354 (31.3%)	23 (2.3%)	683 (66.4%)	
4. Recommended services are identified	329 (37.0%)	728 (62.8%)	3 (0.3%)	
5. Justification for recommended services	318 (28.2%)	738 (71.5%)	3 (0.3%)	
6. Diagnosis matches Medical Necessity/Access to Care standards	930 (98.5%)	130 (1.5%)		
7. Criteria for "B" diagnosis present*	44 (4.5%)	266 (28.5%)		595 (66.9%)
8. Authorization is documented in mental health assessment record	935 (75.3%)	300 (24.2%)	4 (0.3%)	2 (0.2%)
Standard 2. Does enrollee participate in treatment? How does enrollee participate?				
	Present	**Not Present**	**Partial**	**N/A**
1. Record documents client support system (family, friends, etc.)	1,171 (94.3%)	62 (5.0%)	9 (0.7%)	
2. Record documents inquiry about client perceptions and preferences for treatment	1,022 (82.6%)	202 (16.3%)	13 (1.1%)	
3. Client's participation in developing treatment plan/goals is documented	1,100 (88.7%)	70 (5.6%)	43 (3.5%)	27 (2.2%)
4. Client's participation is documented in client's own words	1,070 (86.4%)	169 (13.6%)		
5. Involvement of family/legal guardian documented in plan of care and ongoing treatment	597 (48.2%)	89 (7.2%)	16 (1.3%)	536 (43.3%)
Standard 3. Do agencies coordinate care with PCP and other agencies?				
	Present	**Not Present**	**Partial**	**N/A**
1a. PCP is identified in clinical assessment and plan	924 (74.8%)	281 (22.7%)		31 (2.5%)
1b. Consent is signed for exchange of information with PCP	772 (62.2%)	306 (24.7%)		163 (13.1%)
1c. Consent specifies information to be exchanged and is current with appropriate signatures and dates	677 (56.1%)	272 (22.6%)	13 (1.1%)	244 (20.2%)
1d. Clinical documentation provides evidence of coordination of care with PCP	498 (40.3%)	466 (37.7%)	43 (3.5%)	229 8.5%)

*A person with a "B" diagnosis must meet at least one of the following criteria to be eligible for outpatient services:

1. behaviors/symptoms that are the result of a mental illness;
2. demonstrate high-risk behavior within 90 days;
3. at risk of escalating symptoms due to repeated physical or sexual abuse or neglect;
4. two or more hospital admissions due to mental health diagnosis during the previous two years;
5. psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year or is currently being discharged from a psychiatric hospital;
6. received public outpatient mental health treatment during the previous 90 days and will deteriorate if services are not resumed;
7. children under six years of age with severe emotional or behavioral abnormality in overall functioning.

Standard 4a. Are treatment planning and progress notes appropriate for enrollee?					
	Assessed	**Addressed**	**Not addressed**	**N/A**	**Not assessed**
Development level	1,085 (87.4%)	573 (52.8%)	89 (8.2%)	423 (39.0%)	156 (12.6%)
Cognitive ability	1,146 (92.3%)	523 (45.6%)	102 (8.9%)	521 (45.5%)	95 (7.7%)
Cultural factors	1,003 (80.8%)	251 (25.0%)	130 (13.0%)	622 (62.0%)	238 (19.2%)
Socioeconomic factors	1,106 (89.1%)	559 (50.5%)	149 (13.5%)	398 (36.0%)	135 (10.9%)
Sensory impairments	909 (73.2%)	205 (22.6%)	79 (8.7%)	625 (68.8%)	332 (26.8%)
Language	1,171 (94.4%)	99 (8.5%)	40 (3.4%)	1,032 (88.1%)	70 (5.6%)
Ethnicity	1,168 (94.1%)	148 (12.7%)	84 (7.2%)	936 (80.1%)	73 (5.9%)
Sexual orientation	742 (59.8%)	60 (8.1%)	34 (4.6%)	648 (87.3%)	499 (40.2%)
Spirituality	756 (60.9%)	170 (22.5%)	74 (9.8%)	512 (67.7%)	485 (39.1%)
Beliefs / attitudes about medication	789 (63.6%)	634 (80.4%)	38 (4.8%)	116 (14.7%)	452 (36.4%)
Beliefs / attitudes about mental health treatment	846 (68.2%)	666 (78.7%)	50 (5.9%)	130 (15.4%)	395 (31.8%)
			Yes	**No**	
Was consumer informed of consumer support options?			500 (40.8%)	726 (59.2%)	
Was there a specific assessment/treatment planning conference related to cultural concerns?			238 (19.3%)	993 (80.7%)	

Standard 5. Are treatment diagnosis and prescriber diagnosis consistent?				
	Present	**Not present**	**Partial**	**N/A**
1. Clinical record includes prescriber diagnosis?	1,040 (84.2%)	123 (10.0%)		72 (5.8%)
2. Plan-of-care diagnosis and prescriber diagnosis are consistent?	944 (76.4%)	94 (7.6%)	22 (1.8%)	175 (14.2%)
3. Is a deferred, rule-out or provisional diagnosis noted?	115 (9.7%)			1075 (90.3%)
If #3 is yes...Is reason documented?	84 (7.7%)	24 (2.2%)		977 (90.0%)
If #3 is yes...Is there reassessment to clarify diagnosis?	55 (5.1%)	52 (4.8%)		973 (90.1%)
If #3 is yes...Is diagnosis clarified within 180 days?	41 (3.9%)	56 (5.3%)		958 (90.8%)

Standard 1: This standard speaks to the RSN's ability to manage service utilization effectively. Questions include whether clinical intake assessments are reviewed, whether treatment is authorized by a mental health professional with appropriate specialization, and whether recommended services are identified and justified. Study results indicate that the Washington RSNs may be missing opportunities to manage utilization effectively.

The review showed that 73.5 percent of service authorizations had documentation showing that the authorizations were conducted by a mental health professional. Generally, the remaining authorizations did not indicate the credentials of the person making the authorizations, and reviewers found no evidence of the credentials. Clinical records should always document the credentials of the authorizing person, and measures need to be in place to ensure this.

About one-third of the authorizations described both the diagnosis and psychiatric symptoms, while two-thirds showed only the diagnosis. These percentages reflect many RSNs' practice of relying on providers to establish medical necessity. The minimum documentation required by most RSNs for initial authorization of services is often limited to a covered diagnosis and a Global Assessment of Functioning (GAF) or Children's Global Assessment Scale (CGAS) score below 60. Although the initial assessment is authorized automatically, 1.5 percent of the authorization records did not contain enough documentation to establish medical necessity or meet access-to-care standards for ongoing services. In these cases, the RSNs may have rendered services that were not warranted. Several RSNs perform retrospective chart audits to verify that psychiatric symptoms support the need for the services provided, but that approach does not remedy the situation.

MHD should consider strengthening the documentation RSNs must present for clinical justification of symptoms that establish medical necessity and meet access-to-care standards for authorization of ongoing services.

Analysts reviewed 1,241 clinical charts and found that 300 (24.2 percent) did not document the service authorization. Several RSNs kept authorizations in financial sections of electronic health records or databases. This practice does not encourage the clinician and the consumer to develop a treatment plan within the limits of the authorization. Tailoring a treatment plan to what can be accomplished within the authorization period can be an effective way to focus and prioritize treatment. Reviewers often observed routine authorizations for six months or a year. This practice promotes the perception, for both the clinician and the consumer, that care is open-ended and that maintenance, rather than recovery, is the goal of treatment. Reviewers also noted that the very low rate of service denial across the state supports these recommendations.

To manage utilization of services and to determine medical necessity, access to care, and level of care, the RSNs need detailed clinical information about diagnosis and psychiatric symptoms, recommended services, and the justification for those services. ***RSNs' authorization practices need to reflect an array of authorized services based on the individual's functioning and level of need at a specific point in time. Ideally, these services should be designed to maximize the enrollee's ability to lead a full and independent life.***

Standard 2: Questions for Standard 2 include whether the chart documents the enrollee's support system (including family and friends), the enrollee's participation in developing his or her treatment plan or goals, a description of the enrollee's participation in his or her own words, and involvement of the enrollee's family or legal guardian in ongoing treatment.

Analysis showed that 94.3 percent of charts documented the enrollee's support system of family and friends; 88.7 percent documented enrollee participation in developing treatment plan/goals; 86.4 percent showed evidence of enrollees' participation in their own words; and 82.6 percent showed provider inquiry into the enrollees' perceptions and preferences for treatment. Reviewers also examined charts for evidence that, when appropriate, an enrollee's family or legal guardian was involved in the plan of care and ongoing treatment. The review found that 85.0 percent of the 702 applicable charts included the family or legal guardian in the plan of care and ongoing treatment.

Overall, RSNs meet this standard more than 80 percent of the time. Existing audits appear to be working, and continuing them should increase percentages to above 90 percent.

Standard 3: Standard 3 addresses coordination of care with the enrollee's PCP and with ancillary agencies classified as Corrections/Justice, Guardian/Advocate, Hospital, Housing, School/Education Program, Social Services/DSHS, or Vocational Rehabilitation. Questions include whether the clinical assessment identifies a PCP; whether the chart shows evidence of coordination of care with the PCP; whether consents are signed for each other agency involved in caring for the enrollee; and whether the chart shows a two-way exchange of information between the provider and other agencies.

The review found that 74.8 percent of charts documented a PCP in the clinical assessment and plan; 62.2 percent showed consent being signed for exchange of information with the PCP; 56.1 percent had complete and current consents; and 40.3 percent showed evidence of coordination of care with the PCP. The review data confirm the observation that while consents generally were completed at intake, often they were not executed. Also, consents executed at intake often were not kept up to date. In 3.5 percent of the cases, the mental health provider sent information to the PCP but received nothing in return. On a more positive note, 40 percent of the charts showed an exchange of information between the clinician and the PCP.

Reviewers also analyzed coordination of care by ancillary agency type. Standard 3 was met for agency coordination if each listed agency had a complete release of information and a provider was identified, and if the chart showed coordination of care with that agency.

As shown in Table 4, only about half of 998 charts documented coordination of care with other agencies. This occurred most often with vocational rehabilitation agencies (60.4 percent) and guardians/advocates (59.5 percent). Interestingly, coordination of care was documented least often with hospitals (35.7 percent). Reviewers also observed that consents for exchange of information with ancillary agencies often were not current or did not explicitly identify the agency contact.

Considering the proportion of charts with no documented consent for exchange of information with the PCP (24.7 percent), and of the charts that indicated no coordination of care with the PCP, most RSN enrollees did not have their mental health care coordinated with their PCPs. The findings regarding coordination of care with ancillary agencies are somewhat more encouraging but similar. Clearly, this is a significant issue across the state. ***MHD and the RSNs need to consider ways to improve care coordination. The RSNs also need to require their providers to review information releases with enrollees regularly to ensure that they are current and relevant.***

Table 4. Coordination of care for mental health enrollees by agency type (N, % of agency type).

Agency type	Coordination documented	Coordination not documented	Total of agency type
Corrections/Justice	47 (54.0%)	40 (46.0%)	87
Guardian/Advocate	72 (59.5%)	49 (40.5%)	121
Hospital	25 (35.7%)	45 (64.3%)	70
Housing	64 (52.9%)	57 (47.1%)	121
Other Treatment Program	13 (43.3%)	17 (56.7%)	30
School/Education Program	89 (49.7%)	90 (50.3%)	179
Social Services/DSHS	163 (48.4%)	174 (51.6%)	337
Vocational Rehabilitation	32 (60.4%)	21 (39.6%)	53
Total of agencies	**505 (50.6%)**	**493 (49.4%)**	**998**

Standard 4: Questions for this standard address whether treatment planning is appropriate to the enrollee's development level, cognitive ability, gender identity, socioeconomic and cultural factors, sensory impairments, and language and ethnicity. Reviewers first determined whether these issues were assessed, then whether the clinician addressed any significant issue that was assessed. Among the charts reviewed, 94.4 percent documented the enrollee's language being assessed; 94.1 percent showed the enrollee's ethnicity being assessed; 92.3 percent showed the enrollee's cognitive ability assessed; and 89.1 percent showed socioeconomic factors assessed.

Standard 4 calls for the clinician to ask about an array of issues that might be incorporated in the enrollee's care plan to make treatment more accessible and effective. Cases in which issues are assessed but, when identified, are not addressed in the treatment plan should raise concern.

Table 5 shows the proportion of charts in which an assessed issue[†] was addressed or not addressed in the treatment plan. Assessed issues were *not* addressed in treatment plans in 36.2 percent of charts with regard to the enrollee's ethnicity and sexual orientation; in 34.1 percent of charts with regard to cultural factors; and in 30.3 percent of charts with regard to spirituality.

Also of concern are issues that are not assessed, and therefore cannot be identified, because the clinician does not ask about them. As shown in Table 3 on pages 24–25, the issues assessed least often included sexual orientation, absent from 40.2 percent of charts; spirituality, absent from 39.1 percent; beliefs/attitudes about medication, absent from 36.4 percent; and beliefs/attitudes about mental health treatment, absent from 31.8 percent.

Typically, issues that are sensitive or less obvious were not assessed (for example, sexual orientation). ***The RSNs need to take steps to ensure that clinicians address all identified issues in the treatment plan. When conducting routine audits, the RSNs should monitor how often the enrollee's sexual orientation, spirituality, beliefs/attitudes about medication and mental health treatment, and other issues are being addressed. Clinicians may need additional training, depending on the audit results.***

[†] "Assessed issue" means an issue identified by the clinician in an assessment or progress note that materially affects the enrollee—e.g., blindness, language, spirituality, etc.

Table 5. Proportion of issues addressed and not addressed in mental health treatment plans.

Standard 4a. Is an assessed issue addressed in the treatment plan?[a]		
	Addressed	**Not addressed**
Development level	573 (86.6%)	89 (13.4%)
Cognitive ability	523 (83.7%)	102 (16.3%)
Cultural factors	251 (65.9%)	130 (34.1%)
Socioeconomic factors	559 (79.0%)	149 (21.0%)
Sensory impairments	205 (72.2%)	79 (27.8%)
Language	99 (71.2%)	40 (28.8%)
Ethnicity	148 (63.8%)	84 (36.2%)
Sexual orientation	60 (63.8%)	34 (36.2%)
Spirituality	170 (69.7%)	74 (30.3%)
Beliefs / attitudes about medication	634 (94.3%)	38 (5.7%)
Beliefs / attitudes about mental health treatment	666 (93.0%)	50 (7.0%)

[a] These data exclude charts in which assessed issues were determined by the clinician to be not applicable, or which documented that the enrollee did not wish to address the issue.

Standard 5: Questions for Standard 5 include whether the clinical record includes a treatment plan diagnosis and a prescriber diagnosis; if so, whether the diagnoses are consistent; and whether the clinical record notes a deferred, rule-out, or provisional diagnosis.

Analysis found that the prescriber diagnosis was present in 84.2 percent of charts, and the plan-of-care diagnosis and prescriber diagnosis were consistent in 76.4 percent. Timely and frequent audits would enable the RSNs to improve the consistency of plan-of-care diagnosis and prescriber diagnosis.

As shown in Table 6, 77.8 percent of charts with deferred diagnoses documented a reason for the deferral. However, only about half of these charts showed a reassessment to clarify the diagnosis, and clarification occurred within 180 days only 42.3 percent of the time. This delay in resolving deferred diagnoses is a general concern. ***The RSNs need to address the resolution of deferred, rule-out, or provisional diagnoses through timely and frequent audits.***

Table 6. Resolution of deferred, rule-out, or provisional diagnoses (N, % of deferred).

	Present	**Not present**	**Total observed**
Is a deferred, rule-out or provisional diagnosis noted?	115 (100%)		
If #3 is yes...Is reason documented?	84 (77.8%)	24 (22.2%)	108
If #3 is yes...Is there reassessment to clarify diagnosis?	55 (51.4%)	52 (48.6%)	107
If #3 is yes...Is diagnosis clarified within 180 days?	41 (42.3%)	56 (57.7%)	97

Mental health regulatory and contractual standards

Acumentra Health's 2008 review of RSN compliance addressed federal and state standards related to Enrollee Rights and Grievance Systems. The Enrollee Rights section of the review protocol assesses the degree to which the RSN has written policies in place on enrollee rights; communicates those rights to enrollees annually; makes that information available in accessible formats and in language that enrollees can understand; and monitors its provider agencies to ensure full implementation of enrollee rights. The Grievance Systems section evaluates the RSN's policies and procedures regarding grievance and appeal processes and state fair hearings and the RSN's process for monitoring adherence to mandated timelines.

MHD's Medicaid waiver exempts RSNs from having to comply with some portions of the federal regulatory standards. MHD also has adopted special procedural requirements to provide additional direction for RSNs—for example, in notifying enrollees about authorization decisions.

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

Compliance scoring methods

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

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

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

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

Summary of compliance review results

Enrollee Rights: As shown in Figure 4, four RSNs (CCRSN, GCBH, NSMHA, and SCRSN) fully met this standard, and the remaining RSNs substantially met the standard.

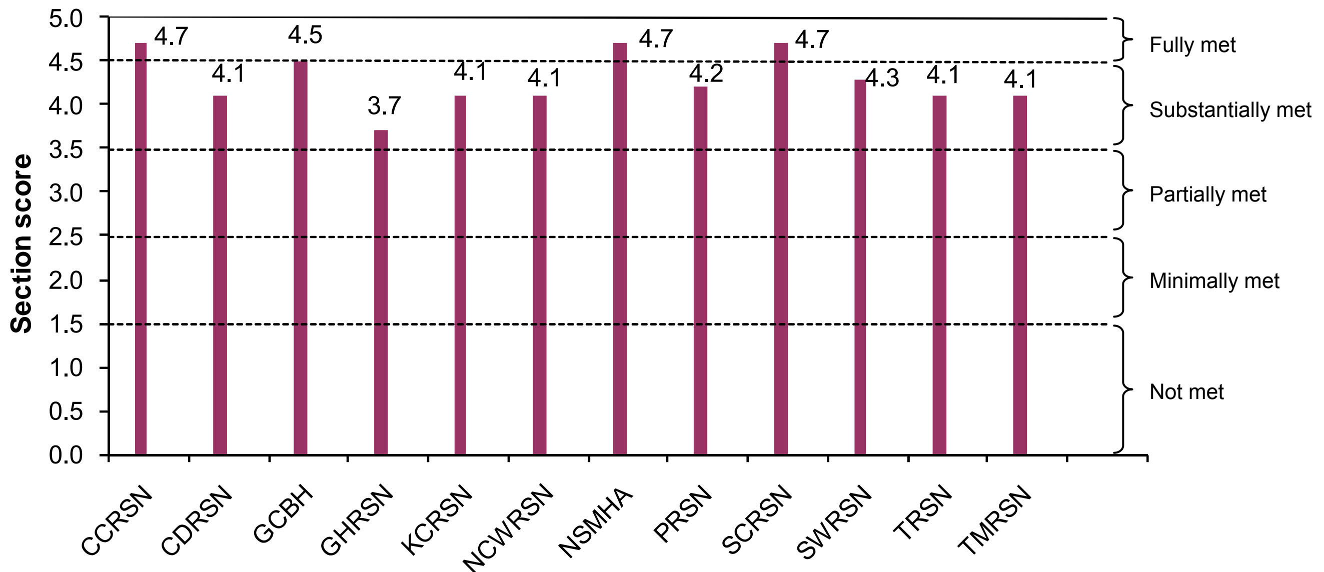

Figure 4. RSN compliance scores: Enrollee Rights.

Strengths

- Across the state, RSN enrollees have multiple sources of information about their rights. The primary source is the state's *Benefits Booklet for People Enrolled in Medicaid*. Published annually in eight languages, the booklet is available at provider agencies and is distributed to all Medicaid-eligible people annually and to enrollees at intake. It presents information on basic enrollee rights, how to obtain services, and how to pursue grievances, appeals, and fair hearings, and it lists contact information for the agencies that comprise each RSN's provider panel. Consumer rights are posted in RSN facilities and provider agencies in eight languages, using a template provided by the state.

  Several RSNs have developed comprehensive materials regarding enrollee rights, including pamphlets with detailed descriptions of local service delivery systems. Some RSNs maintain customer service lines to facilitate referrals to appropriate services and to manage complaints, grievances, and appeals. The Ombuds typically provides additional information. The majority of RSNs also maintain websites designed to inform the general public about mental health services.
- RSNs inform enrollees about grievance, appeal, and fair hearing procedures and time frames by distributing the state benefits booklet and other information at RSN facilities, at provider agencies, and through the Ombuds.
- RSNs' administrative monitoring of provider agencies and reviews of clinical records monitor for enrollee rights notifications at the time of the initial assessment. The majority of RSNs also monitor for other rights issues, including advance directives, referral for

cultural assessments, and use of second opinions. Some RSNs have developed specific quality assurance activities related to enrollee rights.

- Only a few RSNs experienced changes in providers in their service delivery systems during 2007. When changes did occur, enrollees usually received timely written notices and support for transition to other services or care providers.

Opportunities for improvement

- Many RSNs rely on the list of enrollee rights in the *Benefits Booklet for People Enrolled in Medicaid* as their general framework for rights notification. Some RSNs and provider agencies distribute other rights listings to enrollees, but several of these RSNs lack a complete and specific list of enrollee rights. As a result, presentations of enrollee rights vary considerably across RSNs. ***MHD needs to guide the RSNs in standardizing a complete list of enrollee rights.***
- Federal regulations require that a comprehensive list of individual staff at provider agencies be available to enrollees, noting specialties and languages spoken, and that enrollees be informed of the availability of this list annually. While the RSNs typically list language capabilities at provider agencies, only a few RSNs maintain the required list of individual providers. ***To facilitate consumer choice among service providers, the RSNs need to make this information available to enrollees.***
- Federal regulations require RSNs to maintain policies and procedures governing the use of seclusion and restraint. MHD's contract does not address this issue specifically; as a result, few RSNs have adequate policies and procedures in this area. Although several RSNs require skill training for clinical staff related to behavioral interventions, RSNs monitor seclusion and restraint only in E&T facilities. ***MHD's contract with the RSNs needs to incorporate requirements for monitoring the use of seclusion and restraint.***
- Enrollees need to receive information regarding both medical and mental health advance directives. Because MHD's 2007 contract with RSNs does not address medical advance directives specifically, most RSNs do not notify enrollees of their rights in this area. Across the state, RSNs have developed very few mental health advance directives for individual enrollees. ***Each RSN needs to ensure ongoing community education and staff training regarding both medical and mental health advance directives. RSNs also should be prepared to assist enrollees and/or their families in filing complaints regarding noncompliance with both medical and mental health advance directives. MHD needs to ensure that RSN responsibilities related to advance directives include medical advance directives.***
- RSN practices are inconsistent with regard to notifying enrollees when providers change the levels of previously authorized services. Documentation did not always reflect when individual service plans were changed with agreement of the enrollee. In several cases, provider agencies reduced or terminated services for large numbers of enrollees without clear documentation of notice. One notable example involved an agency's decision to transfer medication management from a psychiatric provider to a PCP. ***MHD needs to provide guidance to ensure that RSNs adequately notify enrollees whenever a previously authorized service is terminated, suspended, or reduced at any level within the RSN.***

- RSNs do not consistently facilitate access to services for non-English-speaking enrollees. Informational materials are not uniformly available in prevalent non-English languages, including Spanish. Notices are not always provided in the enrollee's native language, in part because RSNs do not always identify the enrollee's preferred language for oral and written communication at the time services are requested. Although translation services generally are available, enrollees are not consistently informed of the availability of those services to assist in interpreting written materials, including notices. The RSNs need access to demographic information about their entire Medicaid-eligible population so that they can provide notices and other materials in non-English languages or alternative formats. ***MHD needs to provide each RSN with an eligibility file on a routine basis. The eligibility file should contain information about each Medicaid-eligible person within the RSN's service area who might need information in a non-English language or an alternative format.***
- Neither the *Benefits Booklet for People Enrolled in Medicaid* nor supplemental RSN materials adequately inform enrollees of their options for out-of-network or specialty services. Each RSN provided examples of contracting for out-of-network services, but no clear process and criteria for out-of-network referrals were apparent. Although letters regarding denial of services advise enrollees of the availability of second opinions, the use of second opinions varies considerably across RSNs. The RSNs seldom monitor access to second opinions within provider agencies. ***The RSNs need to develop monitoring methods to track enrollees' access to second opinions.***
- Several RSNs provide only limited information about steps for an enrollee to follow to obtain an evaluation for inpatient services. Information about access to crisis and post-hospital follow-up services is very limited. ***MHD needs to provide guidance to RSNs as to how to inform enrollees about access to these services.***
- Enrollees are not fully informed about access to specialty care that goes beyond the scope of the mandated geriatric, child, and minority specialty evaluations—for example, therapy for eating disorder. ***MHD needs to guide RSNs as to how to ensure access to mental health specialties beyond those currently defined.***
- All RSNs monitor enrollee rights at intake as part of their clinical chart reviews. However, the RSNs have no monitoring methods to ensure that enrollees in long-term care receive notice of their rights at routine intervals. In addition, medical necessity for services is not routinely reassessed during the 180-day review for each enrollee. Across the state, ***RSNs need to monitor enrollees' medical necessity for treatment on a continuing basis. Periodic (annual) reassessments for enrollees in ongoing mental health care should include reviewing the enrollee's rights and obtaining the enrollee's informed consent for treatment.***

Grievance Systems: As shown in Figure 5, eight of the 12 RSNs fully met this standard, and the remaining RSNs substantially met the standard.

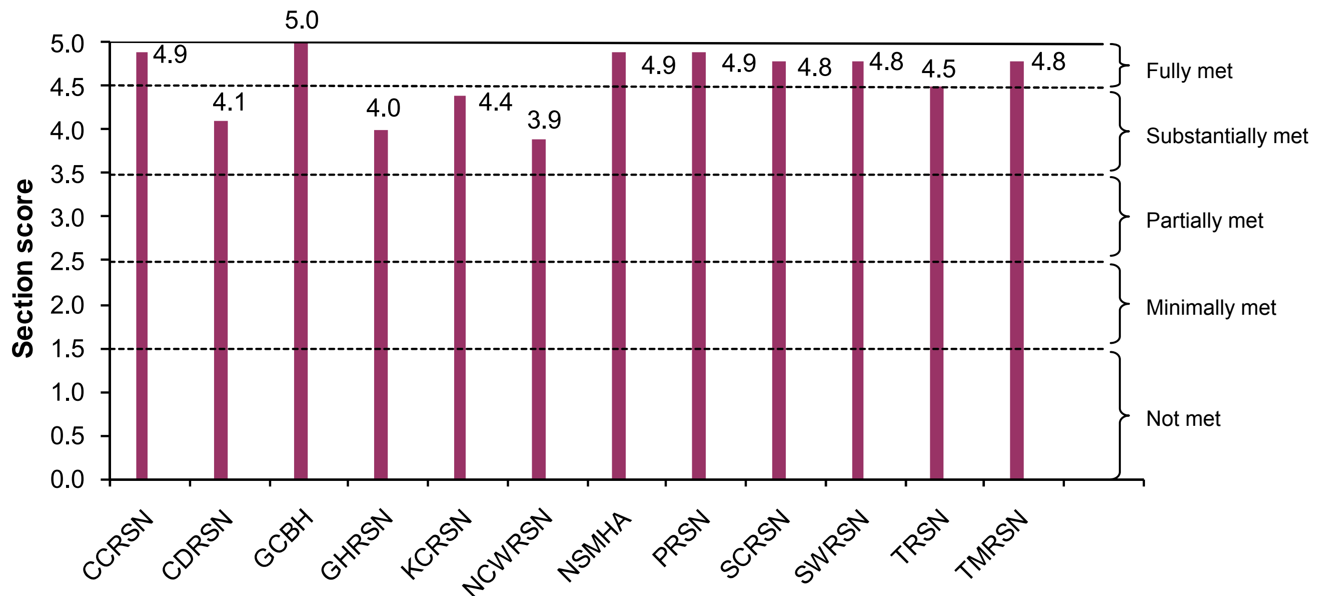

Figure 5. RSN compliance scores: Grievance Systems.

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

Across the state, RSNs report few grievances. Not all complaints at the provider agency level are monitored and reported, because the Exhibit N forms report only formal grievances. As a result, RSNs find it difficult to identify issues that may need action at the agency or RSN level. For example, although GCBH received a perfect score on this portion of the compliance review, GCBH processed very few grievances during 2007.

Similarly, very few appeals have occurred across the system because the RSNs seldom deny service authorization. An enrollee who receives an adverse NOD may request a second opinion. If the enrollee is not satisfied with the second opinion, he or she may file an appeal.

Strengths

- All RSNs maintain policies and procedures for managing grievances and appeals. RSNs typically review grievance and appeal reports during meetings of the quality management committee and/or board of directors. A few RSNs define complaints and grievances broadly, recording enrollee concerns and responding to system issues identified through complaints and grievances. NSMHA provides a model for structuring the grievance process and for incorporating information from this process into the RSN's quality management plan.

Opportunities for improvement

- The RSNs typically have policies and procedures in place to meet federal requirements. However, they do not consistently incorporate analysis of grievances and appeals into their quality assurance/performance improvement (QAPI) work plans. At the time of review, two RSNs lacked a formal quality management committee. RSNs that delegated responsibilities for grievances and appeals to their provider agencies do not appear to maintain tracking systems sufficient to monitor the resolution and disposition of all grievances and appeals handled at the provider agency level. ***RSNs need to ensure that their ongoing quality assurance activities take account of complaints and grievances handled by provider agencies.***
- The Ombuds for each RSN reports enrollee complaints about care to the RSN. However, the Exhibit N forms submitted by the RSNs omit complaints filed at the provider agency level. In addition, the timelines established for grievances are not applied to complaints. ***MHD needs to require each RSN to collect and review all complaints, not only grievances, from providers, Ombuds, and the RSN's own grievance system as part of the QAPI process.*** This would provide a more robust source of data from which to analyze trends and identify areas for system improvement.
- Several RSNs lack provisions for enrollees to file appeals orally following a denial of services. ***RSNs need to review their procedures to ensure that enrollees receive adequate assistance in filing grievances and complaints, specifically when an enrollee expresses a concern orally to the RSN or to a provider. MHD needs to require RSNs to ensure that enrollees can file appeals orally as well as in writing.***
- Creation of the NOD as distinct from the NOA in mid-2007 has resulted in inconsistent notification practices across the RSN system. ***MHD needs to clarify its expectations for the timing, content, and format of NODs.***

Corrective action plans

For 2008, MHD required RSNs to submit corrective action plans (CAPs) to address regulatory and contractual requirements in areas where their compliance scores failed to improve over the previous three years or were particularly low, and where MHD's EQRO Oversight Committee identified other issues. Table 7 shows the issues identified in each compliance area.

The previous EQR cycle identified issues for at least half of the RSNs regarding enrollee rights, NOA procedures, delegation and monitoring of subcontractors, authorization practices, and issues related to service capacity, access, and specialty or out-of-network referrals.

Acumentra Health's 2008 compliance review addressed improvement and continuing issues in enrollee rights and grievance systems, discussed in the preceding pages. Next year's compliance review will address the RSNs' response to issues identified by Acumentra Health in 2008.

Table 7. Issues in RSN corrective action plans.

Compliance area	42 CFR citations (see Appendix C)	Number of issues identified	Number of RSNs with issues identified
Rights, notices, grievances and appeals			
Specific enrollee rights, confidentiality, protection against discrimination, compliance with federal and state laws	*438.100; 438.224; 438.214*	10	7
Advance directive policies and procedures	*438.10(g); 438.6*	3	3
Culturally competent services	*438.206*	2	2
Notice of action procedures	*438.210; 438.404; 438.408*	9	6
Grievances, appeals, and fair hearings	*438.402; 438.406; 438.408; 438.410; 438.416; 438.420*	7	5
Delegation and monitoring			
Contractual and subcontractual relationships, delegation, monitoring	*438.230; 438.414*	13	7
Quality assurance, data integrity, and monitoring			
Authorizations	*438.210*	6	6
Practice guidelines	*438.236*	5	5
Service capacity, access and utilization, specialty and out-of-network services	*438.206; 438.207; 438.240*	6	6
Data integrity and quality	*438.608; 438.242*	4	4
Costs of services, liability for payment	*438.106*	2	2
Internal monitoring, fraud and abuse, certification	*438.606; 438.608*	5	5

Mental health PIP validation

Many RSNs have conducted QI projects for some years, but the RSNs only recently have begun to apply the CMS criteria to the conduct of formal PIPs. Acumentra Health evaluated the RSNs' PIPs for the first time in 2008.

Because RSNs begin their PIPs at different times, the studies may be in different stages at the time of review. Some may be underway but not yet complete; others may have progressed to the point of collecting baseline and remeasurement data; still others may have progressed to multiple remeasurements. The stage of the PIP at review determines the level of analysis that Acumentra Health applies.

PIP review procedures

Data collection tools and procedures, adapted from CMS protocols, involved document review and onsite interviews. Acumentra Health reviewed PIPs for the following elements:

- a written project plan with a study design, an analysis plan, and a summary of results
- a clear, concise statement of the topic being studied, the specific questions the study is designed to address, and the quantifiable indicators that will answer those questions
- a clear statement of the improvement strategies, their impact on the study question, and how that impact will be assessed and measured
- an analysis plan that addresses project objectives, defines indicators clearly, specifies the population being studied, identifies data sources and/or the data collection procedure, and discusses the methods for analyzing the data and performing statistical tests
- if applicable, a sampling methodology that yields a representative sample
- in the case of data collection that involves a medical chart review, a check on inter-rater reliability
- validation of data at the point of data entry for accuracy and completeness
- validation rules created in the data entry database to determine whether data were missing or whether data fell within valid parameters
- when claims or encounter data are used for population-based analysis, assessment of data completeness
- a summary of results that covers all data collection and analysis, explaining limitations inherent in the data and methodologies and discussing whether the strategies resulted in improvements

PIP scoring system

To determine the level of compliance with federal standards, Acumentra Health scored the RSN's PIPs according to criteria adapted from the CMS protocol and approved by MHD. The scoring methodology involves rating the RSN's performance on as many as 10 standards, listed in Table 8.

Table 8. Standards for RSN PIP validation.

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

Appendix D defines in detail the specific criteria used to evaluate performance.

Each individual standard has a potential score of 100 points for full compliance, with lower scores for lower levels of compliance. The total points for each standard are weighted and combined to determine an overall PIP score. The overall score, in turn, is based on an 80-point or a 100-point scale, depending on the stage of the PIP. If the PIP has completed no more than one remeasurement, the project is scored for demonstrable improvement in the first year (Standards 1–8), with a maximum score of 80 points. If the PIP has progressed to at least a second remeasurement, enabling the reviewers to assess sustained improvement (Standards 9–10), the maximum score is 100 points.

All PIPs submitted by the RSNs for review in 2008 were scored on the 80-point scale. At the time of review, not all RSNs had begun their planned interventions, and most PIPs had not progressed as far as the first remeasurement. Per the approved protocol, Acumentra Health scored all PIPs according to the same criteria, regardless of the stage of completion. As ongoing multi-year QI projects, the PIPs may not meet all criteria the first year but are expected to achieve full compliance as project activities progress.

Table 9 shows the compliance ratings and associated scoring ranges for PIPs graded on the 80-point scale. Appendix D presents a sample scoring worksheet.

Table 9. PIP scoring ranges on 80-point scale.

Compliance rating	Description	Point range
Fully met	Meets or exceeds all requirements	70–80
Substantially met	Meets essential requirements, has minor deficiencies	55–69
Partially met	Meets essential requirements in most, but not all, areas	40–54
Minimally met	Marginally meets requirements	25–39
Not met	Does not meet essential requirements	0–24

Summary of PIP validation results

Table 10 shows the topics of the PIPs submitted by each RSN.

Table 10. PIP topics by RSN.

RSN	PIP topic
CCRSN	Clinical: Employment Outcomes for Adult Consumers
	Nonclinical: Timeliness of Access to Outpatient Services
CDRSN	Clinical: Metabolic Syndrome Screening and Intervention
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
GCBH	Clinical: Impact of Implementing the PACT Model on the Use of Inpatient Treatment
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
GHRSN	Clinical: Increasing Number and Percent of Adults With Depression Diagnosis Who Receive PHQ-9 at Intake and at 6 Months
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
KCRSN	Clinical: Metabolic Syndrome Screening and Intervention
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
NCWRSN	Clinical: None submitted
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
NSMHA	Clinical: Restraint and Seclusion at the Freestanding Evaluation and Treatment Facilities
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
PRSN	Clinical: Metabolic Syndrome Screening and Intervention
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
SCRSN	Clinical: Healthy Partnerships/Motivational Interviewing
	Nonclinical: Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines
SWRSN	Clinical: Increasing Consumer Hospital Diversion Through Utilizing the Crisis Support Unit
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
TRSN	Clinical: Improving Employment Services and Outcomes
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
TMRSN	Clinical: Multisystemic Therapy
	Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization

Clinical PIP topics varied widely, as shown. Three RSNs addressed screening and intervention for enrollees at risk of developing metabolic syndrome, a set of serious health conditions that may result from using atypical antipsychotic medications to treat schizophrenia. Two RSNs conducted projects aimed at improving employment outcomes for adult enrollees. Several other RSNs used practice guidelines, including fidelity with evidence-based practices, to improve the quality of care.

As a nonclinical topic, 10 of the 12 RSNs studied improving the timeliness of outpatient follow-up appointments after discharge from psychiatric hospitalization. MHD's statewide performance measure calls for 80 percent of discharged Medicaid enrollees to be offered non-crisis services within seven days. According to MHD's calculations, all RSNs performed below that benchmark during 2006–2007. Four RSNs began interventions that involved designating a clinical person to contact the enrollee before discharge and facilitate the enrollee's attendance at an outpatient appointment within seven days. The remaining six RSNs awaited complete and accurate baseline data to help inform the development of their interventions. MHD and the RSNs needed to resolve issues with the baseline data files before the RSNs could determine whether their interventions were successful. (See pages 45–46.)

Figure 6 shows the scores by individual *validation standard* for the clinical and nonclinical PIPs, averaged across the 12 RSNs. Average scores were higher for the nonclinical PIPs in most cases, as the template for the "statewide" PIP provided somewhat more thorough documentation than was provided for the RSNs' various clinical PIPs. As a group, the RSNs partially or substantially met Standards 1–6, which involve documenting the study topic, question, indicators and population, the data collection and analysis plan, and intervention goals and strategies. The RSNs only minimally met Standards 7 and 8, which involve analyzing and reporting the results of each intervention. At the time of review, only a few RSNs had collected remeasurement data.

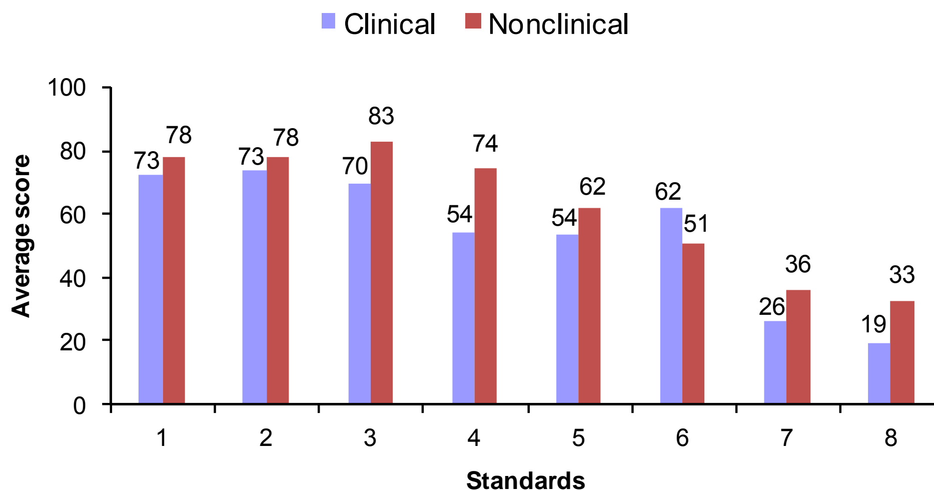

Figure 6. Average scores by validation standard for clinical and nonclinical PIPs.

Several themes emerged as to how the RSNs could strengthen their PIPs.

- RSNs need to demonstrate precisely how their PIP topics relate to the needs of their local Medicaid population, and describe the process used to prioritize the topic selection.

- Many RSNs need to validate and verify their data more carefully, and ensure that the population of each study includes all eligible enrollees.
- As part of each study, the RSN needs to confirm that its intervention is implemented as planned. This will enable the RSN to demonstrate more conclusively that any subsequent improvement is related to the intervention. If no improvement is apparent, evidence of proper implementation can simplify the analysis of barriers to improvement.

Figures 7 and 8 show the scores assigned by Acumentra Health, followed by a discussion of the PIP scores for each RSN.

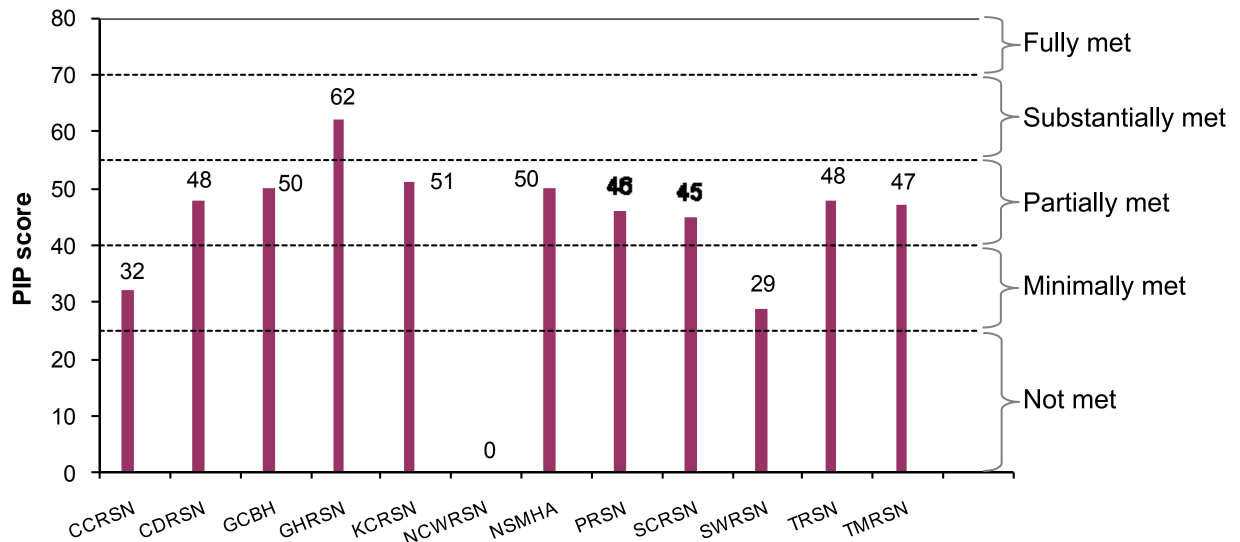

Figure 7. RSN scores on clinical PIPs.

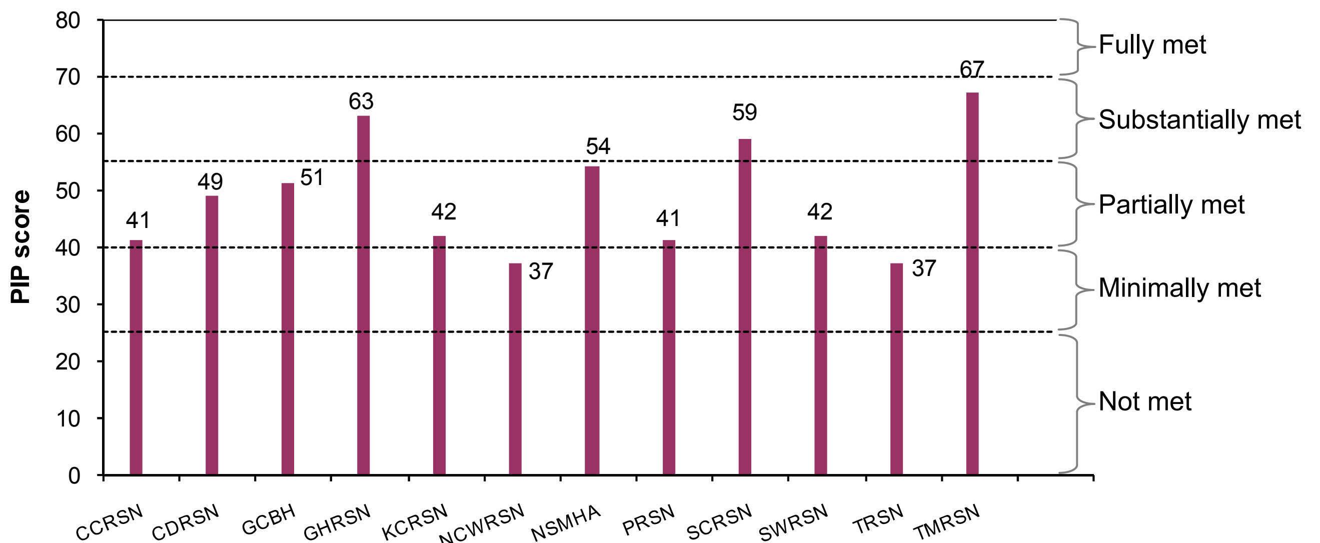

Figure 8. RSN scores on nonclinical PIPs.

PIP descriptions and discussion

Clark County RSN

Clinical: Employment Outcomes for Adult Consumers. The goal of this PIP was to increase the rate of employment of adult enrollees receiving routine outpatient services. CCRSN considered implementing a campaign that would advocate for employment of mental health clients by teaming with community partners to increase awareness of this population's potential to be competitively employed. At the time of review, CCRSN had not settled on an intervention strategy and had not determined the details of its data collection and analysis plan. CCRSN also needed to fill gaps in the documentation of the study question, indicator, and population.

Nonclinical: Timeliness of Access to Outpatient Services. This project, initiated in 2006, sought to improve the timeliness of access to intake for routine mental health services. As modified, the objective for 2007 was to measure whether a network-wide notification and referral process could increase the percentage of enrollees offered an intake appointment within 10 days of requesting routine services. The intervention began in February 2008. At the time of review, no results were available for analysis. CCRSN could strengthen the PIP documentation by providing more detail about how the RSN chose the study topic; clarifying elements of the study question, indicator, and population; and describing more precisely the data collection procedures and analysis plan.

Chelan-Douglas RSN

Clinical: Metabolic Syndrome Screening and Intervention. This PIP sought to reduce the risk of developing metabolic syndrome in enrollees with schizophrenia who use atypical antipsychotic medications. CDRSN planned to screen eligible enrollees for symptoms and, where necessary, intervene by educating enrollees about a healthy lifestyle and linking them to primary care. CDRSN did a good job of defining its study questions and indicators, but left gaps in the documentation of the study population, data collection and analysis plan, and intervention. For example, it did not describe the elements of enrollee education about diet, exercise, or smoking by which CDRSN proposed to reduce the risk of metabolic syndrome, nor how providers were to deliver the intervention. At the time of the review, CDRSN had completed baseline screening and had reported baseline results, but had not completed remeasurement.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. The PIP documentation needed to address some gaps in the definition of the study population, the data collection and analysis plan, and the details of its intervention by which CDRSN planned to improve the timeliness of outpatient follow-up. CDRSN also needed to collect and analyze its remeasurement data, test the data for statistical significance, and present an interpretation of the results.

Greater Columbia Behavioral Health

Clinical: Impact of Implementing the PACT Model on the Use of Inpatient Treatment. The goal of this PIP was to determine whether implementing the Program of Assertive Community Treatment (PACT) could reduce the high rate of inpatient hospitalization for enrollees in Benton and Franklin counties, The study question provided a clear framework for collecting, analyzing, and interpreting the study data. GCBH thoroughly documented the intervention, including an external assessment of the fidelity of implementation. At the time of the review, GCBH still

needed to collect, analyze, and report the results of remeasurement data, and fill gaps in documentation of the study indicator, study population, and data collection process.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. GCBH thoroughly documented the relevance of the study topic and did a good job of defining the study question, indicators, and data collection and analysis plan. As of the review, GCBH was awaiting a revised data set from MHD to assess whether an opportunity existed for improving the indicator, and to identify the provider agencies that would be required to implement interventions. Though remeasurement data were not available, GCBH documented a thorough barrier analysis identifying issues with the validity of the baseline data.

Grays Harbor RSN

Clinical: Increasing Number and Percent of Adults With Depression Diagnosis Who Receive PHQ-9 at Intake and at 6 Months. The goal of this PIP was to build a database of self-reported clinical outcomes, so that GHRSN could evaluate whether implementing its clinical practice guideline was correlated with self-reported improvement in depression symptoms for enrollees.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. This PIP sought to determine whether GHRSN could improve the timeliness of outpatient follow-up appointments by assigning a discharge oversight clinician at the time of hospital admission to arrange follow-up care.

For both PIPs, GHRSN substantially met standards related to defining the study questions and indicators, describing the process of data collection and analysis, and designing interventions to improve follow-up care and treatment outcomes. However, at the time of the review, GHRSN had yet to analyze remeasurement data to determine the success of its interventions.

King County RSN

Clinical: Metabolic Syndrome Screening and Intervention. This PIP sought to reduce the risk of developing metabolic syndrome in enrollees with schizophrenia who use atypical antipsychotic medications. KCRSN planned to screen eligible enrollees for symptoms and, where necessary, intervene by educating enrollees about a healthy lifestyle and linking them to primary care. At the time of the review, KCRSN had completed baseline data collection and reported on the study indicator for the baseline period. However, the PIP had not progressed to remeasurement. KCRSN needed to fill significant gaps in the PIP documentation related to the study population, data collection and analysis, and specific details of the intervention.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. KCRSN did a good job of demonstrating the relevance of the study topic and of defining the outcome indicators. The PIP documentation was less complete in defining the study population and the data collection and analysis plan. KCRSN needed to establish its intervention and incorporate it into the study question, document the intervention strategy in detail, implement the strategy, and measure and report on the results.

North Central Washington RSN

Clinical: None submitted. During the site review, NCWRSN provided a one-page summary of its progress on a clinical PIP. The summary provided a glimpse into a possible study topic and aided discussions during the review, but it did not constitute formal documentation for the PIP. At the time of this report, NCWRSN had not yet selected a study topic.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. NCWRSN substantially met the standards related to defining the study topic, indicator, and population. However, the project was incomplete, as NCWRSN had not yet selected an intervention and had not defined its data collection and analysis plan.

North Sound MHA

Clinical: Restraint and Seclusion at Freestanding Evaluation and Treatment Facilities: This PIP, initiated in 2003, seeks to reduce the use of seclusion and restraint in NSMHA's two E&T facilities. From 2003 to 2007, NSMHA reduced the use of seclusion and restraint by requiring nursing staff to provide prior medical clearance and physical assessments. In 2007, NSMHA implemented an additional intervention, adding a tool to its admission assessment to determine each consumer's level of risk for violence and aggression and to develop a consumer-specific treatment plan. The assessment tool appeared useful in identifying risk factors and creating individual treatment plans, but NSMHA needed to explain the details and expected impact of the intervention more fully. Because only partial data were available for the remeasurement period, no final conclusions were possible.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. NSMHA sought to improve the timeliness of outpatient follow-up by calling hospitalized enrollees within two working days prior to discharge, with the intent of engaging enrollees in outpatient services before discharge. NSMHA substantially defined its study question and indicator, and its intervention strategy can be expected to improve the timeliness of outpatient follow-up. However, NSMHA needed to fill gaps in its documentation of the study population and data collection process. Because the PIP had not progressed to remeasurement, no results were available for analysis.

Peninsula RSN

Clinical: Metabolic Syndrome Screening and Intervention. This PIP sought to reduce the risk of developing metabolic syndrome in enrollees with schizophrenia who use atypical antipsychotic medications. PRSN defined indicators well suited to measure the desired improvement. To create a more suitable framework for data collection and analysis, Acumentra Health suggested that the RSN split the study question into three separate questions corresponding to the three indicators. PRSN needed to describe the intervention steps in greater detail; clarify some issues related to identifying the study population and collecting the necessary data; collect and analyze its remeasurement data, test the data for statistical significance, and present an interpretation of the results.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. PRSN needed to flesh out more of the details of this PIP, especially the specific steps of its intervention strategy and how the strategy was expected to improve the timeliness of follow-up appointments. In addition, PRSN needed to clarify some essential details of its data

collection and analysis process, including the definition of data elements. As with the clinical PIP, PRSN needed to collect and analyze its remeasurement data and report the results.

Spokane County RSN

Clinical: Healthy Partnerships/Motivational Interviewing. Families of children in the RSN system perceived a lack of respect from providers. In response, SCRSN implemented Healthy Partnerships training for providers, based on the principles of motivational interviewing. The PIP was designed to use consumer survey data to determine whether that intervention could increase families' feelings of inclusion and respect while reducing reports of dissatisfaction with mental health treatment services. At the time of review, the documentation was not fully developed in terms of defining the study indicators, population, and data collection process, and SCRSN had yet to collect and analyze data to determine the success of its intervention.

Nonclinical: Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines. SCRSN has worked with provider agencies to define service encounter reporting instructions based on guidelines established by MHD. This PIP sought to determine whether the RSN-specific instructions could reduce reporting errors associated with the use of specific service codes, and whether the intervention strategy could be applied to coding accuracy rates for other service encounters. SCRSN substantially met the standards for defining study questions, indicators, and population, and for designing an effective data collection process. At the time of the review, SCRSN still needed to collect data for both study questions.

Southwest RSN

Clinical: Increasing Consumer Hospital Diversion Through Utilizing the Crisis Support Unit. The PIP documentation exhibited some fundamental problems with the study question, performance indicators, population, and other elements of the study design. Most importantly, SWRSN needed to revise the study question and other elements to address the main purpose of the PIP, which was to determine the success of the Crisis Services Unit in treating enrollees who present for inpatient evaluation but who do not meet medical necessity for hospitalization. Also, the documentation of the data collection and analysis plan was incomplete.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. SWRSN substantially met the standards related to defining the study question and performance indicators. At the time of review, SWRSN had not settled on an appropriate intervention to engage enrollees upon discharge so as to improve their adherence with scheduled appointments. SWRSN needed to strengthen the documentation of its data collection process to demonstrate that it would capture valid and reliable data. In addition, SWRSN needed to document its baseline data, collect remeasurement data after implementing its intervention, and analyze the data for improvement.

Thurston-Mason RSN

Clinical: Multisystemic Therapy. The documentation left gaps in defining the study indicators, population, and data collection and analysis plan. TMRSN needed to explain more fully how the Multisystemic Therapy intervention was expected to improve outcomes for young enrollees in terms of school attendance, suicide attempts, substance abuse, and arrests. No study results were available, as the PIP had not progressed to remeasurement.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. TMRSN did a good job of defining its study question, indicators, population, and data collection and analysis plan. The documentation thoroughly described the intervention strategy, which was well designed to improve system-wide performance. However, as TMRSN had not yet collected remeasurement data, no analysis of results was available.

Timberlands RSN

Clinical: Improving Employment Services and Outcomes. TRSN did a good job of defining its study question, indicators, and intervention, despite some gaps in documenting the study population and data collection plan. TRSN collected remeasurement data showing a significant improvement in the percentage of enrollees employed. However, the data also revealed a large decline in supported employment hours during the follow-up period, calling into question the validity of these results.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. TRSN succeeded in defining an objective and measurable study indicator. However, other aspects of the PIP were less fully documented. TRSN needed to fill gaps in its documentation, including citation of its baseline performance; implement an intervention designed to improve the study indicator; collect and analyze baseline and remeasurement data; and report the results.

Mental health performance measure validation

By contract, MHD requires each RSN to show improvement on a set of performance measures that MHD calculates and reviews. If the RSN does not meet defined improvement targets on any measure, the RSN must submit a performance improvement plan.

1. The RSN must offer non-crisis services to Medicaid recipients within seven days of discharge from a psychiatric inpatient hospital or evaluation and treatment program. Improvement is defined as reaching a target of 80 percent or an improvement of 10 percentage points from the previous quarter. This measure is similar to a national HEDIS measure.
2. The RSN must attempt to obtain a Consumer Outcome Assessment, using the Telesage instrument, at the time of an intake evaluation. Improvement is defined as reaching a target of 80 percent or an improvement of 10 percentage points from the previous quarter.
3. The RSN must attempt to obtain a Consumer Outcome Assessment, using the Telesage instrument, at three- and six-month follow-up periods during a consumer's episode of care. Two indicators are calculated for this term. Improvement is defined as reaching a target of 80 percent or an improvement of 10 percent over baseline.
4. Elapsed time from request for services to first routine service may not exceed 28 days. Improvement is defined as reaching a target of 90 percent or an improvement of 10 percentage points from the previous quarter.

Although RSNs are responsible for meeting performance measure targets, they do not calculate the measures. Looking Glass Analytics, an Olympia-based consulting firm, contracts with MHD to calculate the measures according to methodology supplied by MHD. Data for the calculations are collected through regular encounter data submissions from the RSNs.

As part of annual EQR activities, 42 CFR §438.358 requires the validation of state-mandated performance measures for managed care entities that serve Medicaid enrollees. In October 2008, Acumentra Health assessed the completeness and accuracy of MHD's performance measures and the procedural integrity of the information system for collecting, processing, and analyzing the data used in calculating the measures. The assessment sought to answer these questions:

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

Validation results

MHD provided Acumentra Health with a text file describing the performance measures, their numerators and denominators, and data notes for use in the validation process. However, MHD did not provide the source data tables, limiting the analyses and data validation procedures that Acumentra Health could conduct, including the analysis of inclusion/exclusion criteria. The details provided were insufficient to calculate the performance measure.

Table 11. Performance measure validation ratings.

Performance measure	Benchmark	Status	Rating
RSN must offer non-crisis services to Medicaid recipients within seven days of discharge from a psychiatric inpatient hospital or evaluation and treatment program.	80 percent or an improvement of 10 percentage points from the previous quarter	Currently calculated for the general population; Medicaid enrollees not differentiated	Not met
RSN must attempt to obtain a Consumer Outcome Assessment, using the Telesage instrument, at the time of an intake evaluation.	80 percent or an improvement of 10 percentage points from the previous quarter	Not calculated	Not met
RSN must attempt to obtain a Consumer Outcome Assessment, using the Telesage instrument, at three- and six-month follow-up periods during a consumer's episode of care. Two indicators are calculated for this term.	80 percent or an improvement of 10 percent over baseline	Not calculated	Not met
Elapsed time from request for services to first routine service may not exceed 28 days.	90 percent or an improvement of 10 percentage points from the previous quarter	Not calculated	Not met

Acumentra Health's review found that data challenges have prevented MHD from calculating valid performance measures and assigning the measures to RSNs. Currently, Looking Glass Analytics, on behalf of MHD, calculates only the first measure listed above, the timeliness of outpatient follow-up after an enrollee's discharge from psychiatric hospitalization. The results of that measure do not meet CMS criteria because the calculation is based on a denominator of all patients discharged from state hospitals and E&T facilities, without regard to each patient's Medicaid eligibility.

Finding

42 CFR §438.358 requires the annual validation of performance measures for managed care entities that serve Medicaid enrollees. MHD cannot calculate its performance measures according to specifications required by the state and therefore fails to meet CMS standards for the validation of performance measures. In addition, MHD calculates only one of its four statewide performance measures.

In addition, discussions with MHD staff revealed that MHD has no documented routine process to monitor or verify the calculation of performance measures by Looking Glass Analytics.

Information Systems Capabilities Assessment (ISCA) follow-up

APS Healthcare, MHD's previous EQRO, conducted a state-level ISCA during 2007 to evaluate the extent to which the state's information technology (IT) infrastructure supports the production and reporting of valid and reliable performance measures. The APS Healthcare ISCA report identified the following state-level strengths, challenges, and recommendations for MHD.

Strengths identified by APS Healthcare

1. Moving the IT department to an environment richer in resources has the potential for positive dividends for MHD.
2. The knowledge and skill of the individuals creating the performance measures and their intimacy with the data are impressive.
3. MHD has taken bold steps in outsourcing performance measure work—the product and the process have benefited and will continue to benefit from the changes.

Challenges identified by APS Healthcare

1. The potential downside of the IT move is the eventual loss of long-term institutional memory.
2. It is difficult for the RSNs to manage their environment when the performance measurement of their system is accomplished by another entity and the results are not timely enough to effectively drive the quality process.
3. A system of freezing the data so others can recreate or validate the calculations ultimately must be found.

Recommendations identified by APS Healthcare

1. Consider assigning some of the performance measures to the RSNs to further their understanding of the importance of quality data and to invest in the relationship between data integrity and the ability to measure quality improvement.
2. Continue work on a manual that describes in detail the processes used in calculating the performance measures.
3. Continue developing a method to ensure that data are archived to support future validations and additional analysis. A frozen data set would be the ideal solution.

Results of ISCA follow-up review: Acumentra Health reviewed the challenges and recommendations cited above with MHD and reviewed documentation to ascertain the steps taken by MHD in response to the 2007 report. Results of that review follow.

- MHD has not changed its approach to calculating performance measures since the previous ISCA, although MHD has documented its procedures for performing the calculations.
- Because MHD's database system is dynamic and is updated daily, MHD does not freeze the Medicaid data used in calculating the statewide performance measures. Freezing data through "snapshots" creates a point-in-time copy of a data set for replication, reporting, trend analysis, and future reference. Snapshots also provide an excellent means of data

protection. MHD is discussing with Looking Glass Analytics the creation of snapshots for the performance measure data.

- The Performance Indicator Workgroup, with representatives from the RSNs, provider agencies, and MHD, is working to improve methodology for a clearer interpretation of performance measure targets and results.
- Turnover of MHD's IT staff has been remarkably high; only two original staff members remain. MHD is aware of the institutional risks associated with the high turnover and is working to minimize those risks to ensure continued operations.

In addition to the state-level ISCA, APS Healthcare conducted an ISCA for each RSN in 2007, identifying strengths, challenges, and recommendations. Because the statewide performance measures are based on encounter data submitted by the RSNs, the validity and reliability of the measures ultimately depend on the accuracy and completeness of the RSN data.

In 2008, Acumentra Health reviewed those challenges and recommendations with the RSNs and reviewed documentation to ascertain the steps taken by each RSN in response to the 2007 ISCA. Results of the follow-up review appear in the individual RSN reports delivered to MHD during the year.

Acumentra Health recommendations

1. MHD needs to upgrade the data system used to calculate performance measures in order to identify Medicaid patients receiving E&T or state hospital services, to enable accurate calculation of the measure addressing the timeliness of follow-up care.
2. MHD should consider calculating all performance measures without its benchmarks. This would allow MHD to understand the current status of system issues shown by each performance measure. MHD could then use that information to set or modify its benchmarks.
3. MHD needs to develop instructions for calculating each performance measure, including inclusion/exclusion criteria, source data tables, field names, and, when appropriate, codes (e.g., diagnostic, procedure, Medicaid eligibility, etc.).
4. MHD needs to develop and document a data archiving system to support future validations and additional analysis. A frozen data set would be the ideal solution.
5. MHD needs to develop and document a routine procedure to monitor or verify the calculation of performance measures.

Mental health encounter data validation

Medicaid encounter data must be complete and accurate to be useful in calculating statewide performance measures and determining capitation rates for managed care plans. Each state establishes standards for encounter data completeness and accuracy and defines the types of encounters and the data fields to be submitted by health plans.

This portion of the EQR involved validating the mental health encounter data that the RSNs submitted to MHD. Activities included

- reviewing the state's standards for data accuracy and completeness
- for each RSN, checking each field in all outpatient and inpatient records for missing and out-of-range data and logic problems
- comparing specific data fields in the state's electronic data sets against providers' clinical records to ensure that all data submitted by the providers are accurate, complete, and supported by documentation

Encounter data validation for MHD and the RSNs occurred in 2005 as part of the previous EQR. That review identified problems regarding data structure, data dictionary definitions, physical record structure, and the content of clinical records. Acumentra Health's 2008 validation studies updated the previous review findings.

Encounter data validation procedures

Acumentra Health used sampling to review the state's encounter data sets for accuracy and completeness and to compare each RSN's clinical records with the state's data sets. Analysts first used SAS software to calculate appropriate sample sizes for each RSN with a confidence level of 95 percent and a confidence interval of ±5 points. A sample of 411 encounters typically is large enough to ensure the desired confidence level and interval, enabling valid conclusions about the accuracy and completeness of encounter data.

Acumentra Health analysts then drew random samples of records from the total encounter data file for analysis. The analysts requested clinical records for 100 enrollees from each RSN, which typically would yield at least the required number of encounters. After drawing a random sample of clients whose encounter records totaled at least the desired sample size, analysts compared the information in the clinical records against the information in the state data set.

Acumentra Health followed the steps outlined below, based on the CMS protocol, *Validating Encounter Data*.

1. Review the state's requirements for collecting, processing, and submitting encounter data, based on specifications in MHD's contract with the RSNs, the state's data dictionary, and other information furnished by the state.
2. Review results of the encounter data validation study conducted during the previous EQR cycle to identify follow-up needs.
3. Review the capability of each RSN's information system to capture accurate and complete encounter data, drawing on findings of the most recent ISCA review and on interviews with RSN personnel.

4. Analyze electronic encounter data to establish the magnitude of missing data, types of potentially missing data, overall data quality issues, and problems with how the RSN compiles and submits encounters to MHD. Subtasks include:
    - Verify that the RSN accurately incorporates into its information system the Medicaid enrollment (ID) data supplied by the state and that the RSN is reporting the data back to the state correctly.
    - Apply general edit and consistency checks, such as verifying that critical fields contain values that are consistent across fields.
    - Inspect data fields for general validity, including a review of each data element and of the volume of data by type or place of service.
    - Using standard statistical procedures, analyze data to obtain a validity overview of the RSN's encounter data. This step involves analyzing and interpreting the data in submitted fields, the volume and consistency of encounter data, and utilization rates, both overall and by specific diagnosis, procedure, service, and provider types.
    - Compare the RSN's encounter data with state standards and/or benchmarks.
5. If necessary, review clinical records to confirm findings of the above analysis.

Review results

This review presents the analysis of RSN encounter data in two parts: first, the results of electronic data checks of outpatient, inpatient, demographic, and consumer periodic data; second, the results of comparing the electronic records with the clinical chart documentation.

Electronic data checks

Acumentra Health analysts checked fields in 2,317,499 outpatient encounters for missing and out-of-range data and logic problems, representing all outpatient encounters for the RSNs in 2007. The fields examined included RSN ID, provider ID, consumer ID, primary diagnosis, service date and location, procedure code, claim number, and provider type. All fields except primary diagnosis and provider type had complete data with appropriate values as specified in the state data dictionary. The review found that .01 percent of the records omitted the primary diagnosis and .02 percent of the records omitted the provider type.

Analysts also examined whether procedure codes and service minutes conformed to the state's service reporting instructions. All codes in the outpatient data were valid codes according the service reporting instructions, and no records were found in which the minutes coded exceeded the maximum recommended by the state for the procedure code.

Analysts examined 4,009 inpatient encounters for missing and out-of-range data and logic problems, representing all inpatient encounters reported for the RSNs in 2007. The fields examined were admission and discharge date, consumer ID, provider ID, RSN ID, and primary diagnosis. These records showed no required fields with missing or out-of-range data or data that violated logic checks. An example of the logic checks performed included determining whether any discharge date preceded the admission date.

Next, analysts performed data checks on the demographic dataset, examining 339,916 records. The fields examined included consumer ID, date of birth, gender, ethnicity, Hispanic origin, language preference, Social Security number (SSN), sexual orientation, and first and last names.

Analysts found 37,697 records with missing SSN, 423 records with missing ethnicity data, and 119 records omitting the date of birth (all optional items). The review found 1,694 records with out-of-range SSN values (000-00-0000, 111-11-1111, etc) and 6,006 records with an RSN ID code that did not correspond to the RSN ID code for the RSN. Analysts also found 25 enrollees with more than one value coded for date of birth, 316 with more than one value coded for ethnicity, and 289 with more than one Hispanic origin value.

Analysts reviewed 767,407 records in the periodic data set, which shows additional demographic information such as employment and education status, grade level, living situation, county of residence, annual income, and number of dependents. Analysts checked each of these fields, as well as RSN ID, consumer ID, month, priority, and impairment, for missing and out-of-range values. The review found 40,796 records with missing annual income and 20,284 records with missing dependent information, both optional items.

Table 12 summarizes the results of electronic data checks for all data sets.

Comparison of electronic records with clinical chart documentation

The reviewers audited 5,472 encounter records across the RSNs, more than enough to facilitate statistical inference about the accuracy and completeness of encounter data. The encounters were reported in 1,101 charts. The data fields compared for each encounter included procedure code, provider type, minutes of service, service date, and service location. Reviewers examined the encounter notes to verify that the procedure code accurately described the treatment provided. They also compared electronic data from the state's demographic and periodic data sets with the chart documentation for the 1,101 enrollees.

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

1. chart documentation matches electronic data
2. data found in electronic system are missing from chart
3. data in chart are missing from electronic system
4. data are missing in both chart and electronic system
5. data could not be located in chart
6. data found in chart do not match data in electronic system

Of the 5,472 encounters reviewed from the state's outpatient data set, 84.5 percent had procedure codes that matched the chart documentation; 84.0 percent had provider type data that matched the chart notes; 88.3 percent had matching data on minutes of service; 79.9 percent had matching data on service location; and 89.8 percent had procedure codes that matched the treatment described.

In comparing demographic data, the enrollee's first name in the chart matched the electronic data 98.8 percent of the time. The last name in the chart matched the electronic record 99.2 percent of the time. For date of birth, 99.7 percent of charts matched the electronic data, and for gender, 97.9 percent of charts matched the electronic data.

Table 13 summarizes the electronic record and chart comparison for all fields reviewed.

Table 12. Results of electronic data checks.

Field	State standard	% complete
Outpatient encounter data (N = 2,317,499)		
RSN ID	100% complete (non-missing values), with values known to MHD	100
Consumer ID	100% complete (non-missing values), with values known to MHD	100
Agency ID	100% complete (non-missing values)	100
Primary diagnosis	100% complete (non-missing values), one diagnosis must be present	99.99
Service date	100% complete (non-missing values), must be in valid date format	100
Service location	100% complete (non-missing values), with values specified in data dictionary	100
Provider type	100% complete (non-missing values), with values specified in data dictionary	99.98
Procedure code	100% complete (non-missing values), with values specified in service instructions	100
Claim number	100% complete (non-missing values)	100
Minutes of service	100% complete for records with no per diem CPT/HCPCS codes	100
Inpatient encounter data (N = 4,009)		
RSN ID	100% complete (non-missing values), with values known to MHD	100
Provider ID	100% complete (non-missing values), with values known to MHD	100
Consumer ID	100% complete (non-missing values)	100
Admit date	100% complete (non-missing values)	100
Discharge date	Optional	100
Primary diagnosis	100% complete (non-missing values)	100
Demographic data (N = 339,916)		
RSN ID	100% complete (non-missing values), with values known to MHD	100
Consumer ID	100% complete (non-missing values)	100
First name	100% complete (non-missing values)	100
Last name	100% complete (non-missing values)	100
Date of birth	Optional	99.97
Gender	Optional	99.97
Ethnicity	Optional	99.92
Hispanic origin	Optional	100
Language preference	Optional	100
Social Security Number	Optional	88.06
Sexual orientation	Optional	100
Consumer periodic data (N = 767,407)		
RSN ID	100% complete (non-missing values), with values known to MHD	100
Consumer ID	100% complete (non-missing values)	100
Employment status	Optional	100
Education status	Optional	100
Grade level	Optional	100
Living situation	100% complete (non-missing values), with values specified in data dictionary	100
County of residence	100% complete (non-missing values), with values specified in data dictionary	100
Annual income	Optional	94.68
Number of dependents	Optional	97.36

Table 13. Results of encounter data validation.

Field	Chart matches electronic data	Data found in system missing from chart	Data in chart missing from system	Data missing in chart and system	Data could not be located in chart	Data in chart do not match system data
Procedure code (N=5,472)	4,623 (84.5%)	441 (8.1%)	5(0.1%)	2 (0.0%)	118 (2.2%)	283 (5.2%)
Provider type (N=5,437)	4,569 (84.0%)	348 (6.4%)	15 (0.3%)	1 (0.0%)	120 (2.2%)	384 (7.1%)
Minutes of service (N=5,445)	4,809 (88.3%)	339 (6.2%)	22(0.4%)	8 (0.1%)	102 (1.9%)	165 (3.0%)
Service location (N=5,417)	4,327 (79.9%)	619 (11.4%)	6 (0.1%)	2 (0.0%)	129 (2.4%)	334 (6.2%)
First name (N=1,101)	1,088 (98.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	13 (1.2%)
Last name (N=1,100)	1,091 (99.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	9 (0.8%)
Date of birth (N=1,100)	1,097 (99.7%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (0.2%)
Gender (N=1,100)	1,077 (97.9%)	12 (1.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	11 (1.0%)
Ethnicity (N=1,101)	969 (88.0%)	11 (1.0%)	7 (0.6%)	1 (0.1%)	11 (1.0%)	102 (9.3%)
SSN (N=1,097)	1,070 (97.5%)	13 (1.2%)	0 (0.0%)	0 (0.0%)	3 (0.3%)	11 (1.0%)
Education (N=1,092)	992 (90.8%)	19 (1.7%)	14 (1.3%)	2 (0.2%)	4 (0.4%)	61 (5.6%)

Discussion

In general, more than 90 percent of the RSNs' outpatient, inpatient, and demographic data were valid and accurately reflected in the state's data set.

The RSNs' encounter data were valid and accurately reflected in the state's data set more than 90 percent of the time, except for procedure code, provider type, service minutes, service location, and ethnicity. The data in these fields need to be accurate and complete when recording Medicaid service encounters. A reasonable benchmark for accuracy and completeness would be 95 percent of records.

Service location is of particular concern, because the data in this field matched the state's data only 79.9 percent of the time—slightly below CMS's requirement that these data be valid and accurately reflected in the state's data set more 80 percent of the time. Although the margin of error may raise this result above the 80 percent threshold, this data element still merits special attention.

Recommendations

- MHD needs to focus attention on improving service location validity and accuracy. RSNs and their provider agencies need to perform specialized encounter data validation audits and undertake corrective action until 95 percent of records meet this benchmark.
- Data on procedure code, provider type, service minutes, service location, and ethnicity should be the focus of routine audits that the RSNs and their provider agencies perform to validate encounter data.
- Provider agencies should audit their clinical records monthly for completeness, accuracy, and timeliness, and send copies of the resulting audit reports to the RSNs.
- MHD needs to consider including edits when adjudicating encounters to ensure that SSN values are in range, RSN ID codes correspond to the RSN ID code for the RSN, and only one value is coded for date of birth and ethnicity. Any data submitted, whether required or optional, should be correctly formatted and as accurate as possible. Routine edits as a part of adjudication can prevent many of the data errors discovered during this review.

Physical health care delivered by MCOs

During 2007, HRSA contracted with seven MCOs to deliver physical healthcare services to Medicaid managed care enrollees. Table 14 shows the approximate number and percentage of enrollees assigned to each health plan as of December 2007. Figure 9 shows the counties served by each health plan as of December 2007.

Table 14. Healthy Options MCOs and enrollees served, December 2007.

Health plan	Acronym	Number of enrollees	% of all enrollees
Asuris Northwest Health	ANH	1,489	<1
Community Health Plan	CHP	155,170	31
Columbia United Providers	CUP	31,622	6
Group Health Cooperative	GHC	18,418	4
Kaiser Permanente Northwest	KPNW	837	<1
Molina Healthcare of Washington	MHW	250,981	51
Regence BlueShield	RBS	33,410	7

HO/SCHIP Service Areas 2007

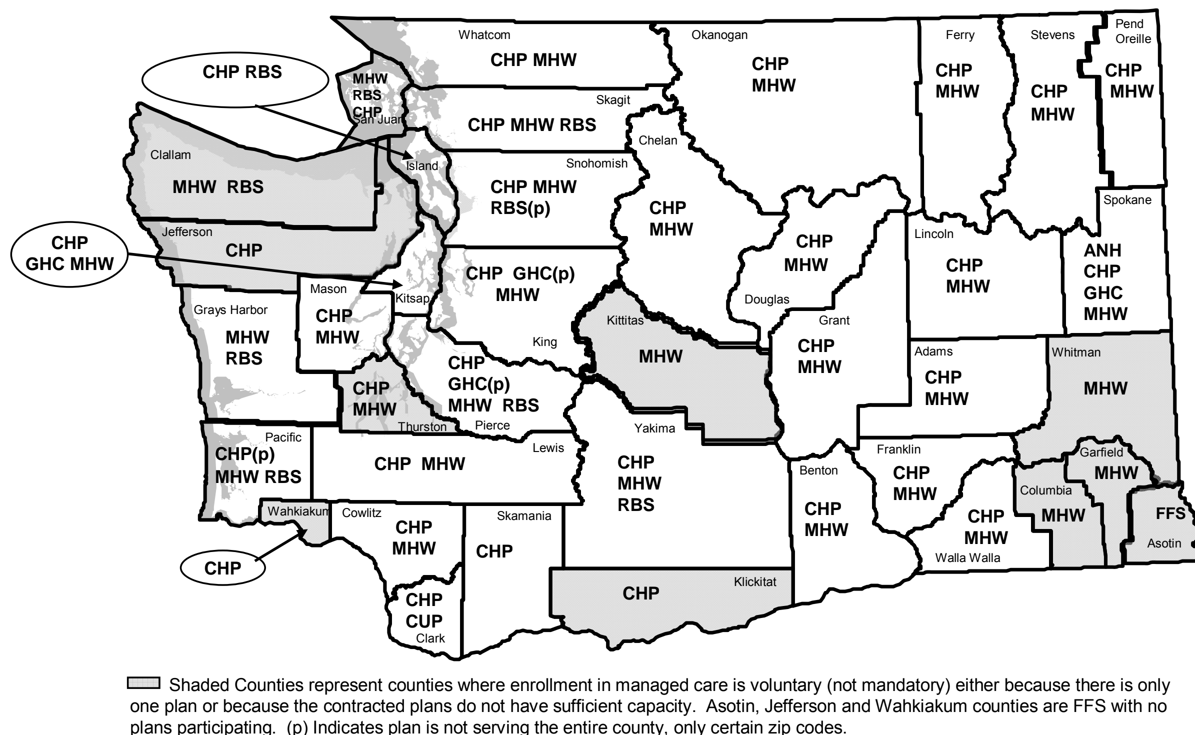

Figure 9. Geographical coverage of Healthy Options MCOs.

During 2007, at least one Healthy Options plan was active in 38 of the state's 39 counties. Enrollment is voluntary in some counties, either because only one health plan serves the county or because the contracted plans lack the provider network to accept new enrollees.

HRSA uses the annual HEDIS measures and CAHPS survey results to gauge the MCOs' performance against national benchmarks. The Healthy Options contract contains specific incentives based on the health plans' HEDIS scores. Acumentra Health's subcontractor, Health Services Advisory Group, audits each MCO's data collection process to ensure data integrity.

TEAMonitor conducts the regulatory/contractual compliance review for all Healthy Options MCOs and validates the health plans' PIPs. Review procedures are based on the CMS protocols for these activities. TEAMonitor requests preassessment documentation from each health plan supporting the plans' compliance with specific regulatory and contractual provisions. Along with these documents, the plans submit written answers to a set of interview questions regarding their policies and procedures in each major review area. Following a desk audit of these materials, TEAMonitor performs a one- to two-day site visit of each plan.

In analyzing quality, access, and timeliness measures for physical health care, this report considers performance at both a statewide and health plan level. In each Statewide Results section, the analysis appears in table format with star ratings. The star ratings show the results of comparing Washington's statewide score with the NCQA Medicaid national average for each element. State averages were calculated by adding individual plan numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and multiplying the resulting proportion by 100. For the national comparison, Acumentra Health used the 2008 Medicaid averages from the NCQA *Quality Compass*.[7]

In this rating system, one star means that Washington scored within the 10th percentile of national scores; two stars, between the 10th and 25th percentile (below average); three stars, between the 25th and 50th percentile (average); four stars, between the 50th and 75th percentile, and five stars, above the 90th percentile (above average). Figure 10 shows the stars and the percentile ranges.

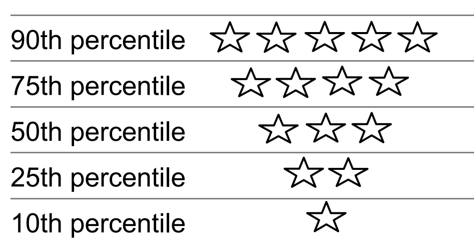

Figure 10. Percentiles and star ratings used for this report.

Access to physical health care

HRSA has several mechanisms in place to monitor MCOs' success in providing access to care for Healthy Options enrollees. Through TEAMonitor, HRSA assesses the MCOs' compliance with regulatory and contractual requirements related to access. (See Appendix C.) HRSA also monitors MCO performance on the standardized clinical performance measures discussed below. CAHPS measures of enrollee perceptions of access were not available for analysis in 2008.

Compliance with access standards

The Healthy Options contract requires each managed care plan to demonstrate that its provider network has sufficient capacity to serve all eligible enrollees, in terms of the number and types of providers required, the geographic location of providers and enrollees, and enrollees' cultural, ethnic, and language needs. Each MCO must ensure timely access to services and must monitor network capacity in relation to enrollee utilization patterns. Generally, the plans must comply with federal regulations in 42 CFR §438 governing access to care, particularly under Availability of Services, Furnishing of Services, Coverage and Authorization of Services, and Additional Services for Enrollees with Special Healthcare Needs (SHCN).

Among the findings of TEAMonitor's 2008 review:

- As a group, the MCOs complied with most requirements for coverage, authorization, and availability of services. Several MCOs provided insufficient documentation of their systems for maintaining and monitoring the adequacy of the delivery network, covering out-of-network services, and making utilization management decisions.
- With regard to furnishing of services, CHP and KPNW failed to document systems for measuring and analyzing demographic and geographical variables within their Medicaid population and for incorporating the findings into their improvement plans.
- More problems were evident with regard to services for enrollees with SHCN. The MCOs typically lacked proficient systems for identifying these enrollees, assessing their needs, developing and implementing treatment plans, and providing direct access to specialists.

Performance on access measures

Three elements of preventive care comprise the access measures for physical health: WCC visits for infants, children, and adolescents. These HEDIS measures assess health plans' success in providing access to WCC, expressed as the percentage of enrollees in each age group who received the recommended numbers of WCC visits:

- Infants in the first 15 months of life should receive *six or more* WCC visits during this period.
- Children in the 3rd, 4th, 5th, and 6th years of life should receive *at least one* WCC visit each year.
- Adolescents ages 12–21 should receive *at least one* WCC visit each year.

Statewide results: Table 15 provides a look at access to health care in Washington, based on the above elements. For infant WCC visits, 2008 is the first year that the Healthy Options plans matched the national average, following a significant increase in the state average from 2007 to

2008. However, child and adolescent WCC visits still lag behind the national average; in 2008, the state averages were significantly below the national averages. About 53 percent of Healthy Options infants received at least six visits in the first 15 months of life. WCC visit rates remained 59 percent for children and at 36 percent for adolescents.

Table 15. Washington scores and national averages for physical health access measures.

Measure	National average	Washington score	Washington rating
Prevention			
Infant WCC Visits (6 or more)	53%	53%	☆☆
WCC Visit, 3–6 years	65%	59%*	☆☆
Adolescent WCC Visit	42%	36%*	☆☆

Stars represent Washington's performance compared with the 2008 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.
*State average is significantly different from the NCQA average.

MCO results: This analysis compares the performance of individual health plans with the statewide scores on the access measures.

The percentages of WCC visits for enrollees in all three age groups varied substantially by health plan (see Table 16). Overall, MHW was the highest performing plan; rates significantly exceeded the state aggregate for the infant and child age groups.

Infants: Almost two-thirds of the infants enrolled with MHW (62 percent) received at least six WCC visits, significantly above the state average of 53 percent. In contrast, CUP's proportion of infants with the recommended number of WCC visits (42 percent) was significantly below the state average.

Ages 3–6: MHW (68 percent) reported the highest proportion of WCC visits for children in this age group—68 percent, significantly higher than the state average of 59 percent and above the national average. In contrast, CUP and GHC reported WCC visit rates that were significantly below the state average.

Adolescents: MHW, at 41 percent, was the best performer in getting adolescents seen for a WCC visit. RBS, at 40 percent, and ANH, at 39 percent, also exceeded the state average of 36 percent. CUP's rate, 29 percent, was significantly below the state average.

Among health plans, the 2008 rates for infants', children's, and adolescents' WCC visits were almost uniformly above the 2007 rates. Only GHC's rates for infants and children were significantly higher than the previous year's rates, while RBS's rates were significantly lower than the previous year for children and adolescents.

All Healthy Options plans have struggled to improve their rates of preventive care for children. As a group, the plans have significantly improved the percentage of infant and children WCC visits since 2004. However, visit rates for adolescents have remained flat.

Table 16. MCO and state scores for access measures.

Measure	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
Prevention								
Infant WCC (6+ visits)	—	49%	42% ▼	54%	—	62% ▲	58%	53%
Child WCC, 3 to 6 Years	54%	64%	52% ▼	53% ▼	50%	68% ▲	61%	59%
Adolescent WCC Visit	39%	35%	29% ▼	36%	34%	41%	40%	36%

▲ Health plan percentage is significantly higher than state average (p<0.05).
▼ Health plan percentage is significantly lower than state average (p<0.05).
— Sample size was less than the minimum required.

Timeliness of physical health care

The Healthy Options contract incorporates federal standards for timely care and makes MCOs responsible for monitoring their networks to ensure that enrollees receive timely care. (See Appendix C.) HRSA assesses the MCOs' compliance with these standards through the TEAMonitor reviews. In addition, HRSA monitors the plans' performance in providing timely postpartum care for female enrollees. CAHPS measures of enrollee perceptions of timeliness were not available for analysis in 2008.

Compliance with timeliness standards

By contract, each MCO must offer designated services 24 hours a day, seven days a week by telephone. For preventive care, office visits must be available from the enrollee's PCP or another provider within designated time frames, depending on the urgency of the enrollee's condition. Federal regulations require each MCO to provide hours of operation for Medicaid enrollees that are no less than the hours for any other patient, and to make services available 24 hours a day, 7 days a week, when medically necessary.

TEAMonitor found that four of the six MCOs demonstrated full compliance with state and federal requirements for timeliness; CHP and KPNW lacked complete documentation in this area.

Performance on timeliness measure

This year, only one measure of timeliness is available for physical health care: the preventive measure of postpartum care. This HEDIS measure assesses the timely initiation of postpartum visits for female enrollees who delivered a live birth during the measurement year, expressed as the percentage of such enrollees who had a postpartum visit on or between 21 days and 56 days following delivery.

Statewide results: Table 17 shows that nearly two-thirds of Healthy Options women are receiving timely postpartum care. In 2008, the statewide average score for postpartum care was essentially the same as in 2007, yet still significantly higher than the national average. The statewide average score has remained relatively constant for several years, while the rest of the nation gradually catches up with Washington's performance.

Table 17. Washington scores and national averages for physical health timeliness measure.

Measure	National average	Washington score	Washington rating
Prevention			
Postpartum Care	59%	62%*	☆☆☆

Stars represent Washington's performance compared with the 2008 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.
*State average is significantly different from the NCQA average.

MCO results: Acumentra Health compared the performance of individual health plans with the statewide score on the timeliness measure (see Table 18).

Among KPNW's female enrollees, 82 percent of those who delivered a live birth received timely postpartum care, a significantly higher percentage than the state average of 62 percent. GHC (at 64 percent) and RBS (at 66 percent) also exceeded the state average, while CHP, CUP, and MHW were slightly below the state average.

Scores improved for CHP, GHC, and RBS from 2007 to 2008, while scores for CUP and KPNW fell. MHW "rotated" this measure in 2008 (i.e., the MCO received permission from NCQA not to conduct this measure); the score shown below is the same as reported in 2007.

Table 18. MCO and state scores for timeliness measure.

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Prevention							
Postpartum Care[a]	60%	60%	64%	82% ▲	61%	66%	62%

▲ Health plan percentage is significantly higher than state average ($p<0.05$).
▼ Health plan percentage is significantly lower than state average ($p<0.05$).
[a]MHW rotated this measure in reporting year 2008.

Quality of physical health care

Federal EQR regulations (42 CFR §438.320), echoed in the Healthy Options contract, define quality as the degree to which a managed care plan "increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." Appendix C itemizes many quality-related standards covered by TEAMonitor's compliance reviews. HRSA also monitors MCO performance on the standardized quality measures discussed below. CAHPS measures of enrollee perceptions of quality were not available for analysis in 2008.

Compliance with quality standards

Quality standards are embedded primarily in the portions of the compliance protocol addressing Primary Care and Coordination, Provider Selection, Practice Guidelines, Quality Assessment and Performance Improvement (QAPI), Enrollee Rights, and Grievance Systems, and in contractual requirements to ensure continuity and coordination of care.

TEAMonitor's 2008 review found:

- The MCOs generally ensured their enrollees an ongoing source of appropriate primary care and ongoing coordination of healthcare services.
- All MCOs used evidence-based practice guidelines in decision making for utilization management, enrollee education, and service coverage.
- All MCOs fully or partially met requirements for provider selection, including credentialing and recredentialing.
- As a group, the MCOs met more than 80 percent of the required elements for enrollee rights and grievance systems, although no MCO met every element. The requirements not met typically involved the language, format, and timing of notices sent to enrollees and the MCO's system of record keeping and reporting on grievances and appeals.

HRSA requires each MCO to maintain a QAPI program that meets federal standards. The MCO must measure and report its performance on standardized measures; conduct PIPs; monitor for over- and underutilization of services; assess care furnished to enrollees with SHCN; and evaluate the QAPI program annually. TEAMonitor found that CHP and RBS fully met these requirements. The other MCOs met most requirements, although several fell short in analyzing and reporting on over- and underutilization or in assessing care for the SHCN population.

Performance on quality measures

Three HEDIS measures are available for analyzing the quality of physical health care: two broad measures of childhood immunization and a measure of diabetes care, blood sugar testing.

The first immunization measure, called Combination #2 (Combo 2), assesses the percentage of enrolled children who turned 2 years old during the measurement year and who received all of the following immunizations by their second birthday:

- four diphtheria, tetanus, and pertussis (DTaP)
- three polio (IPV)

- one measles, mumps, and rubella (MMR)
- three Haemophilus influenza type b (HiB)
- three hepatitis B (Hep B)
- one varicella-zoster virus (VZV) or chicken pox

The second measure, called Combination #3 (Combo 3), assesses the percentage of enrolled children who turned 2 years old during the measurement year and who received all of the above immunizations plus pneumococcal conjugate vaccine (PCV) by their second birthday.

The diabetes care measure assesses the percentage of adult enrollees with diabetes (type 1 or type 2) who received an HbA1c (blood sugar) test during the measurement year. Because children younger than 18 account for more than 80 percent of Washington's Medicaid population, health plans with low overall enrollment may have difficulty finding enough adult enrollees eligible for the diabetes measure components.

Statewide results: Table 19 compares Washington's performance on these quality measures with the nationwide performance.

Washington's Combo 2 immunization results in 2008 (averaging 70 percent) remained below the national average despite a significant improvement from the state's 67 percent average in 2007. The federal benchmarking report, *Healthy People 2010*, sets 90 percent as the target for health plans to achieve by 2010 for the six antigens in Combo 2. Currently, four antigen rates are at or above 90 percent (IPV, MMR, HiB, and Hep B), and the VZV rate has reached 85 percent. The statewide Combo 2 average has risen significantly over the past 5 years. In addition, the PCV immunization rate, averaging 81 percent in 2008, has risen significantly since 2006, when this measure was introduced; as a result, the Combo 3 average also has risen significantly and now slightly exceeds the national average.

The 2008 statewide averages for IPV, HiB, Hep B, and PCV immunizations were significantly higher than the national averages. The state's VZV immunization rate showed a significant gain from 2007 to 2008, yet remained significantly below the national average of 89 percent.

As to diabetes care, the Healthy Options plans as a group continue to significantly outperform the national Medicaid average for HbA1c testing.

Table 19. Washington scores and national averages for physical health quality measures.

Measure	National average	Washington score	Washington rating
Prevention			
Childhood Immunizations (Combo 2)	72%	70%	☆☆
Childhood Immunizations (Combo 3)	65%	67%	☆☆
Treatment			
Diabetes Care (HbA1c test)	77%	81%*	☆☆☆

Stars represent Washington's performance compared with the 2008 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.
*State average is significantly different from the NCQA average.

MCO results: Acumentra Health compared the performance of individual health plans with the statewide scores on the quality measures. (See Table 20.)

For *Combo 2 immunizations*, CHP scored significantly above the state average of 70 percent, while CUP scored significantly below the state average. CHP and MHW significantly improved their scores from 2007 to 2008.

For *Combo 3 immunizations*, CUP scored significantly below the state average of 67 percent. CHP, GHC, and MHW significantly improved their scores from 2007 to 2008.

Plan performance on *diabetes care* (HbA1c testing) ranged from a low of 76 percent (RBS) to a high of 91 percent (GHC). All plans except RBS outperformed the national average. Significance testing was not feasible at the plan level because of the small sample sizes for this measure.

Note: In 2008, GHC identified an issue with the identification of dual-eligible (Medicare and Medicaid) members within the plan's Healthy Options population for previous reporting years. GHC's 2008 data reflect the correction of this issue and accurately represent the plan's Healthy Options members. GHC's 2008 results for this measure are not directly comparable with prior years' averages, nor is the 2008 state average comparable with prior years.

Table 20. MCO and state scores for quality measures.

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Prevention							
Child Immunizations (Combo 2)	76% ▲	62% ▼	72%	76%	72%	68%	70%
Child Immunizations (Combo 3)	72%	58% ▼	70%	70%	68%	66%	67%
Diabetes Care (HbA1c test)	82%	82%	91% ▲	—	79%	76%	81%

▲ Health plan percentage is significantly higher than state average ($p<0.05$).
▼ Health plan percentage is significantly lower than state average ($p<0.05$).
— Sample size was less than the minimum required.

Physical health regulatory and contractual standards

During the first half of 2008, TEAMonitor reviewers scored MCOs on their compliance with more than 60 required elements in 16 categories of standards, based on BBA rules and the Healthy Options contract provisions. TEAMonitor auditors rated each MCO as having met, partially met, or not met the requirements for each standard listed below:

- Availability of Services
- Furnishing of Services (Timely Access)
- Timely Claims Payment
- Program Integrity
- Primary Care and Coordination
- Additional Services for Enrollees with Special Healthcare Needs (SHCN)
- Coverage and Authorization of Services
- Emergency and Post-Stabilization Services
- Enrollee Rights
- Enrollment and Disenrollment
- Grievance Systems
- Performance Improvement Projects (PIPs)
- Practice Guidelines
- Provider Selection (Credentialing)
- Quality Assessment and Performance Improvement (QAPI) Program
- Subcontractual Relationships and Delegation

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

Separately, TEAMonitor and the Aging and Disability Services Administration reviewed the WMIP and MMIP program contractors' compliance with selected regulations and contract provisions (see pages 85 and 89, respectively).

Compliance scoring methods

The comprehensive TEAMonitor audits produce a large amount of data. For purposes of analysis, Acumentra Health designed a scoring system that is intended to provide an easily understandable presentation of the data.

TEAMonitor assigned each of the required elements a score of Met, Partially Met, or Not Met, unless the element was not scored. Using scores from the TEAMonitor reports, Acumentra Health calculated compliance scores for each standard, expressed as a percentage of each standard's elements that were Met. These percentage scores appear in Table 21 and in the MCO Profiles in Appendix B. The scores were calculated as follows.

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

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

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

Summary of compliance review results

Table 21 breaks out the 2008 compliance scores assigned by TEAMonitor for each of 15 standards (excluding PIPs) by health plan. (Note: TEAMonitor combines its review of Regence BlueShield and Asuris, since the two plans share administrative functions and resources.) Figure 11 shows the change in compliance scores on selected standards from 2007 to 2008.

The 2008 scores indicate continuing improvement in compliance with the Availability of Services, Enrollee Rights, Grievance Systems, and QAPI Program standards. As a group, the health plans met at least three-quarters of all elements in those standards. At the same time, the statewide scores fell in 2008 for Claims Payment, Primary Care and Coordination, Additional Services for Enrollees with SHCN, Coverage and Authorization of Services, Emergency and Post-Stabilization Services, Practice Guidelines, and Provider Selection.

The plans demonstrated perfect compliance only with the Enrollment/Disenrollment standard. No plan fully met the standard for Enrollee Rights (13 elements) or for Grievance Systems (19 elements). However, CHP and CUP met 92 percent of the Enrollee Rights elements, and CHP, KPNW, and MHW met 89 to 90 percent of the Grievance Systems elements.

All but one health plan fully complied with the Program Integrity standard in 2008. This regulation requires MCOs to maintain administrative and management arrangements or procedures to guard against fraud and abuse. TEAMonitor added an element to the Subcontractual Relationships and Delegation standard for 2008, making it difficult to compare the 2007 and 2008 scores for that standard.

Many of the Partially Met or Not Met ratings relate to deficiencies in the MCOs' documentation to support compliance. HRSA required the plans to address all of these standards through corrective action plans following the TEAMonitor review. Therefore, the scores shown in Table 21 may not reflect the status of plan performance as of December 2008.

Table 21. MCO compliance scores for physical health regulatory and contractual standards.[a]

Compliance with Managed Care Standards: Health Plan Comparison
(Percentage of elements Met, Partially Met, and Not Met)

Standard (# of elements)	CHP			CUP			GHC			KPNW			MHW			RBS/ANH			State average		
	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM
Availability of Services (5)	**80**	0	20	**100**	0	0	**40**	0	60	**100**	0	0	**100**	0	0	**60**	20	20	**80**	3	17
Furnishing of Services (2)	**0**	50	50	**100**	0	0	**50**	50	0	**50**	50	0	**100**	0	0	**50**	50	0	**58**	33	8
Program Integrity (1)	**100**	0	0	**0**	100	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**83**	17	0
Claims Payment (2)	**50**	0	50	**50**	50	0	**50**	0	50	**50**	50	0	**0**	100	0	**100**	0	0	**50**	33	17
Primary Care and Coordination (1)	**0**	100	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**83**	17	0
Additional Services for Enrollees with Special Healthcare Needs (4)	**25**	25	50	**0**	50	50	**25**	0	75	**25**	0	75	**75**	25	0	**25**	50	25	**29**	25	46
Coverage and Authorization of Services (4)	**100**	0	0	**50**	25	25	**100**	0	0	**100**	0	0	**75**	25	0	**75**	25	0	**83**	13	4
Emergency and Post-stabilization Services (1)	**100**	0	0	**0**	100	0	**0**	100	0	**100**	0	0	**0**	100	0	**0**	100	0	**33**	67	0
Enrollee Rights (13)*	**92**	8	0	**92**	8	0	**75**	17	8	**83**	17	0	**75**	25	0	**83**	17	0	**83**	15	1
Enrollment/Disenrollment (1)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Grievance Systems (19)	**89**	11	0	**74**	21	5	**79**	21	0	**90**	5	5	**90**	10	0	**79**	16	5	**84**	14	2
Practice Guidelines (3)	**100**	0	0	**100**	0	0	**67**	33	0	**100**	0	0	**100**	0	0	**100**	0	0	**95**	5	0
Provider Selection (Credentialing) (3)	**0**	100	0	**67**	33	0	**33**	67	0	**67**	33	0	**100**	0	0	**67**	33	0	**56**	44	0
QAPI Program (5)	**100**	0	0	**60**	0	40	**80**	20	0	**40**	40	20	**80**	20	0	**100**	0	0	**77**	13	10
Subcontractual Relationships and Delegation (4)	**0**	100	0	**50**	50	0	**75**	25	0	**25**	25	50	**100**	0	0	**25**	0	75	**46**	33	21

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

Note: Not all health plans were scored on all elements of each standard. Percentages may not add to 100 because of rounding.

*Only CHP was scored on all 13 elements; other plans were scored on 12.

[a] These standards were scored during the first half of 2008. Some "Partially Met" and "Not Met" scores were due to insufficient documentation to support compliance. Since then, health plans with a score of "Partially Met" or "Not Met" for any standard have submitted corrective actions plans; therefore, the above scores may not reflect the status of plan performance as of December 2008.

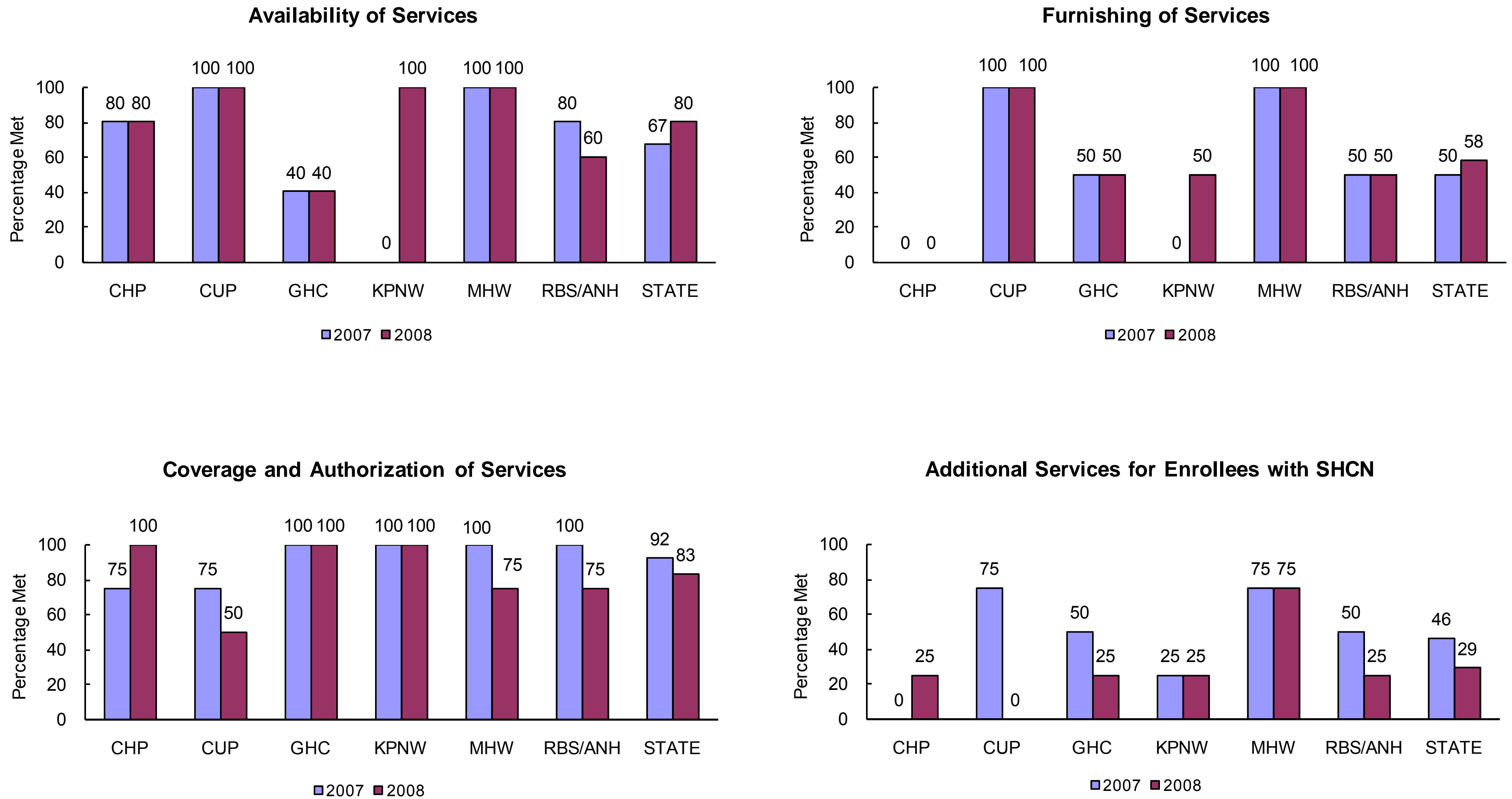

Figure 11. Changes in compliance scores for selected physical health regulatory standards by MCO, 2007–2008.

Timeliness and Quality Standards

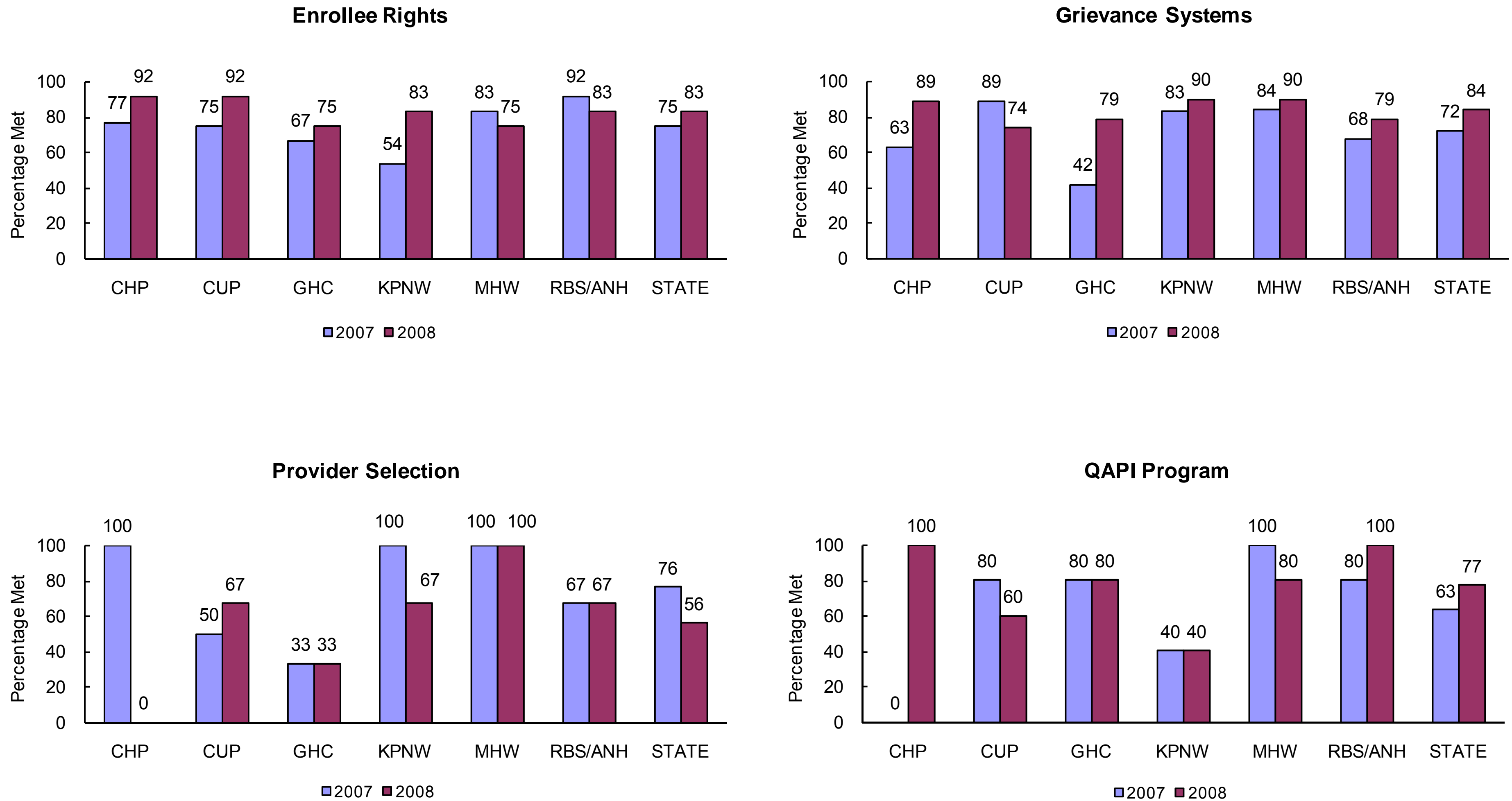

Figure 11. Changes in compliance scores for selected physical health regulatory standards by MCO, 2007–2008 (cont.).

Corrective action plans

In 2008, TEAMonitor reviewed the MCOs' 2007 corrective action plans (CAPs), documenting resolution of corrective action as part of the review process. If, as part of the 2008 review, old or new findings were observed, TEAMonitor documented those findings and required corrective action. The state required a 2008 CAP from MCOs that scored Partially Met or Not Met on the majority of elements reviewed by TEAMonitor or on any element left unresolved or incomplete as a result of the 2007 CAP.

MCOs had to submit their CAPs within 60 days of their final TEAMonitor report. TEAMonitor staff reviewed the corrective action once. If the staff did not accept any part of a health plan's CAP, follow-up was delegated to the assigned state contract manager.

Table 22 shows the disposition of CAPs required in 2008.

Table 22. Disposition of MCOs' corrective action plans.

Health plan	2008 CAPs required	2008 CAPs accepted	2008 CAPs not accepted or partially accepted	2007 CAP status not resolved
CHP	18	18	0	2
CUP	20	14	6	1
GHC	21	18	3	3
KPNW	16	16	0	2
MHW	11	10	1	0
RBS/ANH	18	17	0	1
WMIP	24	21	3	N/A

Overall, TEAMonitor required fewer CAPs in 2008 than in 2007, and TEAMonitor accepted most CAPs. The majority of CAPs involved submitting revised or missing documentation to support compliance with specific regulations and contract requirements. CAPs that were not accepted or partially accepted were related to

- availability of services: evidence of delivery network standards and quality indicators for measurement, analysis, planning, and improvement or corrective action, monitoring of providers, out-of-network services
- coordination and continuity of care: evidence of assessment, treatment plans, and direct access to specialists for enrollees with SHCN
- coverage and authorization of services: concerns related to the decision process and how the MCO monitors and analyzes delegated contractor information
- grievance systems: internal review process out of compliance with contract requirements
- enrollee rights: evidence of monitoring for member notification of terminated providers

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

Physical health PIP validation

The 2008–2009 managed care contract requires each MCO to conduct at least one clinical and one nonclinical PIP. During 2007, each MCO conducted five PIPs—three clinical and two nonclinical—as required by the previous contract. An MCO must conduct a PIP to improve immunization and/or WCC rates if the plan's reported rates fall below established benchmarks (see Appendix C, page C-4.)

PIP validation by TEAMonitor follows CMS standards. MCOs must conduct their PIPs as formal studies, presenting descriptions of the study question, numerator and denominator, confidence interval, and tests for statistical significance. In addition, all Medicaid enrollees must have access to the interventions described in the PIP.

TEAMonitor's 2008 review evaluated the five PIPs each MCO conducted during 2007. Four different HRSA staff members reviewed the PIPs. All reviewers received a scoring guide and training on how to use the tool. The project lead examined all completed PIP reviews. Findings were edited and, in some cases, scores were modified following discussion and agreement between reviewers.

Table 23 shows the topics of the PIPs conducted by each MCO in 2008 and the scores assigned by TEAMonitor. KPNW did not submit its PIPs in a timely manner according to TEAMonitor's instructions and thus received a "Not Met" score for all PIPs. Among the remaining MCOs, all five addressed child and/or adolescent immunizations and WCC visits through their clinical PIPs, and three MCOs addressed asthma care or management. Many of these PIPs were required by contract. The nonclinical PIP topics ranged more widely, as shown.

GHC, MHW, and RBS/ANH earned "Met" scores for the majority of their PIPs, while CHP and CUP received "Partially Met" scores for all PIPs.

A discussion of each MCO's PIPs follows Table 23. The comments regarding strengths, areas for improvement, and other aspects of the PIPs are based on the final TEAMonitor reports. Appendix D itemizes the steps that TEAMonitor used in assessing the MCOs' PIPs.

Table 23. PIP topics and scores by MCO.

Plan	PIP topic	Score
CHP	Clinical: Childhood Immunizations: Improving HEDIS Measurement Rates	Partially Met
	Clinical: Improving Clinical Outcomes for Members with a Diagnosis of Asthma	Partially Met
	Clinical: Well-Child Exams: Improving HEDIS Measurement Rates	Partially Met
	Nonclinical: Access to Care—A Lean Perspective	Partially Met
	Nonclinical: Simple Rules and Access to Care	Partially Met
CUP	Clinical: Improving Well-Child Visits	Partially Met
	Clinical: Improving Early Childhood Immunization Rates	Partially Met
	Clinical: Improving Management of Asthma as a Chronic Disease	Partially Met
	Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Partially Met
	Nonclinical: Improving Member Understanding of Plan Benefits and Services	Partially Met
GHC	Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Met
	Clinical: Improving Childhood and Adolescent Immunization Rates	Met
	Clinical: Ensuring Members Receive Recommended Prenatal Care	Met
	Nonclinical: Improving Physician Communication with Members	Met
	Nonclinical: Member Utilization of Online Services to Enhance Health Information and Patient Self-Care	Partially Met
KPNW	No review because PIPs were not submitted timely according to TEAMonitor instructions. PIPs submitted later are reviewed as part of corrective action.	Not Met
MHW	Clinical: Improvement of HEDIS Well-Child Rates	Met
	Clinical: Improving Childhood Immunization Rates	Met
	Clinical: Adolescent Immunization Status	Met
	Nonclinical: Improving Member Knowledge of Benefits	Partially Met
	Nonclinical: Pre-Service Authorization Dates	Partially Met
RBS/ ANH	Clinical: Improve Appropriate Medication Use for Medicaid Members with Asthma	Met
	Clinical: Medicaid Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Met
	Clinical: Improving the Rate of Child Immunizations in the Medicaid Population	Met
	Nonclinical: Improve Response Time of Pharmacy Prior Authorization Denials	Partially Met
	Nonclinical: Improve Getting Help from Customer Service for Medicaid and PEBB Enrollees	Met

Community Health Plan

Table 24 displays the topics and scores of CHP's PIPs in the past three years. CHP carried over two clinical projects from 2006 through 2008, aimed at improving asthma care outcomes and improving WCC visit rates. In 2008, CHP continued one clinical PIP from 2007, and began two new nonclinical PIPs aimed at improving access to care. CHP conducted contractually required PIPs related to well-child care and immunizations.

Table 24. Community Health Plan PIP topics and scores, 2006–2008.

Topic	2006	2007	2008
Clinical: Improve Clinical Outcomes for Members With a Diagnosis of Asthma	Met	Met	Partially Met
Clinical: Well-Child Exams: Improving HEDIS Measurement Rates	Partially Met	Partially Met	Partially Met
Clinical: Childhood Immunizations: Improving HEDIS Measurement Rates	Not conducted	Partially Met	Partially Met
Nonclinical: Access to Care—A Lean Perspective	Not conducted	Not conducted	Partially Met
Nonclinical: Simple Rules and Access to Care	Not conducted	Not conducted	Partially Met

Strengths

- CHP's PIP addressing asthma care has been considered a best practice, although it received a "Partially Met" score in 2008 because of inconsistent documentation regarding new measures added.
- Monthly data sent to clinics regarding children who are fully immunized is a "best practice across all health plans," according to TEAMonitor.
- Data displays were strong across several PIPs; TEAMonitor cited as a best practice CHP's use of Performance Evaluation Tool graphs to provide clinic-specific feedback.

Opportunities for improvement

- CHP failed to improve its score on two PIPs carried over from 2007: Well-Child Exams and Childhood Immunizations. In the case of one PIP, it is possible that not enough time had elapsed since the start of new interventions to demonstrate improvement; in the other case, TEAMonitor cited insufficient documentation.
- TEAMonitor found that CHP could have condensed its two nonclinical projects into a single project with two interventions.
- CHP would benefit from providing increased analytic support to staff conducting PIPs, to help in designing the projects and evaluating performance measures.

Columbia United Providers

Table 25 displays the topics and scores of CUP's PIPs in the past three years. As shown, CUP carried over its three clinical PIPs from 2006 through 2008. CUP also carried over two nonclinical PIPs initiated in 2007. The plan conducted contractually required PIPs related to immunizations and well-child care.

Table 25. Columbia United Providers PIP topics and scores, 2006–2008.

Topic	2006	2007	2008
Clinical: Improving Early Childhood Immunization Rates	Met	Met	Partially Met
Clinical: Improving Management of Asthma as a Chronic Disease	Partially Met	Partially Met	Partially Met
Clinical: Improving Well-Child Visits	Partially Met	Partially Met	Partially Met
Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Not conducted	Partially Met	Partially Met
Nonclinical: Improving Member Understanding of Plan Benefits and Services	Not conducted	Partially Met	Partially Met

Strengths

- The asthma PIP documented multiple interventions over time and featured a novel intervention. Outreach work with local school districts was cited as a best practice.
- Clinical PIPs were well documented and featured excellent use and display of data.
- CUP used several robust interventions to address emergency department utilization patterns for both enrollees and providers. These included educational programs for both audiences and an incentive program directed toward the clinics.

Opportunities for improvement

- TEAMonitor recommended that CUP consider providing performance feedback to clinics regarding immunization and WCC rates.
- The PIP targeting childhood immunization rates did not clearly measure the effect of the intervention and did not answer the study question.
- The PIP targeting WCC visits did not collect data to correlate the intervention with a change in WCC rates.
- For the nonclinical PIPs, TEAMonitor recommended that CUP establish a better link between the projects and research literature.

Group Health Cooperative

Table 26 displays the topics and scores of GHC's PIPs in the past three years. GHC carried over one clinical PIP and one nonclinical PIP from 2006 to 2008 and one clinical PIP from 2007 to 2008. GHC began two new PIPs in 2008, aimed at improving prenatal care and improving physician communication with members.

Table 26. Group Health Cooperative PIP topics and scores, 2006–2008.

Topic	2006	2007	2008
Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Not conducted	Partially Met	Met
Clinical: Improving Childhood and Adolescent Immunization Rates	Met	Partially Met	Met
Clinical: Ensuring Members Receive Recommended Prenatal Care	Not conducted	Not conducted	Met
Nonclinical: Improving Member Utilization of Online Services	Met	Met	Partially Met
Nonclinical: Improving Physician Communication with Members	Not conducted	Not conducted	Met
Clinical: Improving Antidepressant Medication Management During the Acute Phase of Treatment	Not conducted	Partially Met	Not conducted
Nonclinical Project: Improving Primary Care Access	Not conducted	Partially Met	Not conducted

Strengths

- GHC achieved "Met" scores for four of its five PIPs, with the other earning a "Partially Met" score.
- GHC's PIP documentation was consistently thorough, with well-documented rationale for projects, including references to relevant literature and benchmarks.
- TEAMonitor cited excellent description of methods and display of measurement data, including trend data.
- GHC implemented a wide range of interventions in all five active projects. Documenting the impact of interventions with monthly data was considered a best practice.
- Performance feedback used in the PIPs on well-child and well-adolescent visits was identified as a best practice.

Opportunities for improvement

- Although GHC has made progress in improving well-child and well-adolescent visit rates, TEAMonitor cited the need for further improvement to meet the statewide averages.
- In the Improving Member Utilization of Online Services PIP, the measures designed to demonstrate active use of the website showed no improvement. GHC may need to develop and implement other interventions aimed at increasing enrollee use of the website.

Kaiser Permanente Northwest

Table 27 displays the topics and scores of KPNW's PIPs in 2006 and 2007. TEAMonitor did not review KPNW's PIPs in 2008 because the PIPs were not submitted in a timely manner according to instructions. PIPs submitted late are reviewed as part of corrective action.

Table 27. Kaiser Permanente Northwest PIP topics and scores, 2006–2007.

Topic	2006	2007	2008
Clinical: Adolescent Immunizations	Partially Met	Partially Met	*
Clinical: Pediatric Obesity	Not Met	Partially Met	*
Clinical: Well-Child Visits	Not Met	Partially Met	*
Nonclinical: Postpartum Follow-up	Met	Met	*
Nonclinical: Telephone Access to Membership Services	Not conducted	Met	*

*TEAMonitor reviewed no PIPs for KPNW in 2008.

Strengths

- Because KPNW's PIP documents will be reviewed as part of corrective action for 2008, no strengths can be reported at this time.

Opportunities for improvement

- Because KPNW's PIP documents will be reviewed as part of corrective action for 2008, no improvement opportunities can be reported at this time.

Molina Healthcare of Washington

Table 28 displays the topics and scores of MHW's PIPs in the past three years. As shown, MHW carried over two clinical PIPs from 2006 to 2008. MHW began three new PIPs in 2008, aimed at improving adolescent immunization status, member knowledge of benefits, and the timeliness of service authorization decisions. MHW conducted contractually required PIPs for immunizations and well-child care.

Table 28. Molina Healthcare of Washington PIP topics and scores, 2006–2008.

Topic	2006	2007	2008
Clinical: Improving Childhood Immunization Rates	Met	Met	Met
Clinical: Improving HEDIS Well-Child Rates	Met	Partially Met	Met
Clinical: Adolescent Immunization Status	Not conducted	Not conducted	Met
Clinical: Asthma Medication Prescribing Practices	Met	Partially Met	Not conducted
Nonclinical: Improving Member Knowledge of Benefits	Not conducted	Not conducted	Partially Met
Nonclinical: Pre-Service Authorization Dates	Not conducted	Not conducted	Partially Met
Nonclinical: Improving Quality of the Specialty Network	Partially Met	Partially Met	Not conducted
Nonclinical: Improving Satisfaction With Customer Service	Partially Met	Partially Met	Not conducted

Strengths

- TEAMonitor cited MHW's PIP documentation as a best practice, with clear and concise writing and good data tables and charts describing performance, barriers, and interventions over time.
- MHW's PIPs featured excellent use of statistical analyses to document outcomes.

Opportunities for improvement

- TEAMonitor recommended new interventions and providing performance feedback to provider offices for two PIPs: Improving Childhood Immunization Rates and Improving HEDIS Well-Child Rates.
- For the nonclinical PIPs, TEAMonitor found that MHW needed to strengthen its documentation of the study rationale and study questions.

Regence BlueShield/Asuris Northwest Health

Table 29 displays the topics and scores of RBS/ANH's PIPs in the past three years. RBS/ANH carried over all projects from 2006 through 2008, maintaining a "Met" score on three of the PIPs and improving another PIP from "Partially Met" to "Met" in 2008. RBS/ANH conducted contractually required PIPs for immunizations and well-child care.

Table 29. Regence BlueShield/Asuris Northwest Health PIP topics and scores, 2006–2008.

Topic	2006	2007	2008
Clinical: Improve Appropriate Medication Use for Members With Asthma	Partially Met	Met	Met
Clinical: Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Partially Met	Met	Met
Clinical: Improve Rate of Child Immunizations	Met	Met	Met
Nonclinical: Improve Response Time of Pharmacy Prior-Authorization Denials	Partially Met	Partially Met	Partially Met
Nonclinical: Improve Getting Help From Customer Service	Partially Met	Partially Met	Met

Strengths

- RBS/ANH achieved "Met" scores for four of its five PIPs, with the other scored "Partially Met." The score of the nonclinical PIP addressing customer service improved from "Partially Met" in 2006 and 2007 to "Met" in 2008.
- TEAMonitor cited as a best practice the PIP related to well-child visits for Hispanic enrollees, which addressed health disparities.
- Other best practices cited by TEAMonitor included excellent use of tables and graphs to display data in all PIPs and the use of novel measures, such as emergency room utilization, in the PIP involving HEDIS measures for patients with asthma.

Opportunities for improvement

- The PIP addressing timeliness of prior authorization for pharmacy prescriptions showed no evidence of sustained improvement and reflected some difficulties with evaluating the variables. TEAMonitor noted that high staff turnover and a new data system may have contributed to the lack of data collection.

Washington Medicaid Integration Partnership Evaluation

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

The state contracts with MHW to conduct this pilot project in Snohomish County, with expansion planned as the pilot project matures. MHW is expected to

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

The WMIP target population is Medicaid enrollees age 21 or older who are aged, blind, or disabled, including Medicaid-only enrollees and those dually eligible for Medicare and Medicaid. WMIP excludes children under 21, Healthy Options enrollees, and recipients of Temporary Assistance for Needy Families. As of October 2008, WMIP enrollment totaled nearly 3,000.

Because the WMIP population differs categorically from the traditional Medicaid population, it is not possible to compare the WMIP data meaningfully with the data reported by Healthy Options plans or with national data for health plans serving traditional Medicaid recipients. However, it is possible to evaluate changes from the 2006 WMIP baseline measurements for some indicators of diabetes care and service utilization.

For 2008, MHW reported seven HEDIS measures for the WMIP population: comprehensive diabetes care, general hospital/acute care and nonacute care utilization, ambulatory care utilization, anti-depression medication management, follow-up after hospitalization for mental illness, and use of high-risk medications for the elderly. This report analyzes the results of those measurements. MHW also conducted the CAHPS survey of member satisfaction with WMIP services, validated by means of CMS's ISCA tool. The CAHPS results will be reported separately in early 2009.

Table 30 presents the WMIP results for comprehensive diabetes care from 2006 through 2008. The 2008 rates for eye exams, lipid profile and control, monitoring of nephropathy, and blood pressure control were higher than the rates reported in 2007, although only blood pressure control (140/90 mm Hg) was significantly higher.

Table 30. WMIP comprehensive diabetes care measures, 2006–2008.

	2006	2007	2008
HbA1c tests (percentage tested)	84.55	82.90	82.16
Enrollees with HbA1c levels poor control (percentage with HbA1c>9.0%)	37.73	42.49	43.87
Enrollees with HbA1c levels good control (percentage with HbA1c<7.0%)	n/a	36.79	36.06
Dilated retinal exams (percentage examined)	52.73	54.40	59.11
Lipid profile (LDL-C) performed (percentage profiled)	—	76.17	76.58
Lipids controlled (percentage with <100mg/dL)	—	31.09	35.32
Nephropathy monitored annually (percentage monitored)	—	77.72	82.16
Blood pressure control (percentage with <130/80 mm Hg)	n/a	31.61	38.66
Blood pressure control (percentage with 140/90 mm Hg)	n/a	56.48	65.80 ↑

n/a: NCQA did not require this measure until reporting year 2007.
— Definition and methodology changed in 2007; therefore, data from previous years are not comparable.
↓↑ indicates statistically significant differences in percentages from 2007 to 2008 ($p \leq 0.05$).

Tables 31 and 32 present WMIP results for inpatient utilization, general hospital/acute care, in reporting years 2006–2008, and for inpatient nonacute care in 2007 and 2008. Table 33 presents the results for ambulatory care utilization in 2006–2008.

Utilization rates for general hospital/acute care showed nonsignificant changes from 2007 to 2008. Overall, utilization rates have declined since 2006—a positive trend for this population with complex healthcare needs—although the declines were not statistically significant. The outpatient visit rate in 2008 declined significantly from 2007, though remaining higher than the 2006 rate. At the same time, the average length of stay (ALOS) for enrollees in inpatient nonacute care rose significantly from 2007, due primarily to the addition of long-term care enrollees to the program. Rates for ER visits and surgery or procedures performed also exhibited an increase. These observations are consistent with MHW's internal observation that enrolled members had higher clinical needs, driven in part by the additional long-term care enrollment, thereby increasing utilization.

Table 31. WMIP inpatient utilization, general hospital/acute care measures, 2006–2008.

	Discharges/ 1000MM[a]			Days/ 1000MM[a]			ALOS[b]		
	2006	2007	2008	2006	2007	2008	2006	2007	2008
Total inpatient discharges and days	13.55	14.76	14.87	71.86	72.65	70.92	5.30	4.92	4.77
Medical discharges and days	7.33	7.16	8.37	29.63	26.15	32.56	4.04	3.65	3.89
Surgical discharges and days	5.60	7.43	5.83	40.64	34.19	36.02	7.26	6.53	6.17

[a]1000MM = 1000 member months. [b]ALOS = average length of stay.
No statistically significant differences in percentages from 2007 to 2008 ($p \leq 0.05$).

Table 32. WMIP inpatient utilization, nonacute care measures, 2007–2008.

	Discharges/ 1000MM[a]		Days/ 1000MM[a]		ALOS[b]	
	2007	2008	2007	2008	2007	2008
Total inpatient discharges and days	1.21	1.43	6.65	28.50	5.52	19.98 ↑

[a]1000MM = 1000 member months. [b]ALOS = average length of stay.
↓↑ Indicates statistically significant differences in percentages from 2007 to 2008 ($p \leq 0.05$).

Table 33. WMIP ambulatory care measures, 2006–2008.

	Visits/1000MM[a]		
	2006	2007	2008
Outpatient visits provided	417.32	470.32	456.31 ↓
Emergency room visits	96.21	104.28	112.10 ↑
Surgery or procedures performed	11.60	10.70	13.47 ↑
	Stays/1000MM[a]		
	2006	**2007**	**2008**
Observation room stays resulting in discharge	0.87	0.95	1.20

[a]1000MM = 1000 member months.
↓↑ Indicates statistically significant differences in percentages from 2007 to 2008 ($p \leq 0.05$).

Tables 34 and 35 present WMIP results for two new behavioral health measures in 2008. The three-part antidepressant medication management measure examines

- optimal practitioner contacts—the adequacy of clinical management of patients with newly diagnosed major depression episodes and prescriptions
- percentage of patients initiated on an antidepressant drug who received an effective acute-phase trial of medications (three months)
- percentage of patients who completed a period of continuous treatment for major depression (six months)

The follow-up measure looks at continuity of care—the percentage of enrollees age 6 or older who were hospitalized for selected mental disorders and were seen on an outpatient basis by a mental health provider within 30 days or within 7 days after discharge from the hospital.

Table 34. WMIP antidepressant medication management measures, 2008.

	Optimal practitioner contacts	Effective acute-phase treatment	Effective continuation-phase treatment
Percentage of patients	26.83	41.46	39.02

Table 35. WMIP follow-up after hospitalization for mental illness measures, 2008.

	30-day follow-up	7-day follow-up
Percentage of patients receiving follow-up	47.37	28.95

Table 36 reports an additional behavioral health measure for 2007 and 2008, use of high-risk medications for the elderly—the percentage of enrollees age 65 or older who received at least one prescription, or at least two different prescriptions. For this measure, NCQA states that a lower rate represents better performance.

Table 36. WMIP use of high-risk medications for the elderly measures, 2007–2008.

	One prescription		At least two prescriptions	
	2007	**2008**	**2007**	**2008**
Percentage of patients receiving medication	19.08	18.43	4.62	4.10

No statistically significant differences in percentages from 2007 to 2008 ($p \leq 0.05$).

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

Many factors may contribute to the utilization patterns for this population of enrollees who present more acute episodes and generally require more care. The number of days per thousand member months for inpatient nonacute care more than quadrupled from 2007 to 2008, and the corresponding ALOS more than tripled. ER visit rates for this population have gone up consistently since 2006, rising significantly by 8 percentage points in 2008, while outpatient visits fell significantly from 2007 to 2008. Ideally, one might hope that hospitalizations and ER visits would decrease while outpatient visits increased. The HEDIS trends underscore the challenge of managing health care for this population.

At this time, no normative data exist with which to compare the WMIP results. As the program continues, analysis of year-to-year changes may point to opportunities for improvement. HRSA will need to explore opportunities for comparing the WMIP performance measures with the data for similar programs or populations in other states.

Because the WMIP program administers the mental health benefit for enrollees, opportunities exist for shared learning between WMIP and the RSN system overseen by MHD.

- ***WMIP program managers with MHW should collaborate with RSNs to learn more about their use of the Recovery Model, including enrollee outcomes, barriers to care, outreach, and intervention practices.***
- ***WMIP program managers in DHS should meet with MHD to share program outcomes and explore ways to improve care processes to meet the common needs of their service populations.***
- ***MHW should discuss with NSMHA or other RSNs the feasibility of a collaborative project, the outcome of which could benefit the WMIP population. An example might be the development of a new nonclinical PIP to improve the delivery of noncritical services after psychiatric hospitalizations.***

WMIP compliance review

HRSA and the Aging and Disability Services Administration (ADSA) reviewed MHW's compliance with BBA managed care regulations and WMIP contract provisions. This review addressed most of the same standards as those addressed by TEAMonitor's MCO compliance reviews, but examined more elements based on specific provisions of the WMIP contract. Table 37 reports the WMIP compliance scores for each of 14 standards (excluding PIPs).

As shown, MHW fully met the majority of elements for 11 of the 14 standards, including all 18 elements of Grievance Systems and all 6 elements of Enrollment/Disenrollment. The majority of elements scored as Partially Met were based on WMIP contract provisions—most notably under Furnishing of Services, Additional Services for Enrollees with Special Healthcare Needs, and Coverage and Authorization of Services—rather than BBA regulations. The review found that MHW failed to meet the standard related to processes for integrating various data sources (e.g. encounter, eligibility, and screening data), although MHW later corrected the deficiency.

Table 37. WMIP compliance scores.

Standard (# of elements)	Percentage of elements Met (M), Partially Met (PM), Not Met (NM)		
	M	PM	NM
Availability of Services (3)	**67**	33	0
Furnishing of Services (8)	**25**	75	0
Program Integrity (3)	**67**	33	0
Claims Payment (3)	**67**	33	0
Primary Care and Coordination (1)	**100**	0	0
Additional Services for Enrollees with Special Healthcare Needs (14)	**57**	43	0
Coverage and Authorization of Services (6)	**50**	50	0
Enrollee Rights (12)	**92**	8	0
Enrollment/Disenrollment (6)	**100**	0	0
Grievance Systems (18)	**100**	0	0
Practice Guidelines (5)	**60**	40	0
QAPI Program (5)	**60**	40	0
Health Information Systems (3)	**67**	0	33
Long-Term Care Coordination (1)	**0**	100	0

WMIP PIP validation

For 2008, MHW conducted five PIPs targeting improvements in care and nonclinical services for the WMIP population. All five projects were carried over from 2007, including two contractually required PIPs on chemical dependency topics. Table 38 shows the PIP topics and the scores assigned by TEAMonitor, along with TEAMonitor's list of project strengths.

Table 38. WMIP PIP topics and scores.

Topic	Score
Clinical: Improving Identification of Members at High Risk for Chemical Dependency Issues • *Training with state agency staff and identified expert in substance abuse issues to evaluate the original chemical dependency screening process* • *Training on brief intervention techniques* • *Annual refresher training for existing staff about screening, assessment, and brief intervention interviewing, and intensive training for new staff*	Met
Clinical: Improving Compliance with Chemical Dependency Assessment and Follow-Up Referrals for Chemical Dependency • *Clarity of written PIP and use of data analytical tools such as barrier analysis, trend data, and chart of improvements related to barriers*	Met
Clinical: Improving the Rate of Completion of Documented Care Plans • *Clarity of written PIP and use of data analytical tools such as barrier analysis, trend data, and chart of improvements related to barriers*	Met
Nonclinical: Increasing Successful Initial Contacts Between WMIP Members and the Care Coordination Team • *Ability to reach members, assess their needs, and intervene has a direct impact on members' health status and potentially on their functional status* • *Recruiting other departmental resources to help with initial contacts* • *Completion of initial health-risk assessments has been made a company "scorecard" with monthly internal reporting requirements*	Partially Met
Nonclinical: Improving Satisfaction with Customer Service • *Separation of CAHPS data and analysis from Healthy Options will improve the clarity of results and help distinguish differences between the two populations being served*	Partially Met

Washington Medicare/Medicaid Integration Project Evaluation

In June 2005, Washington launched the Medicare/Medicaid Integration Project (MMIP) as a new resource for Medicare- and Medicaid-eligible clients age 65 and older in King and Pierce counties. The MMIP focused on preventive care and healthcare coordination to improve health outcomes and reduce expenditures for dual-eligible clients, who are frail and have complex healthcare needs. The state contracted with Evercare Premier to conduct this project combining medical and long-term care services in one package. Evercare was expected to

- provide network doctors and providers to serve this population
- provide consulting nurses available on the phone 24 hours per day
- assign each client to a care manager to help coordinate medical and long-term care services
- provide value-added services and additional benefits, such as enhanced hearing and vision benefits and medical transportation

The MMIP target population was dual-eligible enrollees age 65 or older. Enrollment was voluntary and was coordinated by Evercare representatives. Enrollees could disenroll at any time. Program enrollment reached 230 members during 2007; as of October 2007, 177 members were enrolled. The MMIP pilot program ended in July 2008.

For 2008, Evercare reported six HEDIS measures for the MMIP population: inpatient care utilization–general hospital/acute care and nonacute care, ambulatory care utilization, comprehensive diabetes care, antidepression medication management, and drugs to be avoided in the elderly. Evercare also conducted four non-HEDIS health status screening measures: depression, dementia, falls risk, and transition of care.

In 2008, the state received permission from CMS to waive the performance validation audit requirement. Because the sample size pulled for the measurement year was smaller than that required for reporting purposes, the 2008 HEDIS measures are not included in this report. The non-HEDIS measures, developed by MMIP program management, reflect data collection from April 2007 through December 2007. Three of the four non-HEDIS measures meet the reporting criteria for sample size. The denominator for the transition of care measure was less than 30; therefore, results are not included in this report. Tables 39 to 41 display the non-HEDIS reporting measures for screening of falls risk, dementia, and depression.

Table 39. Washington MMIP falls risk screening measure.

Measure	Screened	Not screened	Total
Falls Risk Screening			
Active members screened	135 (76%)	42 (24%)	177 (100%)
Positive response to screening question	6 (4%)	n/a	135
Received supplemental assessment following positive response	6 (100%)	n/a	6

Table 40. Washington MMIP dementia screening measure.

Measure	Screened	Not screened	Total
Dementia Screening			
Active members screened	135 (76%)	42 (24%)	177 (100%)
Positive response to screening question	7 (5%)	n/a	135
Received supplemental assessment following positive response	7 (100%)	n/a	7

Table 41. Washington MMIP depression screening measure.

Measure	Screened	Not screened	Total
Depression Screening			
Active members screened	119 (77%)	35 (23%)	154 (100%)
Positive response to screening question	13 (11%)	n/a	119
Received supplemental assessment following positive response	13 (100%)	n/a	13

MMIP compliance review

During 2007, HRSA and ADSA reviewed Evercare's compliance with provisions of the managed care contract and Medicaid managed care regulations The HRSA/ADSA review addressed the same standards as those addressed by TEAMonitor's MCO compliance reviews, but examined a greater number of elements based on special provisions of the MMIP contract relating to long-term care. Table 42 reports the MMIP compliance scores for each of 15 standards (excluding PIPs).

As shown, Evercare fully met the majority of elements for 9 of the 15 standards, including all 12 elements of Enrollee Rights. All elements scored as Not Met, as well as many Partially Met elements, were based on MMIP contract provisions rather than BBA regulations. For example, the review found that Evercare had failed to establish written long-term care and service plans for each client, and failed to obtain contracts with home and community-based service providers before authorizing services for certain clients. For some other aspects of long-term care, Evercare's documentation of policies and procedures was inadequate.

Table 42. Washington MMIP compliance scores.

Standard (# of elements)	Percentage of elements Met (M), Partially Met (PM), Not Met (NM)		
	M	PM	NM
Availability of Services (6)	**67**	33	0
Furnishing of Services (2)	**67**	33	0
Program Integrity (1)	**100**	0	0
Claims Payment (2)	**50**	50	0
Primary Care and Coordination (1)	**100**	0	0
Additional Services for Enrollees with Special Healthcare Needs (14)	**36**	43	21
Coverage and Authorization of Services (3)	**67**	33	0
Emergency and Post-stabilization Services (3)	**33**	0	67
Enrollee Rights (12)	**100**	0	0
Enrollment/Disenrollment (2)	**100**	0	0
Grievance Systems (19)	**53**	47	0
Practice Guidelines (3)	**33**	67	0
Provider Selection (Credentialing) (3)	**67**	33	0
QAPI Program (5)	**20**	80	0
Subcontractual Relationships and Delegation (4)	**0**	100	0

MMIP PIP validation

HRSA/ADSA reviewed five PIPs submitted by Evercare for the MMIP, using a validation tool similar to the TEAMonitor tool for evaluating MCO PIPs. The review found that none of the MMIP PIPs met the federal validation criteria (see Table 43). Reviewers noted that the studies either failed to break out results for MMIP enrollees from Evercare's overall client population, or failed to define the study population adequately. Four studies focused on community dwelling enrollees and appeared to exclude enrollees in nursing homes; these studies therefore involved sampling, but Evercare did not define its sampling methodology, nor its rationale for excluding nursing home enrollees.

Table 43. Washington MMIP PIP topics and scores.

Topic	Score
Ensuring Culturally Appropriate Materials and Services	Not met
Improving Behavioral Health Services	Not met
Reducing Rates of Polypharmacy	Not met
Reducing Voluntary Enrollment	Not met
Reduction in Beers List Medications	Not met

MMIP satisfaction surveys

The state required that satisfaction surveys be conducted for MMIP members (or the responsible parties) and for healthcare providers. Market Strategies, Inc. (MSI) of Seattle conducted the surveys in 2007.

Member Satisfaction Survey

The objectives of this survey were to determine

- MMIP members' overall satisfaction with healthcare services provided by Evercare (including attitudes of physicians, specialists, and other staff, customer services response, communication, etc.)
- member satisfaction and loyalty at the site level and likelihood of continued membership
- likelihood that the member would recommend Evercare to other consumers

MSI conducted a telephone survey of MMIP enrollees in June 2007. Forty-nine of 102 enrollees (48 percent) completed interviews. The small sample size provided a statistical margin of +/- 14 percentage points at the 95 percent confidence level and should be viewed as directional only.

Key findings of the survey were:

- Overall satisfaction and loyalty levels were high.
- 89 percent of enrollees or responsible parties were somewhat or very satisfied.
- 80 percent rated Evercare as 7 or higher on a 10-point scale.
- 92 percent indicated that they planned to continue their membership.
- 88 percent were likely to recommend Evercare.

- Half of the enrollees/responsible parties knew their care manager. Managers scored high on most attributes (e.g., listening, answering questions, providing supplies).
- Nearly all enrollees had seen their personal doctor in the past six months, and the majority rated the experience very highly.
- Getting prescriptions filled or refilled was easy.
- Certain services, such as ease of getting help from customer service or arranging for assistance with bathing, house cleaning, and transportation, could be improved.

Provider (Physicians and Long-term Care Providers [LTC]) Satisfaction Survey

The objectives of this survey were to

- understand and measure provider satisfaction and loyalty to Evercare
- identify and prioritize opportunities for improvement
- support and facilitate action planning efforts

Physicians (161) and LTC providers (28) mailed a total of 189 surveys during late summer 2007, while 23 physicians and 16 LTC providers completed the survey via mail or the Internet. Again, the margin of error was wide (+/- 14 percentage points). Findings are directional and should be interpreted with caution.

Key findings of the survey were:

- The majority of physicians and LTC providers were satisfied with and loyal to Evercare.
  - 87 percent were satisfied with Evercare.
  - 80 percent would recommend Evercare to a colleague.
  - 85 percent were likely to continue working with Evercare.
- Generally, Evercare performed well across the realm of the provider experience, especially regarding customer service, effectiveness of the care managers, and the quality and value of care provided
- Some providers believed that certain areas could be improved:
  - specialty care access, referral implementation, and the appropriateness of required authorizations
  - customer service: first call resolution
  - reimbursement and payment: Medicare reimbursement and approval rates

Discussion and Recommendations

This annual report summarizes the performance of Washington's MCOs and RSNs in measures of access, timeliness, and quality and in meeting state and federal standards for Medicaid managed care. The synthesis of data in this report offers an opportunity to examine the results of individual EQR activities from a systems point of view. The resulting picture of the strengths and shortcomings of Washington's Medicaid program should help HRSA define QI expectations for the MCOs and RSNs and design effective incentives and rewards for improvement. The health plans, in turn, could encourage providers to use a systems approach in delivering care for all enrollees. Improvement efforts should focus on providing evidence-based care.

DSHS has expressed the long-term goal of integrating the delivery of medical and mental health care for Medicaid enrollees. This year's EQR annual report is the first to incorporate the review of mental health services provided through RSNs. DSHS expects that the EQR eventually will evaluate medical and mental health services on a standardized basis, using similar measures and methodologies. However, the 2008 EQR results for the RSNs represent baseline findings, against which the RSNs' performance will be re-evaluated for improvement in future years.

What's working well in Washington

Focus on children. Recent state legislation and policy initiatives have focused on improving health care and providing medical homes for children, the predominant segment of the population served by Washington's Medicaid program.

SSB 5093, enacted in 2007, expands children's access to health care, increases primary care payments, and calls for system changes to ensure that all children get regular care from a medical home that provides preventive and WCC services and referral to needed specialty services. State agencies must collaborate with parents, schools, communities, health plans, and providers to identify health improvement goals for children and to adopt innovative purchasing strategies to achieve those goals.

In response to SSB 5093, DSHS has recommended to the legislature a five-year program called the Children's Healthcare Improvement System (CHIS), aimed at ensuring the delivery of care within a medical home.[8] The guiding criteria for CHIS are:

- Select evidence-based indicators that are linked to improved child health.
- Measure and monitor PCP and clinic performance using outcome measures that produce valid and consistent data.
- Reward PCPs and clinics that demonstrate adherence to best practice or evidence-based clinical and patient experience performance measures.

DSHS-HRSA will link provider rate increases to QI measures related to providing a medical home and will determine how to apply contract incentives for providers and health plans that promote sustained improvement in those measures through use of evidence-based practices.

Proposed recommendations arising from SSB 5093 will be incorporated into the work performed for the HB 2549 initiative, focusing on the medical home model and payment redesign.

HB 2549, effective as of June 2008, establishes pilot projects to advance the medical home model, subject to appropriation of specific funds. DOH is to administer a statewide medical home collaborative program. The Health Care Authority must work with the Puget Sound Health Alliance to identify medical home reimbursement strategies and incentives (such as increasing rates for PCPs) and performance measures. In October 2008, DOH convened an expert panel to begin developing the medical home change package. DOH has conducted focus groups with PCPs to improve understanding of the needs of PCPs.

HB 1088, also enacted in 2008, targets reform of children's mental health services. The law sets goals for the structure of the children's mental health system by 2012, including continuum of services; equity in access; availability of high-quality, culturally competent services; use of evidence-based practices; and integrated services for at-risk children. By January 1, 2009, DSHS is to revise the children's benefit package to include family- and community-based wraparound services and to allow additional outpatient therapy hours. DSHS is to contract with RSNs to implement a wraparound model of integrated mental health service delivery for children, targeting those at high risk of correctional placement or psychiatric hospitalization.

Access to care. The medical MCOs are fully complying with most requirements for coverage, authorization, and availability of services. The mental health RSNs typically provide timely access to outpatient care through contact with provider agencies or a central access coordination point for the service region. All RSNs provide telephone access to crisis services 24 hours a day, 7 days a week, and all can dispatch designated mental health professionals for emergency evaluations around the clock.

The Partnership Access Line, funded by HB 1088, provides "just in time" telephone-based psychiatric consultation to PCPs regarding children with psychiatric problems. The goal of the project is to improve PCPs' confidence in meeting the needs of these children, in view of the limited availability of child psychiatrists. The project is being piloted in two regions of the state and will expand to other regions in the future.

MHD supported the implementation of a statewide PIP to increase the percentage of patients seen for non-crisis outpatient services within seven days of discharge from a community hospital or E&T facility. This percentage has declined across the state in recent years. MHD's benchmark calls for 80 percent of Medicaid enrollees discharged from a psychiatric hospital to be offered non-crisis services within seven days. Ten RSNs elected to participate in this PIP.

The state has undertaken several pilot projects to improve access to health care for specific subpopulations of Medicaid enrollees.

- **Patient Navigator:** In September 2008, DSHS initiated this program at four pilot sites across the state, with the goal of helping Medicaid enrollees in minority communities navigate the healthcare system and obtain the treatment and information they need. The program matches minority enrollees with guides who know about the local culture and healthcare system. The pilot sites are in Seattle (Children's Hospital); Mason, Thurston, and Grays Harbor counties (CHOICE Regional Health Network); Yakima and Benton counties (Yakima Valley Farm Workers Clinic); and the Colville Indian Reservation in Ferry and Okanogan counties. The legislature earmarked $600,000 for the four pilots, which have begun hiring and training community health workers to serve as patient navigators working with Medicaid enrollees. Eventually the projects will be evaluated to gauge their effectiveness, probably through measures of chronic care.

- **Mental health wraparound:** HB 1088 required DSHS to contract with RSNs to implement wraparound mental health services for children in as many as six pilot sites (four in regions with no existing wraparound programs and two in regions with existing programs). In March 2008, DSHS awarded contracts for three pilot sites, to NSMHA, GHRSN, and SWRSN. The three sites began serving clients in July 2008 and were serving 18 young people and their families as of December 2008.
- **PACT teams:** The Program of Assertive Community Treatment (PACT) is an evidence-based, recovery-oriented mental health service delivery model, using a transdisciplinary team approach to provide intensive outreach-oriented services to people with severe and persistent mental illnesses and co-occurring disorders. Since July 2007, 10 PACT teams across the state have been serving clients through RSNs, with priority given to state hospital patients. The teams are nearing full enrollment capacity and will serve as many as 800 enrollees statewide. Existing resources are being used to evaluate a wide range of consumer outcomes. To date, more than 90 percent of consumers have reported being highly satisfied with PACT services.

Quality of care. TEAMonitor's 2008 review found that MCOs generally ensure their enrollees an ongoing source of appropriate primary care and ongoing coordination of healthcare services. All MCOs use evidence-based practice guidelines in decision making for utilization management, enrollee education, and service coverage. All MCOs fully or partially meet requirements for provider selection, including credentialing and recredentialing.

RSNs across the state are implementing the Recovery Model of care, with emphasis on increasing enrollees' dignity, respect, and involvement in the design and delivery of mental health services. Increased consumer involvement in care has resulted in greater awareness of system issues, improvements in quality of care, and support for innovative program strategies (e.g., supported employment). The Ombuds system has strengthened RSNs' capacity to respond to consumer concerns, manage complaints and grievances fairly and equitably, and offer community training about issues related to enrollee rights. The RSNs conduct many training and technical assistance activities for provider agencies, fostering collaborative approaches to treatment.

Value-based purchasing. HRSA's efforts to align provider payments with quality improvements through contract incentives for MCO performance have led to gains in measures of childhood immunizations and WCC visits. As identified in previous annual reports, several MCOs have passed these incentives downstream, either to providers for improving care or to enrollees for obtaining care. The CHIS proposal included recommendations to

- reimburse Washington Medicaid providers at higher rates for historically underused procedures such as dental disease prevention services and WCC visits
- reimburse for selected services not previously paid by Medicaid, including developmental assessment and screening of young children, vaccine administration, dental services, maintenance of after-hours clinics, depression screening, development of asthma action plans, group WCC visits, care coordination, and provision of medical home resources
- provide financial incentives for clinic-based performance

These recommendations will be incorporated into the HB 2549 initiative. In 2009, a multi-agency workgroup will examine how to integrate the recommendations into the new design for medical home in Washington.

Improving clinical care. The Healthy Options MCOs continue to perform above the national average Medicaid performance in several clinical measures. For example, the MCOs compare favorably to the national norm in providing *diabetes care*, as measured by the HbA1c testing indicator. Washington's success in providing timely *postpartum care* for female enrollees has been evident for some years, although gains have slowed in this area. Two-thirds of Medicaid children are receiving *Combo 2 immunizations*, and the Combo 2 rate has risen steadily since 2002. These improvements have stemmed from focused QI efforts through health plan PIPs, HRSA's special initiatives and partnerships, and contract incentives.

Performance measurement. HRSA continues to invest resources for more detailed analysis of HEDIS data, such as member-level and trend analysis, to examine MCO performance by enrollee subpopulation and county over time. Future analysis will examine performance across the Medicaid system as a whole, encompassing FFS as well as managed care.

Preventive care for children with chronic conditions. HRSA, DOH, and MCOs jointly fund the Washington State Collaborative to Improve Health (WSC), a multi-year initiative to improve care for Washingtonians with chronic disease. The collaborative combines the QI efforts of local clinics, tribal organizations, and MCOs to improve preventive care for children and adults with chronic conditions. The WSC has incorporated the child learning tracks that formerly were a focus of the HRSA-funded Children's Health Improvement Collaborative. The ongoing goal is to help clinics adopt and use best practices in delivering care for low-income children who suffer from asthma and are overweight, and to establish medical homes for children.

The path to future improvements: Mental health care

The Washington RSNs are still in transition to the BBA regulatory environment. Many are still updating policies and procedures, enrollee information materials, and other operations in response to EQR requirements. The RSNs generally are dedicated to serving Medicaid enrollees and have made commendable efforts to maintain their effectiveness in the face of resource limitations.

Care coordination. Although Washington has established the goal of integrating primary care and mental health services, most RSNs have not progressed beyond initial steps toward that goal. Some RSNs emphasize the importance of identifying the enrollee's PCP and referring the enrollee to establish primary care, as appropriate. Some RSNs refer enrollees to pediatricians for Early and Periodic Screening, Diagnosis, and Treatment, although follow-up and coordination of services for those enrollees appears to be limited. Transitions for medication management from mental health providers to PCPs also appear to present problems.

- ***MHD needs to work with RSNs to establish standards and priorities for coordinating mental health and primary care services.***
- ***MHD needs to takes steps to ensure exchange of information between the mental health clinician and PCP, and between the mental health clinician and ancillary agencies. Efforts should focus on ensuring that***
    - ***releases of information (ROIs) are current and renewed regularly***
    - ***ROIs are executed, the information exchange is monitored, and steps are taken quickly to remedy breakdowns in information sharing***
    - ***information exchange continues as long as necessary to support the enrollee's care***

Managing care. Many RSNs have not yet implemented their own level-of-care guidelines for outpatient services. Currently, most service authorizations are based solely on qualifying diagnoses. Services are authorized for six months or a year, with limited attempts to manage resources for ongoing mental health care. Although provider agencies may complete thorough and comprehensive clinical assessments, only limited information from these assessments is considered in the authorization process. Clinical assessments often do not fully address functional impairment and the services needed to support progress toward the enrollee's recovery. Effective management of outpatient services depends on comprehensive annual reassessments with definition of treatment goals to address functional impairment.

- ***MHD needs to increase efforts to clarify the criteria for initial and continuing care, to assist RSNs in effectively managing outpatient mental health services in line with the Recovery Model.***
- ***MHD needs to require RSNs to ensure that providers***
    - ***document psychiatric symptoms that establish medical necessity and meet access-to-care standards for authorization of ongoing services***
    - ***clarify deferred, rule-out, or provisional diagnoses within 180 days***
    - ***assess and address sensitive cultural issues when developing treatment plans, including the enrollee's sexual orientation, spirituality, beliefs/attitudes about medication and mental health treatment, and other sensitive issues***

Mental health assessments. Reviewers found many cases in which comprehensive assessments occurred only at intake and were more than 10 years old. Although the enrollee's clinical status is updated with each service reauthorization, reassessments tend to be very brief and generally focus on only the primary diagnosis. The clinician may be aware of significant changes in an enrollee's life over time, and may even document those changes in progress notes. However, this information can easily be lost with clinician turnover and thinning of charts. Also, treatment may become short-sighted, or new spheres of interest may not be addressed without a periodic, comprehensive reassessment of the enrollee's treatment needs.

- ***MHD needs to establish a policy regarding the frequency of comprehensive reassessment of the enrollee's treatment needs.***

Provider oversight. RSNs delegate many responsibilities associated with meeting federal standards to provider agencies as part of their contracting processes. While each RSN has a process for monitoring the delivery of services, the RSNs do not always fully monitor other responsibilities delegated to provider agencies, such as handling of grievances and appeals. In addition, most RSNs use a review protocol aligned with the Washington Administrative Code and statutes, which does not cover all federal regulatory requirements.

- ***MHD needs to clarify the requirements for RSNs to monitor their provider networks versus the state's licensing of community mental health agencies. The RSNs need to ensure that they monitor all delegated functions as required by federal regulations, and take corrective action as needed.***

Data improvements. MHD's data systems support the calculation of statewide performance measures and PIP indicators. However, MHD's data structure and staffing issues hamper the

fulfillment of these calculations. Because the data system does not distinguish Medicaid enrollees at state hospitals and E&T facilities, the state cannot calculate performance measures that apply only to Medicaid enrollees. Currently, MHD calculates only one of four performance measures, and that measure describes the general population, not the Medicaid population.

MHD has experienced significant turnover of IT staff and analysts. Although MHD has devoted some staff resources to calculating the statewide PIP indicators, the state has yet to produce timely and accurate calculations.

- ***MHD needs to upgrade the data system used to calculate performance measures in order to identify Medicaid patients receiving state hospital or E&T services, to enable accurate calculation of the measure of timely follow-up care.***
- ***MHD needs to calculate all four of its statewide performance measures for the RSNs serving Medicaid enrollees.***
- ***MHD needs to devote sufficient staff resources to produce timely and accurate calculations of the statewide PIP indicators.***

Compliance issues. The RSN compliance reviews identified numerous opportunities for improvement with regard to enrollee rights and grievance systems (see pages 30–35). The following broad recommendations arise from the compliance reviews:

Notices of determination/notices of action: The creation of separate enrollee notices for eligibility determinations and other decisions at the RSN and provider level has complicated the notification of enrollees regarding their rights to due process.

- ***MHD needs to ensure that RSNs notify enrollees of their rights to due process in resolving eligibility determinations as well as decisions to suspend, terminate, or reduce services.***
- ***MHD needs to clarify the RSNs' responsibility to ensure that all decisions at the provider level are mutually negotiated with enrollees, and that enrollees are notified of their rights to appeal decisions if they do not agree.***

Translation services: The RSNs do not consistently inform enrollees of their right to obtain translation services to help them understand written notices sent by the RSNs.

- ***MHD needs to clarify that the requirements to provide interpretation and translation apply to all types of communication with enrollees.***

Use of complaint/grievance data: Enrollee complaints at the provider level are not reported to the RSNs consistently.

- ***MHD needs to revisit the complaint and grievance system to ensure that adequate data are available to identify system issues that affect the quality of care.***

Enrollment data: The RSNs lack access to demographic information about their Medicaid-eligible population, including ethnicity and primary language spoken. RSNs rely on their providers to identify needs for interpreter services or materials in alternative formats.

- ***MHD needs to provide the RSNs with demographic data about all Medicaid-eligible people within their service areas.***

Enrollee information: MHD publishes the *Benefits Booklet for People Enrolled in Medicaid* annually and has it translated into eight languages. Although MHD updates this information on its website, enrollees often receive information that is out of date. For example, during 2007, some RSNs' provider panels changed significantly, and MHD implemented changes to the notification system (notices of determination/notices of action) mid-year.

- ***MHD needs to develop a method to inform enrollees of changes in the benefit package, notification system, and provider listings on a timely basis.***

The path to future improvements: Physical health care

The following discussion highlights HRSA's progress in responding to the previous EQR recommendations and recaps recommendations that remain valid to sustain long-term improvement in the delivery of Medicaid services.

Value-based purchasing. Contractual pay-for-performance incentives have focused the MCOs on working to improve immunization and preventive care rates for children. Early results of this strategy have been positive, and moving the incentives downstream may lead to further improvement. MCOs and provider clinics share the vision of improving patient care. Acumentra Health recommends that HRSA

- ***redirect a significant portion of MCO incentive funds to the provider level***

Improving preventive care. While most children in Healthy Options have access to primary care, the majority of children still are not receiving preventive care regularly when they visit their PCPs. HRSA has responded to the previous EQR recommendations as follows:

- ***collaborate with MCOs to provide performance feedback to clinics and providers regarding preventive services:*** Integrate HRSA's five-year plan for provider incentives into the HB 2549 initiative, specifically addressing provider performance feedback as well as financial incentives to clinics.
- ***continue support for shared learning*** to help providers collaborate in their efforts to improve care for children: HRSA continues to seek a source of sustained funding for the WSC. Providers will need the tools and technical assistance provided through the shared learning model to incorporate recommendations arising from HB 2549.

MCOs may be able to improve care for their Medicaid enrollees by participating in joint projects or by pooling resources to target areas such as childhood immunizations and WCC. As previously suggested, Acumentra Health recommends that HRSA

- ***consider organizing a statewide PIP targeting WCC visit rates that would pool resources and capitalize on partnerships***

PIPs. The Healthy Options MCOs previously invested considerable resources in conducting PIPs to meet state contractual requirements that exceeded the federal requirements. As recommended in the 2007 EQR annual report, HRSA has reduced the number of PIPs required each year from five to a minimum of two and a maximum of four, depending on corrective actions for each MCO. In addition, HRSA has indicated that MCO participation in the Washington State Collaborative to Improve Health fulfills the requirement for one PIP.

Compliance review. TEAMonitor has refined its compliance review process over the past three years by providing a clear summary of the compliance findings to guide the MCOs in correcting any deficiencies. Although progress is evident, Acumentra Health recommends that TEAMonitor

- ***consider incorporating visits to provider clinic sites into its annual compliance review***
- ***consider requiring NCQA accreditation for all Medicaid MCOs.*** This rigorous and comprehensive evaluation program incorporates evidenced-based clinical and service quality standards for consumer protection.
- ***continue to refine and standardize procedures and scoring methods*** to define clear expectations for the health plans and to make year-to-year comparisons more meaningful and reliable
- move beyond a narrow focus on regulatory compliance to ***offer health plans more technical assistance and support.*** The TEAMonitor process offers an opportunity for the state to identify specific technical assistance needs for each health plan.

Data improvements. The past two HEDIS reports noted that because of inadequate encounter data, the Healthy Options MCOs must devote considerable resources to medical chart reviews to collect some of the data they need to report HEDIS measures. Better encounter data would enable the MCOs to redirect some of the resources spent on data collection toward providing better care for enrollees. Acumentra Health again recommends that HRSA

- ***continue to help the MCOs study and overcome barriers to collecting adequate administrative data for HEDIS measures.*** HRSA could consider conducting an optional study aimed at improving or validating encounter data, as per the EQR protocol.
- ***encourage MCOs to serve as a resource*** to support clinics as they implement electronic medical record and data systems or engage in related QI activities

The path to future improvements: WMIP

Because the WMIP program administers the mental health benefit for enrollees, opportunities exist for shared learning between WMIP and the RSN system overseen by MHD.

- ***WMIP program managers with MHW should collaborate with RSNs to learn more about their use of the Recovery Model, including outcomes (such as barriers to care, outreach, and intervention practices).***
- ***WMIP program managers in DHS should meet with MHD to share program outcomes and explore ways to improve care processes to meet the common needs of their service populations.***
- ***Molina should discuss with NSMHA or other RSNs the feasibility of a collaborative project, the outcome of which could benefit the WMIP population. An example might be the development of a new nonclinical PIP to improve the delivery of noncritical services after psychiatric hospitalizations.***

The path to future improvements: EQR follow-up

Future improvements will result from the interplay of the physical and mental health managed care quality strategies, QI activities, and annual reporting. The EQR results, reported annually, should inform the quality strategies, which are deployed through contract requirements. Acumentra Health recommends that HRSA

- ***implement contractual requirements for all MCOs and RSNs to address the specific recommendations in this report***
- ***merge and integrate the DHS and MHD Medicaid quality strategies to reflect a coordinated approach to managed care for physical and mental health***

HRSA has pursued an incremental approach to quality improvement, preserving the activities that have proved to work well and phasing out activities that have proved less valuable. The above recommendations are intended to help HRSA and the health plans continue to strengthen the foundation for excellence in Medicaid managed care, comply with federal standards, and improve the quality of care by using resources as efficiently as possible.

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Appendix A. RSN Profiles

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

RSN scores, strengths, and opportunities were based on Acumentra Health's compliance review of each RSN.

Chelan-Douglas RSN A-3
Clark County RSN A-7
Grays Harbor RSN A-11
Greater Columbia Behavioral Health A-15
King County RSN A-19
North Central Washington RSN A-23
North Sound Mental Health Administration A-27
Peninsula RSN A-31
Southwest RSN A-35
Spokane County RSN A-39
Thurston-Mason RSN A-43
Timberlands RSN A-47

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RSN Profile
Chelan-Douglas Regional Support Network (CDRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**82.7%**	**Grievance Systems**	**81.5%**
Enrollee rights: General	100%	Grievance system: General	100%
Information requirements	80%	Requirements and filing	60%
Notification timing	100%	Language and format	80%
Notification content	80%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	80%
Respect and dignity	80%	Handling of grievances and appeals	80%
Treatment options	80%	Resolution of grievances and appeals	80%
Advance directives	80%	Format and content of notices (fair hearing)	80%
Seclusion and restraint	60%	Expedited resolution of appeals	80%
Compliance with state and federal laws	80%	Information on providers	60%
		Record keeping and reporting	60%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Metabolic Syndrome Screening and Intervention	Substantially Met	Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization	Partially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- CDRSN's policies and procedures outlining the encounter data validation process are accurate, complete, and up-to-date, and include consideration of methods for addressing duplication of efforts.
- CDRSN's IT staff plans to attend Quality Management Committee meetings on a quarterly basis to ensure that the IT aspects of RSN operations are integrated into the quality assurance and improvement process.
- CDRSN affirmed that there was no delay in reporting encounter data to the state since the previous ISCA.
- In 2008, CDRSN began serving in a facilitator role for the Washington State Rural Consortium. CDRSN is meeting the challenges of this role, but because of staffing limitations, ongoing sustainability is a concern.
- CDRSN's IT staff provides data analysis and report distribution for operations management and performance improvement purposes. However, insufficient staff will limit the RSN's capability to improve upon its existing data analysis capabilities. Currently, data analysis and reporting is an ad-hoc process, but CDRSN plans to develop a written policy and procedure outlining this process.
- CDRSN has a written standard policy and procedure for corrective actions, but it does not specifically address corrective actions related to information systems.

CDRSN, headquartered in East Wenatchee, contracts with providers to deliver comprehensive and culturally sensitive mental health services to eligible adults, children, and their families throughout Chelan and Douglas counties. CDRSN's philosophy is to achieve and maintain members' highest level of functioning in the community and discourage inappropriate placement of persons in state institutions. During December 2007, CDRSN provided outpatient services to 709 out of 18,379 (3.9%) Medicaid enrollees.

Data source: Chelan-Douglas RSN 2008 External Quality Review Report.

RSN Profile
Chelan-Douglas Regional Support Network (CDRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	81.5%	Date of birth	100.0%
Provider type	80.5%	Gender	97.6%
Minutes of service	90.6%	Ethnicity	94.0%
Service location	85.0%	Social Security number	98.8%
First name	97.6%	Education	91.7%
Last name	97.6%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	9 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	95.1%
	Diagnosis matches medical necessity/ access-to-care standards	95.1%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	94.9%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	46.4%
	Clinical documentation provides evidence of coordination of care with other agencies	66.3%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	45.5%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved in a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	84.5%
	Rule-out diagnosis is resolved within 180 days	3.2%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Chelan-Douglas Regional Support Network (CDRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	

• Policies and procedures are comprehensive and consistent with the philosophy of the Recovery Model.
• Ongoing care coordination ensures appropriate referrals for services covered under the enrollee's medical plan.
• CDRSN actively monitors the requirement for specialty assessments within its provider agencies.
• CDRSN facilitates implementation of mental health advance directives.
	• CDRSN needs to develop a method of tracking the use of interpreter services and the frequency of delivery of services in non-English languages.
	• CDRSN needs to monitor
	  ○ access and quality of after-hour crisis services
	  ○ providers' use of seclusion and restraint
	• Enrollees need information on
	  ○ out-of-network and specialty services
	  ○ medical and mental health directives

Grievance Systems	
• CDRSN provides training and technical assistance to providers regarding grievances and appeals. • CDRSN has developed sound practices for handling and resolving complaints and grievances within the RSN.	• CDRSN needs to develop procedures to monitor complaints and grievances, including those resolved at the provider level. • CDRSN needs to collect data on complaints and grievances at the provide level and include the findings into ongoing quality assurance activities.
Performance Improvement Projects (PIPs)	
Clinical	
• Relevant study topic; well-defined study question and study indicators	• Need to clearly define criteria for study population; need complete description of intervention and data verification procedures
Nonclinical	
• Initiated intervention strategy to address follow-up after hospitalization	• Need to refine the data collection and analysis plan
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • First name, Last name • Date of birth, Gender • Social Security number	Less than 95% accurate for: • Procedure code, Provider type • Minutes of service, Service location • Ethnicity • Education
Completeness	
• Inpatient encounter data, demographic data, and consumer periodic data were all complete.	• Outpatient encounter data were incomplete (Provider type).
Clinical Record Review	
• CDRSN performs well in documenting the enrollee's support system and participation in treatment planning. • Provider agencies generally appear consistent in ensuring that clinical records include prescriber diagnoses and that the plan-of-care diagnosis and prescriber diagnosis are partially or fully consistent.	• CDRSN's providers needs to document service authorization in charts. • CDRSN needs to consider ways to improve care coordination with PCPs. • CDRSN needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, and language) are addressed by clinicians in the treatment plan. • CDRSN needs to include in its audits a review to ensure that providers are documenting the reasons for deferred, rule-out, or provisional diagnoses, and to monitor the timeliness of resolving these diagnoses.

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RSN Profile
Clark County Regional Support Network (CCRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**94.5%**	**Grievance Systems**	**98.5%**
Enrollee rights: General	100%	Grievance system: General	80%
Information requirements	100%	Requirements and filing	100%
Notification timing	80%	Language and format	100%
Notification content	100%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	100%
Respect and dignity	80%	Handling of grievances and appeals	100%
Treatment options	100%	Resolution of grievances and appeals	100%
Advance directives	80%	Format and content of notices (fair hearing)	100%
Seclusion and restraint	100%	Expedited resolution of appeals	100%
Compliance with state and federal laws	100%	Information on providers	100%
		Record keeping and reporting	100%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Employment Outcomes for Adult Consumers	Minimally Met	Timeliness of Access to Outpatient Services	Partially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- CCRSN's skilled information service staff members create Crystal Reports containing charts, trend data, etc., that are reviewed and discussed at monthly meetings with representatives of RSN management and provider agencies.
- CCRSN participates with its provider agencies in performing extensive audits.
- The RSN reported no lag time or late reporting occurrences in 2008, and no significant changes in its information systems.
- Several RSN information service policies and procedures have been updated and are in draft, awaiting review and approval. These updates are expected to be finalized by November 1, 2008.
- At the time of the 2007 ISCA, CCRSN acted in a facilitator role for the Washington State Rural Consortium. The ISCA noted that CCRSN was "challenged to manage competing priorities" deriving from its role in the consortium, its responsibilities to the Clark County Community Services Department, and its internal RSN management needs. Since then, Chelan-Douglas RSN has assumed the role of facilitator for the consortium. CCRSN continues to participate in the consortium with responsibility to address the needs and issues of its provider agencies and of the RSN. Currently CCRSN meets its IT challenges; however, the RSN lost its IT manager during 2008. The Clark County Human Resources Department is assessing whether to replace the IT manager position or redirect those duties to the Clark County IT group.

CCRSN coordinates public mental health services in Clark County and has operated as a prepaid mental health plan since 1995. CCRSN contracts with local agencies to deliver responsive, accountable, and clinically effective treatment and prevention programs for persons with mental illness. During December 2007, CCRSN provided outpatient services to 2,458 out of 53,400 (4.6%) Medicaid enrollees.

Data source: Clark County RSN 2008 External Quality Review Report.

RSN Profile
Clark County Regional Support Network (CCRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	92.8%	Date of birth	98.9%
Provider type	82.7%	Gender	98.9%
Minutes of service	95.8%	Ethnicity	96.8%
Service location	75.2%	Social Security number	98.9%
First name	100%	Education	94.7%
Last name	100%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	15.1%
	Diagnosis matches medical necessity/ access-to-care standards	100%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	82.2%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	18.8%
	Clinical documentation provides evidence of coordination of care with other agencies	42.4%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	72.7%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	59.4%
	Rule-out diagnosis is resolved within 180 days	2.1%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Clark County Regional Support Network (CCRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	
• Comprehensive policies and procedures addressing enrollee rights, with awareness of dignity, respect, and privacy. • Emphasis on the Recovery Model, with consumers involved in staff roles, peer counseling and working committees. • Well-defined process for contracting with providers and regular monitoring of provider agencies. • Well-developed informational materials and consumer handbook.	• Continued technical assistance is needed to assure provider understanding of requirements of federal and state laws. • CCRSN needs to ensure that all agencies include both medical and mental health advance directives in enrollees' clinical records, as appropriate. • CCRSN needs to adapt its review protocol to monitor for privacy at provider agencies.
Grievance Systems	
• CCRSN has an effective system for monitoring grievances and complaints. • CCRSN integrates information from grievances and complaints into its quality assurance plan.	• CCRSN needs to ensure that enrollees consistently receive notices of changes in ongoing services initiated by provider agencies.
Performance Improvement Projects (PIPs)	
Clinical	
• Relevant study topic	• Refine study question, indicators, population, data collection and analysis
Nonclinical	
• Well-defined study topic and study question; good improvement strategy	• Need to clearly define study population and data collection procedures
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • Minutes of service • First name, Last name • Date of birth, Gender • Ethnicity • Social Security number	Less than 95% accurate for: • Procedure code • Provider type • Service location • Education
Completeness	
• Outpatient and inpatient encounter data, demographic data, and consumer periodic data were all complete.	
Clinical Record Review	
• Enrollee's support system is well documented in charts. • Enrollee's participation in development of the treatment plan and goals is well documented.	• To better manage utilization of services and determine medical necessity, access to care, and level of care, CCRSN needs to obtain detailed clinical information about diagnosis and psychiatric symptoms, recommended services, and their justification, and ensure a matching diagnosis. • CCRSN needs to consider ways to improve care coordination with PCPs. • CCRSN needs to continuously monitor whether clinicians are assessing enrollees' perceptions and preferences for treatment. • Clinicians need to document that issues directly related to the treatment process were assessed (e.g., enrollee's attitudes about treatment and medication, etc.).

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RSN Profile
Grays Harbor Regional Support Network (GHRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**73.6%**	**Grievance Systems**	**81.5%**
Enrollee rights: General	60%	Grievance system: General	100%
Information requirements	60%	Requirements and filing	80%
Notification timing	100%	Language and format	80%
Notification content	80%	Content of notice of action	80%
Information on grievances	100%	Timing of notice of action	100%
Respect and dignity	80%	Handling of grievances and appeals	80%
Treatment options	80%	Resolution of grievances and appeals	80%
Advance directives	60%	Format and content of notices (fair hearing)	80%
Seclusion and restraint	60%	Expedited resolution of appeals	100%
Compliance with state and federal laws	60%	Information on providers	60%
		Record keeping and reporting	60%
		Continuation of benefits	80%
		Effectuation of reversed appeal resolutions	80%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Increasing Number and Percent of Adults with Depression Diagnosis who Receive PHQ-9 at Intake and at Six Months	Substantially Met	Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization	Substantially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- GHRSN has developed new reports that should improve the analysis of mental health encounter data for quality improvement.
- GHRSN has developed policies and procedures covering data backup and recovery, disaster recovery, and system security.
- GHRSN's contractor has implemented methods to identify and correct duplicate enrollee ID numbers and to correct and resubmit pended encounters. However, the contractor lacks written policies and procedures for these processes and formal timelines for completing these tasks.
- County staff has received training in privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

GHRSN, headquartered in Aberdeen, authorizes all Medicaid-funded mental health services provided in Grays Harbor County. GHRSN contracts with two regional providers—Seattle-based Sea Mar Community Health Center, which specializes in serving Latino residents, and Olympia-based Behavioral Health Resources—to provide outpatient mental health services. BHR operates a crisis clinic in Hoquiam. During December 2007, GHRSN provided outpatient services to 548 out of 13,837 (4.0%) Medicaid enrollees.

Data source: Grays Harbor RSN 2008 External Quality Review Report.

RSN Profile
Grays Harbor Regional Support Network (GHRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	92.7%	Date of birth	100.0%
Provider type	85.7%	Gender	96.2%
Minutes of service	93.1%	Ethnicity	91.5%
Service location	93.4%	Social Security number	98.1%
First name	100.0%	Education	94.1%
Last name	100.0%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	9 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	84.0%
	Diagnosis matches medical necessity/ access-to-care standards	96.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	76.2%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	35.6%
	Clinical documentation provides evidence of coordination of care with other agencies	52.9%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	18.2%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	45.5%
	Rule-out diagnosis is resolved within 180 days	0.0%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page.

RSN Profile
Grays Harbor Regional Support Network (GHRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	
• Policies and procedures are comprehensive and consistent with the philosophy of the Recovery Model. • Ongoing care coordination ensures appropriate referrals for services covered under the enrollee's medical plan. • GHRSN collaborates effectively with contracted providers to accomplish goals related to client services.	• GHRSN needs to ensure that its policies address o all required elements of enrollee rights o management of behavioral incidents and prohibiting inappropriate use of seclusion and restraint o medical and mental health advance directives • GHRSN needs to increase monitoring of o privacy and confidentiality of provider agencies o discussions between consumers and providers of available treatment options o providers' use of seclusion and restraint • GHRSN needs to ensure that information materials refer to o all service providers in order to facilitate access to services o availability and location of crisis and emergency services o how to obtain specialty services
Grievance Systems	
• GHRSN makes active use of the Ombuds to provide direct assistance to clients with complaints, grievances, and other issues related to enrollee rights.	• GHRSN needs to monitor enrollee complaints, grievances, and appeals. • .GHRSN needs to incorporate an analysis of grievances and appeals in its overall quality assurance work plan. • Notices issued for the denial of services need to explain more fully the criteria used for denying services.
Performance Improvement Projects (PIPs)	
Clinical	
• Well-defined study topic, study question, and study indicators	• Need to collect and analyze remeasurement data
Nonclinical	
• Well-defined study topic, study question, and study indicators	• Need to collect and analyze remeasurement data
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • First name, Last name, Date of birth, Gender • Social Security number	Less than 95% accurate for: • Procedure code, Provider type, Minutes of service, Location • Ethnicity, Education
Completeness	
• Inpatient encounter data, demographic data, and consumer periodic data were all complete.	• Outpatient encounter data were incomplete (primary diagnosis).
Clinical Record Review	
• Enrollee support system is well documented in charts. • Enrollee's participation in developing treatment plan or goals is fairly well documented.	• GHRSN needs to obtain detailed clinical information about diagnosis and psychiatric symptoms, recommended services, and their justification, and ensure a matching diagnosis. • GHRSN needs to consider ways to improve care coordination. • GHRSN needs to monitor the enrollee's perceptions and preferences for treatment continuously to determine whether they are being assessed. • GHRSN needs to review the measures each provider agency has in place to ensure care coordination and timely reassessment of deferred, rule-out, or provisional diagnoses.

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RSN Profile
Greater Columbia Behavioral Health (GCBH)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**89.1%**	**Grievance Systems**	**100%**
Enrollee rights: General	100%	Grievance system: General	100%
Information requirements	80%	Requirements and filing	100%
Notification timing	100%	Language and format	100%
Notification content	80%	Content of notice of action	100%
Information on grievances	80%	Timing of notice of action	100%
Respect and dignity	100%	Handling of grievances and appeals	100%
Treatment options	100%	Resolution of grievances and appeals	100%
Advance directives	80%	Format and content of notices (fair hearing)	100%
Seclusion and restraint	80%	Expedited resolution of appeals	100%
Compliance with state and federal laws	100%	Information on providers	100%
		Record keeping and reporting	100%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Impact of Implementing the PACT Model on the Use of Inpatient Treatment	Partially Met	Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalizations	Partially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- In September 2008, GCBH hired a new quality manager who will assist in developing performance indicators to establish a balanced performance measurement framework.
- GCBH audits the provider network's IT capabilities annually and documents the findings in provider audit reports.
- GCBH affirmed that there was no delayed reporting of encounter data to the state since the previous ISCA.
- GCBH can download eligibility files from the MHD website; however, the data are not always accurate until updated by the state's Community Services Division. GCBH believes that the implementation of ProviderOne will resolve this issue by enabling current verification of client eligibility.

GCBH, headquartered in Kennewick, is a consortium providing public mental health services for 11 counties and the Yakima Nation in south central and eastern Washington. Reflecting its commitment to consumer-driven care, GCBH maintains a citizen's advisory board that reviews GCBH plans and policies and provides input to the GCBH board of directors. In addition, consumers receiving GCBH services participate in workgroups and on committees. During December 2007, GCBH provided outpatient services to 5,039 out of 135,484 (3.7%) Medicaid enrollees.

Data source: Greater Columbia Behavioral Health 2008 External Quality Review Report.

RSN Profile
Greater Columbia Behavioral Health (GCBH)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	94.0%	Date of birth	100.0%
Provider type	95.6%	Gender	100.0%
Minutes of service	80.3%	Ethnicity	94.2%
Service location	91.9%	Social Security number	98.8%
First name	100.0%	Education	98.8%
Last name	100.0%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review		
Standard	**Key elements***	**Found in chart**
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	0.0%
	Diagnosis matches medical necessity/ access-to-care standards	100.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	94.0%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	30.0%
	Clinical documentation provides evidence of coordination of care with other agencies	50.0%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	81.8%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	92.0%
	Rule-out diagnosis is resolved within 180 days	2.5%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Greater Columbia Behavioral Health (GCBH)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	

• GCBH publishes its own enrollee handbook with information about services and enrollee rights.
• GCBH's Quality Review Team conducts comprehensive site visits that include surveys of allied providers, clinicians, and consumers.
• GCBH's consumer services coordinator conducts consumer rights training each year, covering enrollee rights, mental health directives, grievances, appeals, and fair hearings.
	• GCBH needs to ensure that enrollees are informed about
	  ○ access to out-of-network services and specialty care
	  ○ medical and mental health advance directives
	  ○ time frames for filing grievances, appeals, and fair hearings
	• GCBH needs to maintain a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender.
	• GCBH needs to track the use of translation/interpreter services and whether enrollees need information in alternative formats.
	• GCBH needs to monitor for use of seclusion and restraint as part of its credentialing and recredentialing activities.

Grievance Systems	
• GCBH adheres to the required grievance timelines. Grievance response letters are informative and clearly describe the grievance resolution. • When providers changed during 2007, planning efforts resulted in a smooth transition to the new provider, with written notice provided to all enrollees.	
Performance Improvement Projects (PIPs)	
Clinical	
• Well-developed study topic, study question, and improvement strategy	• Collect and analyze baseline and remeasurement data
Nonclinical	
• Well-defined study topic, indicators, and data collection and reporting procedures	• Develop interventions
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • Provider type • First name, Last name • Date of birth, Gender • Social Security number, Education	Less than 95% accurate for: • Procedure code • Minutes of service, Service location • Ethnicity
Completeness	
• Outpatient and inpatient encounter data were all complete. • Demographic data and consumer period data were complete.	
Clinical Record Review	
• In general, charts document well the enrollee's support system and participation in developing the treatment plan and goals. • Enrollee's language, ethnicity, socioeconomic factors, and cognitive ability are well documented.	• To better manage utilization of services and determine medical necessity, access to care, and level of care, GCBH needs to obtain detailed clinical information about diagnosis and psychiatric symptoms, recommended services, and their justification, and ensure a matching diagnosis. • GCBH needs to consider ways to improve care coordination. • GCBH needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, and language, and sensory impairments) are addressed by clinicians in the treatment plan.

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RSN Profile
King County Regional Support Network (KCRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**83.6%**	**Grievance Systems**	**86.2%**
Enrollee rights: General	80%	Grievance system: General	80%
Information requirements	100%	Requirements and filing	80%
Notification timing	100%	Language and format	80%
Notification content	80%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	60%
Respect and dignity	80%	Resolution of grievances and appeals	100%
Treatment options	80%	Expedited resolution of appeals	80%
Advance directives	60%	Format and content of notices (fair hearing)	80%
Seclusion and restraint	80%	Expedited resolution of appeals	100%
Compliance with state and federal laws	80%	Information on providers	80%
		Record keeping and reporting	100%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Metabolic Syndrome Screening and Intervention	Partially Met	Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization	Partially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- KCRSN has developed a survey process to assess the business continuity plans of its provider agencies, and has distributed the assessment results to the agencies to help guide them in improving their plans. To ensure consistent oversight, KCRSN performs onsite reviews of the agencies, including a review of policies and procedures. KCRSN plans to use the review results to benchmark agency progress from year to year.
- KCRSN affirmed that there was no delayed reporting of encounter data to the state since the previous ISCA.

King County began providing coverage for Medicaid and low-income residents in the early 1970s, was certified as an RSN in 1990, and began implementing managed care in 1995. KCRSN, the state's largest RSN, operates with a network of 16 outpatient community mental health agencies and 11 residential providers serving Medicaid enrollees and low-income non-Medicaid residents. KCRSN has instituted a multi-year system change initiative to better serve its clients by implementing recovery-oriented services throughout its provider network. During December 2007, KCRSN provided outpatient services to 13,941 out of 178,230 (7.8%) Medicaid enrollees.

Data source: King County RSN 2008 External Quality Review Report.

RSN Profile
King County Regional Support Network (KCRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	83.3%	Date of birth	100.0%
Provider type	85.6%	Gender	100.0%
Minutes of service	93.2%	Ethnicity	95.6%
Service location	90.5%	Social Security number	91.1%
First name	100.0%	Education	95.6%
Last name	100.0%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	5.2%
	Diagnosis matches medical necessity/ access-to-care standards	100.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	80.0%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	27.8%
	Clinical documentation provides evidence of coordination of care with other agencies	22.5%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	100.0%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	80.9%
	Rule-out diagnosis is resolved within 180 days	3.8%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
King County Regional Support Network (KCRSN)

<table>
<tr><th>Strengths</th><th>Opportunities for improvement</th></tr>
<tr><td>Regulatory and Contractual Standards</td><td></td></tr>
<tr><td colspan="2">Enrollee Rights</td></tr>
<tr><td>• Service delivery is structured in terms of the Recovery Model; each provider agency submits detailed Recovery Model plan.
• KCRSN conducts cross-agency systems training, including enrollee rights issues.
• KCRSN monitors for confidentiality and privacy, including releases of information for individuals in the enrollee’s natural support system.</td><td>• KCRSN needs to maintain a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender.
• KCRSN needs to monitor provider agencies for
o use of seclusion and restraint
o privacy
o discussion of treatment options with enrollees
• KCRSN needs to ensure that its policies and procedures address all required enrollee rights.
• KCRSN needs to ensure that medical and mental health advance directives are addressed, including where to refer enrollees with complaints about non-compliance.
• KCRSN needs to ensure that all services listed in the benefit booklet are available to enrollees.</td></tr>
<tr><td colspan="2">Grievance Systems</td></tr>
<tr><td>• KCRSN maintains a customer service line to facilitate referrals and to manage complaints, grievances and appeals.</td><td>• KCRSN needs to monitor provider agencies regarding
o notice provided when ongoing services change
o timelines for complaints and grievances filed with provider agencies and subcontractors</td></tr>
<tr><td>Performance Improvement Projects (PIPs)</td><td></td></tr>
<tr><td colspan="2">Clinical</td></tr>
<tr><td>• Developed study topic, study question, and indicators</td><td>• Need to more thoroughly define the intervention strategy and collect and analyze remeasurement data</td></tr>
<tr><td colspan="2">Nonclinical</td></tr>
<tr><td>• Relevant study topic and clearly-defined indicators</td><td>• Need to establish intervention strategy and describe data verification procedures</td></tr>
<tr><td colspan="2">Encounter Data Accuracy and Completeness</td></tr>
<tr><td colspan="2">Accuracy</td></tr>
<tr><td>More than 95% accurate for:
• First name, Last name
• Date of birth, Gender
• Ethnicity
• Education</td><td>Less than 95% accurate for:
• Procedure code
• Provider type
• Minutes of service, Service location
• Social Security number</td></tr>
<tr><td colspan="2">Completeness</td></tr>
<tr><td>• Outpatient and inpatient encounter data, demographic data, and consumer period data were all complete.</td><td></td></tr>
<tr><td colspan="2">Clinical Record Review</td></tr>
<tr><td>• The enrollee’s support system and enrollee participation in developing treatment plan and goals are generally well documented in charts.
• Prescriber diagnosis and plan-of-care diagnoses generally appear consistent.</td><td>• KCRSN needs to obtain detailed clinical information about diagnosis and psychiatric symptoms, recommended services, and their justification, and ensure a matching diagnosis.
• KCRSN needs to consider ways to improve care coordination with PCPs.
• KCRSN needs to take steps to ensure that all identified issues (including enrollee’s ethnicity, spirituality, and language) are addressed by clinicians in the treatment plan.</td></tr>
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RSN Profile
North Central Washington Regional Support Network (NCWRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**80.9%**	**Grievance Systems**	**76.9%**
Enrollee rights: General	80%	Grievance system: General	100%
Information requirements	80%	Requirements and filing	60%
Notification timing	100%	Language and format	60%
Notification content	60%	Content of notice of action	80%
Information on grievances	100%	Timing of notice of action	80%
Respect and dignity	80%	Resolution of grievances and appeals	80%
Treatment options	80%	Expedited resolution of appeals	60%
Advance directives	80%	Format and content of notices (fair hearing)	80%
Seclusion and restraint	80%	Expedited resolution of appeals	80%
Compliance with state and federal laws	80%	Information on providers	80%
		Record keeping and reporting	60%
		Continuation of benefits	80%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
PIP not submitted	Not Met	Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization	Minimally Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- NCWRSN is working hard to come into full compliance regarding data submission. Since the RSN began a new system of data checking before forwarding encounters to the state, all data sent to the state have been error-free.
- NCWRSN has implemented a new single repository information system that allows better aggregation and analysis of data. The RSN currently is creating management and utilization reports.
- NCWRSN has not created a formal system to track and schedule responses to provider agency requests for IT support. Most agency requests for IT support involve reporting and coding issues. NCWRSN has responded by providing the agencies with further clarification about service reporting manual and coding procedures.
- NCWRSN for years has had a policy and procedure for submitting data certifications, but has had problems submitting certifications on time. To correct this issue, NCWRSN maintains a log to manage certifications and batch transmissions.
- NCWRSN submitted a new disaster recovery and business continuity plan to MHD as part of the most recent contract monitoring. MHD notified NCWRSN that the submitted plan meets full contract requirements.
- NCWRSN reported no lag time or late reporting through March 2008, and no significant changes in its information systems during 2008.

NCWRSN administers local mental health systems in Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties, including areas previously served by the Northeast RSN. NCRSN's mission is to ensure that people of all ages with mental illness can better manage their illness, achieve their personal goals, and live, work, and participate in their community. In mid-2008, NCRSN had about 49,000 enrollees in its expanded service area. During December 2007, NCRSN provided outpatient services to 1,185 out of 50,492 (2.3%) Medicaid enrollees.

Data source: North Central Washington RSN 2008 External Quality Review Report.

RSN Profile
North Central Washington Regional Support Network (NCWRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	86.7%	Date of birth	100.0%
Provider type	82.1%	Gender	98.9%
Minutes of service	91.6%	Ethnicity	81.7%
Service location	84.5%	Social Security number	95.7%
First name	95.7%	Education	78.5%
Last name	97.9%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	9 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	67.0%
	Diagnosis matches medical necessity/ access-to-care standards	100.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	93.3%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	55.8%
	Clinical documentation provides evidence of coordination of care with other agencies	33.9%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	18.2%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	68.9%
	Rule-out diagnosis is resolved within 180 days	13.0%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
North Central Washington Regional Support Network (NCWRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	
• NCWRSN has developed its own enrollee handbook to explain specific rights provisions. • NCWRSN conducts regular monitoring for all provider agencies. • NCWRSN involves the Ombuds on an ongoing basis.	• NCWRSN needs to ensure protection of enrollee's personal health information. • NCWRSN needs to maintain a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender. • NCWRSN needs to inform enrollees about o crisis services available across its service area o how to obtain out-of-network services o available treatment options and alternatives • NCWRSN needs to monitor provider agencies regarding use of seclusion and restraint, use of interpreters, medical and mental health advance directives, and access to medical records.
Grievance Systems	
• NCWRSN provided training to provider staff regarding grievances and appeals in 2007.	• NCWRSN needs to ensure that its grievance and appeals policy includes all required elements. • NCWRSN needs to ensure that provider agencies report complaints, grievances, and appeals to the RSN. • NCWRSN needs to make notices available in non-English languages. • NCWRSN needs to incorporate information about grievances and appears into its ongoing quality assurance program.
Performance Improvement Projects (PIPs)	
Clinical	
No PIP submitted	• No PIP submitted
Nonclinical	
• Relevant study topic and clearly defined study indicators	• Further define study question and develop an intervention strategy
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • First name, Last name • Date of birth, Gender • Social Security number	Less than 95% accurate for: • Procedure code, Provider type • Minutes of service, Service location • Ethnicity, Education
Completeness	
• Inpatient encounter data were all complete. • Demographic data and consumer period data were complete.	• Outpatient encounter data were incomplete (Provider type).
Clinical Record Review	
• In general, charts document well the enrollee's support system and participation in developing treatment plan and goals. • NCWRSN's provider agencies are generally ensuring that treatment plan diagnoses and prescriber diagnoses are consistent.	• NCWRSN needs to obtain detailed clinical information about diagnosis and psychiatric symptoms, recommended services, and their justification, and ensure a matching diagnosis. • NCWRSN needs to perform routine audits of authorizations and of provider charts to determine whether the assessment, care plan, and progress notes support the diagnosis and services rendered to the enrollee. • NCWRSN needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, and language) are addressed by clinicians in the treatment plan.

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RSN Profile
North Sound Mental Health Administration (NSMHA)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**93.6%**	**Grievance Systems**	**96.9%**
Enrollee rights: General	100%	Grievance system: General	100%
Information requirements	100%	Requirements and filing	100%
Notification timing	100%	Language and format	80%
Notification content	80%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	80%
Respect and dignity	100%	Resolution of grievances and appeals	100%
Treatment options	100%	Expedited resolution of appeals	100%
Advance directives	80%	Format and content of notices (fair hearing)	100%
Seclusion and restraint	100%	Expedited resolution of appeals	100%
Compliance with state and federal laws	80%	Information on providers	100%
		Record keeping and reporting	100%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Restraint and Seclusion at Freestanding Evaluation & Treatment Facilities	Partially Met	Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization	Partially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- NSMHA employs a data analyst who, along with IT staff, prepares and presents meaningful data to targeted audiences.
- NSMHA continues to revise its policies and procedures as deemed necessary. In addition, the RSN collects and reviews the policies and procedures of provider agencies to ensure that processes are in place to address accountability and compliance requirements.
- NSMHA updates its policies and procedures monthly or as needed. The RSN sends provider agencies a memorandum notifying them of policy changes. In addition, all policy memorandums are published on the RSN's website.
- NSMHA and provider agencies participate in monthly meetings that include IT and QI discussions.
- NSMHA affirmed that there was no delayed reporting of encounter data to the state since the previous ISCA.
- NSMHA does not have a process in place to review provider policies and procedures. NSMHA has hired a consultant to perform a regional information systems review and provide feedback for system improvements.

NSMHA, headquartered in Mount Vernon, serves enrollees in Island, San Juan, Skagit, Snohomish, and Whatcom counties. NSMHA contracts to provide crisis and commitment services, inpatient treatment, outpatient, and specialized services. NSMHA has been selected as one of the sites for the Wraparound Pilot program. Key goals are to increase the meaningful inclusion of family voice and choice, effectively coordinate needs and services for families in multiple systems, and increase self-reliance. During December 2007, NSMHA provided outpatient services to 4,755 out of 119,787 (4.0%) Medicaid enrollees.

Data source: North Sound RSN 2008 External Quality Review Report.

RSN Profile
North Sound Mental Health Administration (NSMHA)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	94.0%	Date of birth	100.0%
Provider type	92.1%	Gender	100.0%
Minutes of service	95.5%	Ethnicity	88.0%
Service location	85.0%	Social Security number	100.0%
First name	97.6%	Education	91.6%
Last name	100.0%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	0.0%
	Diagnosis matches medical necessity/ access-to-care standards	0.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	97.1%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	52.4%
	Clinical documentation provides evidence of coordination of care with other agencies	46.7%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	100.0%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	86.7%
	Rule-out diagnosis is resolved within 180 days	4.9%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
North Sound Mental Health Administration (NSMHA)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	
• RSN policies and decision-making practices reflect the Recovery Model. • NSMHA emphasizes uniform policies and clinical practices in its provider network. • NSMHA produces a brochure that provides information useful to enrollees in terms of rights and access to service. • NSMHA sponsors trainings to support clinical initiatives. • NSMHA has a single access point for referral/crisis services.	• NSMHA needs to maintain a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender. • NSMHA needs to inform enrollees about how to obtain out-of-network and specialty services and Medicaid services not provided by the RSN. • NSMHA needs to ensure that its policy covers both medical and mental health advance directives and where to file complaints about noncompliance.
Grievance Systems	
• NSMHA has a well-developed system to manage complaints and grievances, and integrates this information into quality management efforts.	• NSMHA needs to ensure that notices are written in easily understood language. • Policies and procedures pertaining to notices of termination, suspension, or reduction of previously authorized services do not address decisions made by provider agencies. • NSMHA needs to develop a process to identify authorizations submitted outside of the required time frames.
Performance Improvement Projects (PIPs)	
Clinical	
• Relevant study topic; well-defined study question and indicators	• Define data collection procedures and explain intervention more fully
Nonclinical	
• Well-defined study topic and question, indicators, and improvement strategy	• Describe data collection and verification procedures more thoroughly
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • Minutes of service • First name, Last name • Date of birth, Gender • Social Security number	Less than 95% accurate for: • Procedure code, Provider type • Service location • Ethnicity • Education
Completeness	
• Outpatient encounter data were all complete. • Inpatient encounter data were all complete. • Demographic data were all complete. • Consumer period data were all complete.	
Clinical Record Review	
• A majority of charts identified the enrollee's PCP and had the requisite consents in place. • NSMHA's provider agencies are doing a good job of ensuring that clinical records include prescriber diagnoses and that the plan-of-care diagnosis and prescriber diagnosis are consistent.	• NSMHA and its provider agencies need to carefully audit charts to increase family/guardian involvement in the enrollee's care and treatment plan. • NSMHA needs to consider ways to improve care coordination with PCPs. • NSMHA needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, and language) are addressed by clinicians in the treatment plan.

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RSN Profile
Peninsula Regional Support Network (PRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**84.5%**	**Grievance Systems**	**95.4%**
Enrollee rights: General	100%	Grievance system: General	100%
Information requirements	80%	Requirements and filing	100%
Notification timing	80%	Language and format	80%
Notification content	80%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	100%
Respect and dignity	80%	Resolution of grievances and appeals	100%
Treatment options	80%	Expedited resolution of appeals	80%
Advance directives	100%	Format and content of notices (fair hearing)	100%
Seclusion and restraint	60%	Expedited resolution of appeals	100%
Compliance with state and federal laws	100%	Information on providers	80%
		Record keeping and reporting	100%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Metabolic Syndrome Screening and Intervention	Partially Met	Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization	Partially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- PRSN has hired a new quality manager to help aggregate and analyze data in order to improve the efficiency of reporting.
- Provider agencies' system data are stored on secure servers at Kitsap Mental Health Services, PRSN's IT contractor. To ensure business continuity, Kitsap has a written disaster recovery plan identifying the procedures to be deployed in the event of power failures, system crashes, and natural disasters.
- PRSN reported no lag time or late reporting occurrences since the previous ISCA, and no significant changes in its information systems.
- PRSN lacks a systematic process for reviewing provider agencies' HIPAA security arrangements. The RSN plans to develop such a process and include it in the annual administrative review of each agency.

PRSN, headquartered in Port Orchard, administers mental health programs in Clallam, Jefferson, and Kitsap counties. The RSN's executive board, comprising nine county commissioners, sets policy and has oversight responsibilities. During December 2007, PRSN provided outpatient services to 2,356 out of 38,836 (6.1%) Medicaid enrollees.

Data source: Peninsula RSN 2008 External Quality Review Report.

RSN Profile
Peninsula Regional Support Network (PRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	92.0%	Date of birth	99.0%
Provider type	85.6%	Gender	94.9%
Minutes of service	90.8%	Ethnicity	62.2%
Service location	79.4%	Social Security number	99.0%
First name	100.0%	Education	89.8%
Last name	99.0%		
Completeness Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	5.6%
	Diagnosis matches medical necessity/ access-to-care standards	98.1%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	95.4%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	50.0%
	Clinical documentation provides evidence of coordination of care with other agencies	57.0%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	72.7%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	87.0%
	Rule-out diagnosis is resolved within 180 days	12.8%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Peninsula Regional Support Network (PRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	
• PRSN has emphasized uniformity in policies and assessment formats throughout the system. • PRSN has developed a handbook for use by enrollees in understanding rights and accessing services. • PRSN conducts targeted chart reviews in areas identified for improvement efforts (second opinions, advance directives, use of interpreters).	• PRSN needs to inform enrollees that they can request a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender. • PRSN's site review protocol needs to address the privacy of reception areas at provider agencies. • PRSN needs to clearly communicate with providers about advising and advocating on behalf of enrollees with regard to treatment options. • PRSN needs to develop a policy on the use of seclusion and restraint, and monitor for these practices as part of its credentialing and recredentialing site visits.
Grievance Systems	
• PRSN conducted trainings on advance directives during 2007.	• PRSN needs to implement a process to ensure that notices are delivered in native language to non English-speaking enrollees.
Performance Improvement Projects (PIPs)	
Clinical	
• Relevant study topic; well-defined study indicators	• Further define intervention and study questions
Nonclinical	
• Well-defined study indicators and study population	• Develop data verification procedures and develop an intervention strategy
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • First name, Last name • Date of birth • Social Security number	Less than 95% accurate for: • Procedure code, Provider type • Minutes of service, Service location • Gender • Ethnicity • Education
Completeness	
• Outpatient encounter data were all complete. • Inpatient encounter data were all complete. • Demographic data were all complete. • Consumer period data were all complete.	
Clinical Record Review	
• In general, charts document well the enrollee's support system and participation in developing the treatment plan and goals. • Prescriber diagnosis and plan-of-care diagnoses generally appear consistent.	• PRSN needs to perform routine audits of authorizations and of provider charts to determine whether the assessment, care plan, and progress notes support the diagnosis and services rendered to the enrollee. • PRSN needs to consider ways to improve care coordination. • PRSN needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, and language) are addressed by clinicians in the treatment plan.

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RSN Profile
Southwest Regional Support Network (SWRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**86.4%**	**Grievance Systems**	**95.4%**
Enrollee rights: General	100%	Grievance system: General	100%
Information requirements	80%	Requirements and filing	100%
Notification timing	100%	Language and format	60%
Notification content	60%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	100%
Respect and dignity	100%	Resolution of grievances and appeals	100%
Treatment options	100%	Expedited resolution of appeals	100%
Advance directives	80%	Format and content of notices (fair hearing)	80%
Seclusion and restraint	80%	Expedited resolution of appeals	100%
Compliance with state and federal laws	80%	Information on providers	100%
		Record keeping and reporting	100%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Increasing Consumer Hospital Diversion through Utilizing the Crisis Support Unit	Minimally Met	Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization	Partially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- SWRSN reports that it developed a procedure for calculating member months in 2006, as recommended by the ISCA, and has been using the procedure since then. SWRSN has created a draft policy and expects to formalize it in August 2008.
- SWRSN has a process in place for developing new data aggregate reports and uses these reports in its quality improvement meetings. IT staff attends monthly meetings of the Washington State Rural Consortium to discuss data trends. SWRSN maintains a metadata table in MS Access to help manage and track data effectively. Provider agencies receive monthly reports with detailed and high-level information.
- SWRSN reported some lag time and late reporting to the state during 2008. To address these issues, SWRSN implemented a new data checking process that significantly reduced lag time and late reporting.

SWRSN, based in Longview, is a division of the Cowlitz County Human Services Department. SWRSN's mission is to manage the provision of a consumer-driven network of individualized mental health services to reduce stigma and promote recovery and resiliency. During December 2007, SWRSN provided outpatient services to 1,230 out of 18,303 (6.7%) Medicaid enrollees.

Data source: Southwest RSN 2008 External Quality Review Report.

RSN Profile
Southwest Regional Support Network (SWRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	46.8%	Date of birth	99.0%
Provider type	71.6%	Gender	94.8%
Minutes of service	63.6%	Ethnicity	86.5%
Service location	57.1%	Social Security number	96.8%
First name	95.8%	Education	71.6%
Last name	97.9%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	9 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	0.0%
	Diagnosis matches medical necessity/ access-to-care standards	100.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	64.8%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	40.0%
	Clinical documentation provides evidence of coordination of care with other agencies	42.3%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	9.1%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	66.7%
	Rule-out diagnosis is resolved within 180 days	5.7%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Southwest Regional Support Network (SWRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	
• SWRSN publishes an additional consumer booklet to facilitate access to local services. • SWRSN conducts an annual consumer survey including items related to patient rights. • SWRSN conducts trainings for its service provider network.	• SWRSN needs to ensure that materials are available in Spanish and that service providers who are native speakers can conduct therapy in languages other than English. • SWRSN needs to inform enrollees about how to obtain out-of-network services and specialty care. • SWRSN needs include review of seclusion and restraint in its annual review of providers. • SWRSN needs to ensure that its policy addresses both medical and mental health advance directives.
Grievance Systems	
• SWRSN incorporates reporting on complaints and grievances into its quality management system.	• SWRSN needs to monitor enrollee complaints and grievances filed at the provider or RSN level. • SWRSN needs to ensure that Spanish-speaking enrollees receive notices in Spanish. • SWRSN need to ensure that its policies regarding notices of termination, suspension, or reduction of previously authorized services address decisions made by provider agencies. • SWRSN needs to ensure that notices of grievance resolution clearly state the resolution with sensitivity to the client's concern.
Performance Improvement Projects (PIPs)	
Clinical	
• Implemented improvement strategy	• Need to revise study question, indicators and population, and data collection procedures
Nonclinical	
• Defined study question and performance indicators	• Develop intervention to improve indicator and data verification strategies
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • First name, Last name • Date of birth • Social Security number	Less than 95% accurate for: • Procedure code, Provider type, Minutes of service, Service location • Gender, Ethnicity, Education
Completeness	
• Inpatient encounter data were all complete. • Demographic data and consumer period data were complete.	• Outpatient encounter data were incomplete (Provider type).
Clinical Record Review	
• Generally, the enrollee's support system was documented in the initial assessment, and the care plan was signed by the enrollee. • SWRSN's provider agencies are doing a good job of ensuring that clinical records include prescriber diagnoses and that the plan-of-care diagnosis and prescriber diagnosis are consistent.	• SWRSN needs to retain documentation for authorization decisions in the event of grieved denials and financial audits aimed at ensuring appropriate expenditure of Medicaid funds. • SWRSN needs to consider ways to improve care coordination. • SWRSN needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, language, and sensory impairments) are addressed by clinicians in the treatment plan. • SWRSN needs to encourage providers to include family or legal guardian in enrollee's support system, when appropriate.

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RSN Profile
Spokane County Regional Support Network (SCRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**93.6%**	**Grievance Systems**	**95.4%**
Enrollee rights: General	80%	Grievance system: General	80%
Information requirements	100%	Requirements and filing	100%
Notification timing	100%	Language and format	100%
Notification content	80%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	60%
Respect and dignity	100%	Resolution of grievances and appeals	100%
Treatment options	100%	Expedited resolution of appeals	100%
Advance directives	80%	Format and content of notices (fair hearing)	100%
Seclusion and restraint	100%	Expedited resolution of appeals	100%
Compliance with state and federal laws	100%	Information on providers	100%
		Record keeping and reporting	100%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Healthy Partnerships/Motivational Interviewing	Partially Met	Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines	Substantially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- SCRSN continues to demonstrate a strong commitment to quality improvement (QI) and to providing high-quality products.
- SCRSN has hired a data statistician to help improve the quality of its reporting processes and to develop and deliver more effective reports to provider agencies.
- SCRSN's information technology staff has participated actively in the design of quality processes for specific issues, such as inpatient hospitalization and overutilization. The RSN expects to hire a new QI professional to help develop and implement detailed policies and procedures for encounter validations and corrective actions.
- SCRSN monitors agency providers annually to ensure that they meet state requirements for backup, recovery, and business resumption. SCRSN trains provider agencies to meet these requirements and provides the state with proper documentation certifying that all agencies meet the requirements.
- In 2008, SCRSN reported the occurrence of delayed reporting to the state, which the RSN attributes to unclear contract terms. SCRSN expects that a redefinition of contract terms in October 2008 will resolve this problem.

SCRSN is housed within Spokane County's Community Services Division, which administers public mental health dollars for the county and reports to the Board of County Commissioners. SCRSN contracts with several dozen providers of community support, adult residential, and inpatient mental health services for Medicaid enrollees. During December 2007, SCRSN provided outpatient services to 3,720 out of 75,635 (4.9%) Medicaid enrollees.

Data source: Spokane County RSN 2008 External Quality Review Report.

RSN Profile
Spokane County Regional Support Network (SCRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	92.8%	Date of birth	100.0%
Provider type	94.0%	Gender	100.0%
Minutes of service	92.4%	Ethnicity	83.0%
Service location	95.9%	Social Security number	100.0%
First name	100.0%	Education	95.3%
Last name	98.9%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	0.0%
	Diagnosis matches medical necessity/ access-to-care standards	0.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	93.8%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	36.7%
	Clinical documentation provides evidence of coordination of care with other agencies	66.4%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	90.9%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	78.8%
	Rule-out diagnosis is resolved within 180 days	0.0%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Spokane County Regional Support Network (SCRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	
• SCRSN conducts comprehensive site visits, engaging provider agency staff in the internal review process for clinical records. • SCRSN is actively involved with the authorization process delegated to its third-party administrator.	• SCRSN needs to inform enrollees that they can request a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender. • SCRSN needs to ensure that its consumer rights policy includes the entire list of rights. • SCRSN needs to ensure that its policy on advance directives includes both medical and mental health advance directives.
Grievance Systems	
• SCRSN has managed transitions in provider agencies with appropriate notice and transition for enrollees. • SCRSN includes information on grievances and appeals as part of its QI program.	• SCRSN needs to ensure that notices pertaining to service authorization and denial are issued to enrollees. • SCRSN needs to ensure that its policies and procedures regarding notices of termination, suspension, or reduction of previously authorized services address decisions made by provider agencies.
Performance Improvement Projects (PIPs)	
Clinical	
• Relevant study topic with well-defined study question	• Describe data collection and verification procedures
Nonclinical	
• Well-defined study indicator and improvement strategy	• Describe data verification and analysis plan
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • Service location • First name, Last name • Date of birth, Gender • Social Security number • Education	Less than 95% accurate for: • Procedure code, Provider type • Minutes of service, Service location • Ethnicity
Completeness	
• Outpatient encounter data were all complete. • Inpatient encounter data were all complete. • Demographic data were all complete. • Consumer period data were all complete.	
Clinical Record Review	
• In general, charts document well the enrollee's support system and participation in developing the treatment plan and goals. • Prescriber diagnosis and plan-of-care diagnoses generally appear consistent.	• To better manage utilization of services, SCRSN needs to obtain more detailed clinical information about the enrollee's diagnosis and psychiatric symptoms, recommended services, and their justification, and ensure a matching diagnosis. • SCRSN needs to consider ways to improve care coordination. • SCRSN needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, language, and sensory impairments) are addressed by clinicians in the treatment plan.

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RSN Profile
Thurston Mason Regional Service Network (TMRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**80.9**%	**Grievance Systems**	**95.4**%
Enrollee rights: General	80%	Grievance system: General	100%
Information requirements	100%	Requirements and filing	80%
Notification timing	80%	Language and format	100%
Notification content	80%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	100%
Respect and dignity	80%	Resolution of grievances and appeals	80%
Treatment options	80%	Expedited resolution of appeals	100%
Advance directives	80%	Format and content of notices (fair hearing)	100%
Seclusion and restraint	60%	Expedited resolution of appeals	100%
Compliance with state and federal laws	80%	Information on providers	100%
		Record keeping and reporting	80%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Multisystemic Therapy	Partially Met	Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization	Substantially Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- TMRSN has defined its process and procedures for mapping nonstandard codes to standard codes.
- To increase management's ability to analyze data effectively, TMRSN is developing and distributing a series of data reports specifically designed for internal staff, advisory board members, and provider agencies. This includes monthly utilization management data for outpatient and inpatient services.
- TMRSN has revised and approved its policy and procedure for identifying and removing duplicate member ID numbers.
- Thurston County Central Services Information Systems has hired an IT security specialist to work with TMRSN staff to ensure network security and compliance. This specialist also will assist in network security and compliance audits of provider agencies.
- TMRSN has developed an audit tool for monitoring provider compliance. The tool covers provider agency data collection, monitoring, data verification, and security requirements as required by the agencies' contracts with TMRSN.
- TMRSN has taken no action on the previous recommendation to define data completeness standards across all relevant policies and procedures.

TMRSN, headquartered in Olympia, administers public mental health services for Thurston and Mason counties. TMRSN contracts with Olympia-based Behavioral Health Resources and Seattle-based Sea Mar Community Health Centers to provide outpatient, crisis, residential, and inpatient services, and with Providence St. Peter Hospital for geropsychiatric services. For many years TMRSN has supported a consumer-run Clubhouse recognized by the International Center for Clubhouse Development. An evaluation and treatment center that opened in 2005 provides voluntary and involuntary inpatient treatment and crisis outreach and stabilization. During December 2007, TMRSN provided outpatient services to 1,846 out of 35,518 (5.2%) Medicaid enrollees.

Data source: Thurston Mason RSN 2008 External Quality Review Report.

RSN Profile
Thurston Mason Regional Support Network (TMRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	73.9%	Date of birth	100.0%
Provider type	67.2%	Gender	100.0%
Minutes of service	79.3%	Ethnicity	86.0%
Service location	33.0%	Social Security number	95.3%
First name	98.8%	Education	93.0%
Last name	98.8%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	0.0%
	Diagnosis matches medical necessity/ access-to-care standards	96.9%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	95.9%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	45.9%
	Clinical documentation provides evidence of coordination of care with other agencies	57.7%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	27.3%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	82.7%
	Rule-out diagnosis is resolved within 180 days	1.0%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Thurston Mason Regional Support Network (TMRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	

• TMRSN has sound, comprehensive policies regarding enrollee rights.
• TMRSN involves the Ombuds in providing direct assistance to enrollees and training for provider agencies.
• TMRSN has developed a consumer handbook referencing enrollee rights provisions and access to services.
• TMRSN involves its Consumer Council and Quality Review Team in planning and review activities.
	• TMRSN needs to inform enrollees that they can request a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender.
	• TMRSN needs to ensure that enrollees are informed about
	  o all providers within its network
	  o available treatment options and alternatives
	• TMRSN needs to monitor its provider agencies regarding
	  o privacy of reception and office areas
	  o use of seclusion and restraint
	  o medical and mental health advance directives
	  o access to specialty evaluations

Grievance Systems	
• TMRSN manages service authorizations internally and assures timely notices to enrollees regarding authorization decisions. • TMRSN addresses the grievance, appeal, and fair hearing process in its local consumer handbook and through materials distributed by the Ombuds.	• TMRSN should require ongoing reporting from provider agencies related to complaints and grievances. • TMRSN needs to ensure that notices are issued in Spanish when appropriate. • TMRSN needs to ensure that its grievance policy covers all required items.
Performance Improvement Projects (PIPs)	
Clinical	
• Relevant study topic; well-defined study question	• Further explain intervention; collect and analyze baseline and remeasurement data
Nonclinical	
• Well-defined study topic, question, study indicators, population and data collection/analysis, and improvement strategy	• Collect and analyze remeasurement data
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • First name, Last name • Date of birth, Gender • Social Security number	Less than 95% accurate for: • Procedure code, Provider type • Minutes of service, Service location • Ethnicity, Education
Completeness	
• Outpatient and inpatient encounter data, demographic data, and consumer period data were all complete.	
Clinical Record Review	
• In general, charts document well the enrollee's support system and participation in developing the treatment plan and goals.	• TMRSN needs to identify recommended services, justify those services, and ensure a matching diagnosis. • TMRSN needs to consider ways to improve care coordination. • TMRSN needs to review the measures each provider agency has in place to ensure coordination of care and timely reassessment of deferred, rule-out, or provisional diagnoses, and TMRSN needs to audit these practices routinely.

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RSN Profile
Timberlands Regional Support Network (TRSN)

Activity	Score	Activity	Score
Regulatory and Contractual Standards			
Enrollee Rights	**80%**	**Grievance Systems**	**90.8%**
Enrollee rights: General	100%	Grievance system: General	100%
Information requirements	80%	Requirements and filing	80%
Notification timing	80%	Language and format	60%
Notification content	80%	Content of notice of action	100%
Information on grievances	100%	Timing of notice of action	100%
Respect and dignity	80%	Resolution of grievances and appeals	80%
Treatment options	100%	Expedited resolution of appeals	100%
Advance directives	80%	Format and content of notices (fair hearing)	100%
Seclusion and restraint	40%	Expedited resolution of appeals	100%
Compliance with state and federal laws	80%	Information on providers	80%
		Record keeping and reporting	80%
		Continuation of benefits	100%
		Effectuation of reversed appeal resolutions	100%
Performance Improvement Projects (PIPs)			
Clinical		**Nonclinical**	
Improving Employment Services and Outcomes	Partially Met	Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization	Minimally Met

Information Systems Capabilities Assessment (ISCA) Follow-up to 2007 APS Healthcare ISCA

- TRSN has a policy in place for the data certification process, including error handling and tracking, and plans to develop a procedure to support the policy.
- On behalf of TRSN, Clark County RSN performs onsite accuracy and completeness checks. Results of the data checks are documented and available for review.
- TRSN has a policy in place for modalities and service codes. This policy refers to a manual that covers the use and modification of data crosswalk elements.
- TRSN plans to hire a full-time information services administrator, who will attend and participate in Quality Management Committee meetings.
- TRSN affirmed that there was no delayed reporting of encounter data to the state since the previous ISCA.
- TRSN can download eligibility files from the MHD website; however, the data are not always accurate until updated by the Community Services Division. TRSN believes that the implementation of Provider One will resolve this issue by enabling current verification of client eligibility.

TRSN, headquartered in Cathlamet, administers mental health services for Medicaid enrollees in Lewis, Pacific, and Wahkiakum counties. The RSN also contracts with MHD to provide crisis services to any resident not covered by Medicaid. During December 2007, TRSN provided outpatient services to 846 out of 17,656 (4.8%) Medicaid enrollees.

Data source: Timberlands RSN 2008 External Quality Review Report.

RSN Profile
Timberlands Regional Support Network (TRSN)

Activity	Score	Activity	Score
Encounter Data Accuracy and Completeness			
Accuracy—Percent of chart data matching electronic data			
Procedure code	82.1%	Date of birth	100.0%
Provider type	84.9%	Gender	94.9%
Minutes of service	92.4%	Ethnicity	97.9%
Service location	83.0%	Social Security number	97.9%
First name	100.0%	Education	96.9%
Last name	100.0%		
Completeness—Number of data elements 100% complete			
Outpatient encounter data	10 out of 10	Demographic data	4 out of 4
Inpatient encounter data	5 out of 5	Consumer periodic data	4 out of 4

Clinical Record Review

Standard	Key elements*	Found in chart
1-The enrollee records indicate that authorization or reauthorization of services reflect level of care guidelines of the RSN and appropriate clinical decision making.	Diagnosis and psychiatric symptoms are described	83.5%
	Diagnosis matches medical necessity/ access-to-care standards	100.0%
2-The enrollee, and those he/she identifies as family, when appropriate, are participating in the ongoing treatment planning and service provision.	Client's participation in developing treatment plan/goals is documented	99.0%
3-Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.	Clinical documentation provides evidence of coordination of care with PCP	44.2%
	Clinical documentation provides evidence of coordination of care with other agencies	54.6%
4-The treatment planning and progress notes are appropriate to the culture of the client and his/her family.	Assessed cultural issues are addressed	81.8%
5-The treatment plan diagnosis and the prescriber diagnosis are consistent. Rule-out diagnosis is resolved within a timely manner.	Plan of care diagnosis and prescriber diagnosis are consistent	83.5%
	Rule-out diagnosis is resolved within 180 days	0.0%

* Selected elements are representative of the standards reviewed. See individual report for complete list of elements reviewed.

A list of plan **strengths** and **opportunities for improvement** appears on the next page. ⇨

RSN Profile
Timberlands Regional Support Network (TRSN)

Strengths	Opportunities for improvement
Regulatory and Contractual Standards	
Enrollee Rights	

• TRSN network providers use a uniform format for clinical assessments, with an annual reassessment of each enrollee.
• TRSN has helped provider agencies to build staff expertise in specialty areas.
• TRSN encourages active involvement of consumers, family members and advocates in quality management activities.
	• TRSN needs to inform enrollees that they can request a comprehensive list of clinical staff at provider agencies, noting specialties, languages, and gender.
	• TRSN needs to monitor its provider agencies regarding
	  o privacy of reception and office areas
	  o medical and mental health advance directives
	• TRSN needs to develop policies and practices related to use of seclusion and restraint.
	• TRSN needs to ensure that its policy related to enrollee access to medical records addresses all required elements.

Grievance Systems	
• TRSN has an active system for handling enrollee complaints and ensuring that issues are addressed through quality improvement efforts.	• TRSN needs to ensure that it has a process to provide notices in the enrollee's native language. • TRSN needs to ensure that enrollees are informed about how to appeal authorization decisions and have an accurate toll-free number for filing appeals. • TRSN needs to ensure that its policy on handling of grievances and appeals addresses all required procedures, and maintain records of all communications related to grievances and appeals. • TRSN needs to ensure that its policies and procedures pertaining to notices for termination, suspension, or reduction of previously authorized services address provider agency decisions.
Performance Improvement Projects (PIPs)	
Clinical	
• Well-defined study question and indicator	• Need clearer definition of study population and data collection procedures
Nonclinical	
• Well-defined study indicator	• Further define study question and data collection procedures; develop an improvement strategy
Encounter Data Accuracy and Completeness	
Accuracy	
More than 95% accurate for: • First name, Last name • Date of birth • Ethnicity, Social Security number, Education	Less than 95% accurate for: • Procedure code, Provider type • Minutes of service, Service location • Gender
Completeness	
• Outpatient and inpatient encounter data, demographic data, and consumer period data were all complete.	
Clinical Record Review	
• The enrollee's support system and enrollee participation in developing treatment plan and goals are generally well documented in charts. • Prescriber diagnosis and plan-of-care diagnoses generally appear consistent.	• TRSN needs to routinely audit provider charts to determine whether the assessment, care plan, and progress notes support the diagnosis and services rendered to the enrollee. • TRSN needs to consider ways to improve care coordination. • TRSN needs to take steps to ensure that all identified issues (including enrollee's ethnicity, spirituality, and language) are addressed by clinicians in the treatment plan.

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Appendix B. MCO Profiles

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

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

NOTE: In 2007, HRSA did not require Asuris Northwest Health (ANH) to report HEDIS measures; in 2008, ANH reported only the well-child care visit measure, utilization measures, and frequency of selected procedures. TEAMonitor results for ANH's compliance with regulatory and contractual standards are combined with those of Regence BlueShield because the two plans share administrative functions and resources.

Asuris Northwest Health B-3
Columbia United Providers B-5
Community Health Plan B-7
Group Health Cooperative B-9
Kaiser Permanente Northwest B-11
Molina Healthcare of Washington B-13
Regence BlueShield B-15

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MCO Profile
Asuris Northwest Health (ANH)[a]

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	—		
Child WCC Visits	54%		
Adolescent WCC Visits	39%		
Timeliness of Care*			
Postpartum Care After 21–56 days	—		
Quality of Care*			
Childhood Immunizations (Combo 2)	—		
Childhood Immunizations (Combo 3)	—		
Diabetes Care (HbA1c test)	—		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	60%	Enrollee Rights	83%
Furnishing of Services (Timely Access)	50%	Enrollment and Disenrollment	100%
Program Integrity	100%	Grievance Systems	79%
Claims Payment	100%	Practice Guidelines	100%
Primary Care and Coordination	100%	Provider Selection (Credentialing)	67%
Enrollees with Special Healthcare Needs	25%	QAPI Program	100%
Coverage and Authorization of Services	75%	Subcontractual Relationships/Delegation	25%
Emergency and Post-stabilization Services	0%		
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Improve Asthma Medication Use	Met	Improve Customer Service (Getting Help)	Met
Well-Child Visits (Hispanic Disparity)	Met	Improve Pharmacy Response Time for Pre-authorization Denials	Partially Met
Improve Rate of Child Immunizations	Met		

[a]ANH reported HEDIS measures for the first time in 2008.
*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report. Scores include results for Regence BlueShield.

Asuris Northwest Health, an "unbranded" subsidiary of Regence BlueShield, was licensed in 2002. ANH provides coverage for Medicaid clients in Spokane County, serving less than 1 percent of Healthy Options enrollees. ANH insures approximately 50,000 lives, 3 percent of whom are Medicaid clients. Approximately 83 percent of Medicaid clients are 18 years and younger.

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

MCO Profile
Asuris Northwest Health (ANH)

Strengths	Opportunities for improvement
Access to Care*	
Timeliness of Care*	
Quality of Care*	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Program Integrity • Claims Payment • Primary Care and Coordination • Enrollment and Disenrollment • Practice Guidelines • QAPI Program Met 83% of Enrollee Rights elements and 79% of Grievance Systems elements.	Met less than 50% of elements for: 1. Enrollees with Special Healthcare Needs 2. Emergency and Post-stabilization Services 3. Subcontractual Relationships and Delegation
Performance Improvement Projects (PIPs)**	
Childhood immunization PIP fully met standards for the third straight year. Scores of the PIPs on asthma medications and WCC visits fully met standards for the second straight year.	The PIP addressing timeliness of prior authorization for pharmacy prescriptions showed no evidence of sustained improvement and reflected difficulties with evaluating the variables.
TEAMonitor cited as best practices: • focus on health disparities among the Hispanic population as part of the WCC PIP • excellent use of tables and graphs to display data in all PIPs and the use of novel measures, such as emergency room utilization, in the asthma PIP	

*Data source: 2008 Performance Measure Comparative Analysis Report.

**Data source: 2008 TEAMonitor report.

MCO Profile
Columbia United Providers (CUP)

Measure	Score		Measure	Score
Access to Care*				
Infant WCC Visits (6 visits)	42%	▼		
Child WCC Visits	52%	▼		
Adolescent WCC Visits	29%	▼		
Timeliness of Care*				
Postpartum Care After 21–56 days	60%			
Quality of Care*				
Childhood Immunizations (Combo 2)	62%	▼		
Childhood Immunizations (Combo 3)	58%	▼		
Diabetes Care (HbA1c test)	82%			
Regulatory and Contractual Standards—Percent Met**				
Availability of Services	100%		Enrollee Rights	92%
Furnishing of Services (Timely Access)	100%		Enrollment and Disenrollment	100%
Program Integrity	0%		Grievance Systems	74%
Claims Payment	50%		Practice Guidelines	100%
Primary Care and Coordination	100%		Provider Selection (Credentialing)	67%
Enrollees with Special Healthcare Needs	0%		QAPI Program	60%
Coverage and Authorization of Services	50%		Subcontractual Relationships/Delegation	50%
Emergency/Post-stabilization Services	0%			
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
Improving Childhood Immunization Rates	Partially Met		Decreasing Inappropriate ED Utilization	Partially Met
Improving Management of Asthma	Partially Met		Improving Member Understanding of Plan Benefits and Services	Partially Met
Improving Well-Child (EPSDT) Rates	Partially Met			

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

Columbia United Providers was established in 1994 and began providing coverage for Medicaid enrollees in 1995. CUP serves approximately 6 percent of Healthy Options enrollees, including those with S-CHIP and BH+ coverage, in Clark County. CUP insures 37,184 lives, 89 percent of whom are insured by Medicaid. About 83 percent of Medicaid clients are 18 years of age or younger.

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

MCO Profile
Columbia United Providers (CUP)

Strengths	Opportunities for improvement
Access to Care*	
	WCC visit rates for all age groups were significantly below the state average.
Timeliness of Care*	
	Postpartum care rates declined from 2007, though not significantly.
Quality of Care*	
Performed above the state average for diabetes care (HbA1c test, 82%), but not significantly above.	Combo 2 immunization rate (62%) and Combo 3 immunization rate (58%) were significantly below the state average.
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Furnishing of Services (Timely Access) • Primary Care and Coordination • Enrollment and Disenrollment • Practice Guidelines Met 92% of Enrollee Rights elements.	Met less than 50% of elements for: • Program Integrity • Enrollees with Special Healthcare Needs • Emergency and Post-stabilization Services
Performance Improvement Projects (PIPs)**	
Asthma PIP documented multiple interventions over time and featured a novel intervention. Outreach work with local school districts was cited as a best practice.	Childhood immunization PIP did not clearly measure the effect of the intervention and did not answer the study question.
Clinical PIPs were well documented and featured excellent use and display of data.	PIP targeting WCC visits did not collect data to correlate the intervention with a change in WCC rates.
Robust interventions to address emergency department utilization included educational programs for enrollees and providers and an incentive program directed toward clinics.	For nonclinical PIPs, TEAMonitor recommended establishing a better link between the projects and research literature.

*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

MCO Profile
Community Health Plan (CHP)

Measure	Score		Measure	Score
Access to Care*				
Infant WCC Visits (6 visits)	49%			
Child WCC Visits	64%			
Adolescent WCC Visits	35%			
Timeliness of Care*				
Postpartum Care After 21–56 days	60%			
Quality of Care*				
Childhood Immunizations (Combo 2)	76%	▲ 🡅		
Childhood Immunizations (Combo 3)	72%	🡅		
Diabetes Care (HbA1c test)	82%			
Regulatory and Contractual Standards—Percent Met**				
Availability of Services	80%		Enrollee Rights	92%
Furnishing of Services (Timely Access)	0%		Enrollment and Disenrollment	100%
Program Integrity	100%		Grievance Systems	89%
Claims Payment	50%		Practice Guidelines	100%
Primary Care and Coordination	0%		Provider Selection (Credentialing)	0%
Enrollees with Special Healthcare Needs	25%		QAPI Program	100%
Coverage and Authorization of Services	100%		Subcontractual Relationships/Delegation	0%
Emergency and Post-stabilization Services	100%			
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
Improve Asthma Outcomes	Partially Met		Improving Access to Care—A Lean Perspective	Partially Met
Improve Well-Child Exam Rates	Partially Met		Improving Access to Care—Simple Rules	Partially Met
Improve Childhood Immunization Rates	Partially Met			

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
🡅 🡇 MCO percentage for 2008 is significantly higher or lower than the 2007 percentage ($p<0.05$).
*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

Established in 1992, Community Health Plan is a network of community health centers and affiliate providers covering Medicaid enrollees in 33 counties across Washington. CHP is the state's second-largest Medicaid insurer, serving approximately 31 percent of Healthy Options enrollees, including those with S-CHIP and BH+ coverage. CHP insures more than 225,000 lives, 60 percent of whom are insured by Medicaid. About 85 percent of Medicaid clients are 18 years of age or younger.

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

MCO Profile
Community Health Plan (CHP)

<table>
<tr><th>Strengths</th><th>Opportunities for improvement</th></tr>
<tr><td>Access to Care*</td><td></td></tr>
<tr><td>WCC visit rates improved over 2007 for infants, children, and adolescents, though not significantly.</td><td>49% of infants had 6 or more WCC visits in 2008, below the state average, though not significantly.</td></tr>
<tr><td>Timeliness of Care*</td><td></td></tr>
<tr><td>Postpartum care rates improved over 2007, though not significantly.</td><td></td></tr>
<tr><td>Quality of Care*</td><td></td></tr>
<tr><td>Performed better than state average for Combo 2 (76%) and Combo 3 (72%) immunizations and for diabetes care (HbA1c test, 82%), significantly higher for Combo 2.</td><td></td></tr>
<tr><td>Regulatory and Contractual Standards**</td><td></td></tr>
<tr><td>Met 100% of elements for:
• Program Integrity
• Coverage and Authorization of Services
• Emergency and Post-stabilization Services
• Enrollment and Disenrollment
• Practice Guidelines
• QAPI Program
Met 80% of Availability of Services elements and 92% of Enrollee Rights s elements.</td><td>Met less than 50% of elements for:
• Furnishing of Services (Timely Access)
• Primary Care Coordination
• Enrollees With Special Healthcare Needs
• Provider Selection (Credentialing)
• Subcontractual Relationships and Delegation</td></tr>
<tr><td>Performance Improvement Projects (PIPs)**</td><td></td></tr>
<tr><td>TEAMonitor cited the following best practices:
• clinic-specific performance report for fully immunized 6-year olds sent to clinics monthly
• strong data displays across several PIPs, including use of Performance Evaluation Tool graphs to provide clinic-specific feedback</td><td>CHP initiated new interventions in 2007 for the clinical PIP on improving outcomes for members with asthma. Not enough time has elapsed to examine the impact of the interventions; thus, this PIP received a Partially Met score in 2008.
The two nonclinical PIPs were essentially identical except for the intervention and could have been condensed into one PIP.</td></tr>
</table>

*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

MCO Profile
Group Health Cooperative (GHC)

Measure	Score		Measure	Score
Access to Care*				
Infant WCC Visits (6 visits)	54%	↑		
Child WCC Visits	53%	▼ ↑		
Adolescent WCC Visits	36%			
Timeliness of Care*				
Postpartum Care After 21–56 days	64%			
Quality of Care*				
Childhood Immunizations (Combo 2)	72%			
Childhood Immunizations (Combo 3)	70%	↑		
Diabetes Care (HbA1c test)	91%	▲		
Regulatory and Contractual Standards—Percent Met**				
Availability of Services	40%		Enrollee Rights	75%
Furnishing of Services (Timely Access)	50%		Enrollment and Disenrollment	100%
Program Integrity	100%		Grievance Systems	79%
Claims Payment	50%		Practice Guidelines	67%
Primary Care and Coordination	100%		Provider Selection (Credentialing)	33%
Enrollees with Special Healthcare Needs	25%		QAPI Program	80%
Coverage and Authorization of Services	100%		Subcontractual Relationships/Delegation	75%
Emergency and Post-stabilization Services	0%			
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
Well-Child and Well-Adolescent Visit Rates	Met		Improving Member Utilization of Online Services	Partially Met
Child and Adolescent Immunization Rates	Met		Improving Physician Communication with Members	Met
Prenatal Care Rates	Met			

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
↑ ↓ MCO percentage for 2008 is significantly higher or lower than the 2007 percentage ($p<0.05$).
*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

Group Health Cooperative, a nonprofit health care system established in 1947, provides coverage for Medicaid clients in four counties in Washington, serving 4 percent of Healthy Options enrollees, including those with S-CHIP and BH+ coverage. More than 87 percent of GHC's clients receive care in GHC-owned medical facilities. GHC insures more than 580,000 lives, 3 percent of whom are insured by Medicaid. About 80 percent of Medicaid clients are 18 years of age or younger.

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

MCO Profile
Group Health Cooperative (GHC)

Strengths	Opportunities for improvement
Access to Care*	
WCC rates improved from 2007 for all age groups, significantly for infants and children.	
Timeliness of Care*	
Rate of timely postpartum care (64%) improved over 2007 and was above the state average, though not significantly.	
Quality of Care*	
Combo 2 immunization rate (72%) and Combo 3 immunization rate (70%) increased from 2007 to 2008, a significant increase for Combo 3. Both rates were above the state average, although not significantly above.	
Diabetes care (HbA1c testing) rate of 91% was the highest of all plans and was significantly above the state average.	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Program Integrity • Primary Care Coordination • Coverage and Authorization of Services • Enrollment and Disenrollment Met 80 % of QAPI Program elements.	Met less than 50% of elements for: • Availability of Services • Enrollees with Special Healthcare Needs • Emergency and Post-stabilization Services • Provider Selection (Credentialing)
Performance Improvement Projects (PIPs)**	
Fully met standards for all three clinical PIPs, including first-year PIP aimed at ensuring that members receive recommended prenatal care.	Improving Member Utilization of Online Services PIP fell to a “Partially Met” score in 2008 after earning a “Fully Met” score in 2007, as the measures designed to demonstrate active use of the website showed no improvement.
TEAMonitor cited consistently thorough PIP documentation, excellent description of methods and display of measurement data, including trend data.	Although GHC has made progress in improving well-child and well-adolescent visit rates, TEAMonitor cited the need for further improvement to meet the statewide averages.
TEAMonitor cited as a best practice the performance feedback intervention used in the Well-Child and Well-Adolescent Visit Rates PIP.	

*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

MCO Profile
Kaiser Permanente Northwest (KPNW)

Measure	Score		Measure	Score
Access to Care*				
Infant WCC Visits (6 visits)	—			
Child WCC Visits	50%			
Adolescent WCC Visits	34%			
Timeliness of Care*				
Postpartum Care After 21–56 days	82%	▲		
Quality of Care*				
Childhood Immunizations (Combo 2)	76%			
Childhood Immunizations (Combo 3)	70%			
Diabetes Care (HbA1c test)	—			
Regulatory and Contractual Standards—Percent Met**				
Availability of Services	100%		Enrollee Rights	83%
Furnishing of Services (Timely Access)	50%		Enrollment and Disenrollment	100%
Program Integrity	100%		Grievance Systems	90%
Claims Payment	50%		Practice Guidelines	100%
Primary Care and Coordination	100%		Provider Selection (Credentialing)	67%
Enrollees with Special Healthcare Needs	25%		QAPI Program	40%
Coverage and Authorization of Services	100%		Subcontractual Relationships/Delegation	25%
Emergency and Post-stabilization Services	100%			
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
According to TEAMonitor, no documents were reviewed because the PIPs were not submitted according to TeaMonitor preassessment instructions in a timely fashion. PIPs submitted late will be reviewed as part of corrective action.				

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
— Sample size was less than the minimum required during the reporting year.
*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

Kaiser Permanente Northwest, a subsidiary of Kaiser Foundation Health Plan, Inc., was established in 1945 and began providing coverage for Medicaid enrollees in two counties in southwestern Washington in 1993. KPNW insures about 488,500 lives, less than 1 percent of whom are insured by Washington Medicaid. About 94 percent of Medicaid clients are 18 years of age or younger. KPNW's commercial product line has been accredited by NCQA since May 1995.

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

MCO Profile
Kaiser Permanente Northwest (KPNW)

Strengths	Opportunities for improvement
Access to Care*	
Rate of WCC visits for children (50%) improved over the 2007 rates, although not significantly.	Rate of WCC visits for adolescents (34%) was below the state average.
Timeliness of Care*	
Rate of timely postpartum care (82%) was significantly above the state average and was the highest among all plans.	
Quality of Care*	
Combo 2 immunization rate (76%) and Combo 3 immunization rate (70%) were above the state average, though not significantly.	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Program Integrity • Primary Care and Coordination • Coverage and Authorization of Services • Emergency and Post-stabilization Services • Enrollment and Disenrollment • Practice Guidelines Met 83% of Enrollee Rights elements.	Met less than 50% of elements for: • Enrollees With Special Healthcare Needs • QAPI Program
Performance Improvement Projects (PIPs)**	
	KPNW failed to submit PIPs according to preassessment instructions in a timely fashion; therefore, TEAMonitor reviewed no PIP documents.

*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

MCO Profile
Molina Healthcare of Washington (MHW)

Measure	Score		Measure	Score
Access to Care*				
Infant WCC Visits (6 visits)	62%	▲		
Child WCC Visits	68%	▲		
Adolescent WCC Visits	41%			
Timeliness of Care*				
Postpartum Care After 21–56 days	61%			
Quality of Care*				
Childhood Immunizations (Combo 2)	72%	🡡		
Childhood Immunizations (Combo 3)	68%	🡡		
Diabetes Care (HbA1c test)	79%			
Regulatory and Contractual Standards—Percent Met**				
Availability of Services	100%		Enrollee Rights	75%
Furnishing of Services (Timely Access)	100%		Enrollment and Disenrollment	100%
Program Integrity	100%		Grievance Systems	90%
Claims Payment	0%		Practice Guidelines	100%
Primary Care and Coordination	100%		Provider Selection (Credentialing)	100%
Enrollees with Special Healthcare Needs	75%		QAPI Program	80%
Coverage and Authorization of Services	75%		Subcontractual Relationships/Delegation	100%
Emergency and Post-stabilization Services	0%			
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
Improving Childhood Immunization Rates	Met		Improving Member Knowledge of Benefits Dates	Partially Met
Improving HEDIS Well-Child Rates	Met		Pre-Service Authorization Dates	Partially Met
Adolescent Immunization Status	Met			

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
🡡 🡣 MCO percentage for 2008 is significantly higher or lower than the 2007 percentage ($p<0.05$).
*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

Molina Healthcare of Washington provides coverage for Medicaid enrollees in 32 counties across Washington. MHW is the state's largest Medicaid insurer, serving approximately 51 percent of Healthy Options enrollees, including those covered by S-CHIP and BH+. MHW insures approximately 294,400 lives, 91 percent of whom are insured by Medicaid. About 70 percent of Medicaid clients are 18 years of age or younger. MHW currently holds an Excellent Accreditation rating from NCQA for its Medicaid product lines.

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

MCO Profile
Molina Healthcare of Washington (MHW)

Strengths	Opportunities for improvement
Access to Care*	
WCC visit rates were above the state average for all age groups, significantly above for infants and children. MHW had the highest WCC rates of all health plans for all age groups.	
Timeliness of Care*	
MHW rotated the postpartum care visit measure in 2008, thus reporting the same score as measured in 2007.	
Quality of Care*	
Combo 2 immunization rate (72%) and Combo 3 immunization rate (68%) were significantly higher than the 2007 rates.	
Diabetes Care (HbA1c test, 79%) was higher than in 2007, although not significantly higher.	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Furnishing of Services (Timely Access) • Program Integrity • Primary Care and Coordination • Enrollment and Disenrollment • Practice Guidelines • Provider Selection (Credentialing) • Subcontractual Relationships and Delegation Met 90% of Grievance Systems elements and 80% of QAPI Program elements.	Met less than 50% of elements for: • Claims Payment • Emergency and Post-stabilization Services
Performance Improvement Projects (PIPs)**	
All three clinical PIPs fully met standards. The childhood immunization PIP fully met standards for the third straight year.	For the childhood immunization and well-child PIPs, TEAMonitor recommended new interventions and providing performance feedback to providers.
TEAMonitor cited MHW's PIP documentation as a best practice, with clear and concise writing; data tables and charts describing performance, barriers, and interventions over time; and excellent use of statistical analyses to document outcomes.	For the nonclinical PIPs, TEAMonitor found that MHW needed to strengthen its documentation of the study rationale and study questions.

*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

MCO Profile
Regence BlueShield (RBS)

Measure	Score		Measure	Score
Access to Care*				
Infant WCC Visits (6 visits)	58%			
Child WCC Visits	61%	↓		
Adolescent WCC Visits	40%	↓		
Timeliness of Care*				
Postpartum Care After 21–56 days	66%			
Quality of Care*				
Childhood Immunizations (Combo 2)	68%			
Childhood Immunizations (Combo 3)	66%			
Diabetes Care (HbA1c test)	76%			
Regulatory and Contractual Standards—Percent Met**				
Availability of Services	60%		Enrollee Rights	83%
Furnishing of Services (Timely Access)	50%		Enrollment and Disenrollment	100%
Program Integrity	100%		Grievance Systems	79%
Claims Payment	100%		Practice Guidelines	100%
Primary Care and Coordination	100%		Provider Selection (Credentialing)	67%
Enrollees with Special Healthcare Needs	25%		QAPI Program	100%
Coverage and Authorization of Services	75%		Subcontractual Relationships/Delegation	25%
Emergency and Post-stabilization Services	0%			
Performance Improvement Projects (PIPs)**				
Clinical			**Nonclinical**	
Improve Asthma Medication Use	Met		Improve Customer Service (Getting Help)	Met
Well-Child Visits (Hispanic Disparity)	Met		Improve Pharmacy Response Time for Pre-authorization Denials	Partially Met
Improve Rate of Child Immunizations	Met			

↑ ↓ MCO percentage for 2008 is significantly higher or lower than the 2007 percentage ($p<0.05$).
*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report. Scores include results for Asuris Northwest Health.

Regence BlueShield, incorporated in 1997, provides coverage for Medicaid clients in nine counties in central and western Washington. RBS serves approximately 7 percent of Healthy Options enrollees, including those covered by S-CHIP. RBS insures approximately 1,017,000 lives, 3 percent of whom are insured by Medicaid. Approximately 83 percent of Medicaid clients are 18 years of age or younger.

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

MCO Profile
Regence BlueShield (RBS)

Strengths	Opportunities for improvement
Access to Care*	
WCC visits exceeded the state average for all age groups, though not significantly.	WCC visits for all age groups fell from the 2007 rates, significantly below the 2007 rates for children and adolescents.
Timeliness of Care*	
Rate of timely postpartum care (66%) increased from 2007 and exceeded the state average, though not significantly.	
Quality of Care*	
Combo 3 immunization rate (66%) was above the 2007 rate, though not significantly.	
Diabetes Care (HbA1c test, 76%) improved from the 2007 rate, though not significantly.	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Program Integrity • Claims Payment • Primary Care and Coordination • Enrollment and Disenrollment • Practice Guidelines • QAPI Program Met 83% of Enrollee Rights elements and 79% of Grievance Systems elements.	Met less than 50% of elements for: 4. Enrollees with Special Healthcare Needs 5. Emergency and Post-stabilization Services 6. Subcontractual Relationships and Delegation
Performance Improvement Projects (PIPs)**	
Childhood immunization PIP fully met standards for the third straight year. PIPs on asthma medications and WCC visits fully met standards for the second straight year.	The PIP addressing timeliness of prior authorization for pharmacy prescriptions showed no evidence of sustained improvement and reflected difficulties with evaluating the variables.
TEAMonitor cited as best practices: • focus on health disparities among the Hispanic population as part of the WCC visits PIP • excellent use of tables and graphs to display data in all PIPs and the use of novel measures, such as emergency room utilization, in the asthma PIP	

*Data source: 2008 Performance Measure Comparative Analysis Report.
**Data source: 2008 TEAMonitor report.

Appendix C: Elements of Regulatory and Contractual Standards

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

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

Note: In 2008, as determined by MHD, Acumentra Health's review of RSN compliance covered only the regulatory elements related to Enrollee Rights and Grievance Systems. The 2009 and 2010 compliance reviews will address additional managed care regulations.

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

Contract provisions	Healthy Options or *MHD* contract section(s)
Access to care	
The MCO/RSN must provide enough information to enable enrollees to make informed decisions about enrollment and to understand benefit coverage and how to obtain care. For physical health care, written information must discuss how to choose and change PCPs, identifying available PCPs by location, languages spoken, qualifications, and practice restrictions, and how to obtain emergency services, hospital care, and services outside the service area. The MCO must provide information on available specialists, informed consent guidelines, advance directives, grievance procedures, covered benefits, well-child care, translation and interpretation services, and how to obtain a second opinion. For mental health care, RSNs must use the MHD-published benefits booklet to notify enrollees of their benefits, rights, and responsibilities.	5.2.1; *5.1*
The MCO/RSN must ensure ***equal access*** for enrollees and potential enrollees with communication barriers. For oral communication, the MCO/RSN must provide free interpreter services for those with a primary language other than English. The MCO/RSN must ensure that written materials are available in a form that can be understood by each enrollee and potential enrollee, and must translate generally available written materials into prevalent non-English languages.	5.3; *5.1.1.4–5.1.1.5*
The MCO/RSN must maintain and monitor a ***provider network*** sufficient to serve enrollee needs, including out-of-network services as medically necessary. The MCO/RSN must consider factors such as the expected service utilization by the Medicaid population, the number and types of providers required, the geographic locations of providers and enrollees, and enrollees' cultural, ethnic, racial, and language needs.	7.2–7.3; *7.1*
The MCO/RSN's provider network must meet ***distance standards*** in each service area. For physical health care, two PCPs must be available within 10 miles for 90 percent of enrollees in an urban service area, and one PCP must be available within 10 miles in a rural service area. Similar standards exist for obstetrics, pediatric or family practice, and hospital and pharmacy services. For mental health care, service sites must be available within a 30-minute drive in rural areas, within a 90-minute drive in large rural geographic areas, and within a 90-minute public transportation trip in urban areas.	7.9; *7.2.5*
Each MCO must provide all medically necessary ***specialty care*** for enrollees in its service area, whether within or outside the provider network. The MCO must help providers obtain timely referrals to specialty care.	7.12
Timeliness of care	
The MCO/RSN must meet state standards for ***timely access***. For physical health care, designated services must be available 24 hours a day, seven days a week by telephone. Preventive care office visits must be available from the enrollee's PCP or another provider within 30 calendar days; routine care visits, within 10 calendar days; urgent, symptomatic visits within 48 hours; and emergency care, 24 hours a day, seven days a week. For mental health care, the RSN must offer a routine intake evaluation appointment within 10 business days of an enrollee's request. Emergent mental health care must occur within 2 hours of a request, and urgent care must occur within 24 hours of a request. The time period from request to first routine services appointment may not exceed 28 calendar days.	7.4–7.7; *7.2–7.2.1*

Contract provisions	Healthy Options or *MHD* contract section(s)
Quality of care	
"Quality" means "the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 CFR 438.320)."	3.45
MCOs must cover ***medically necessary services*** related to preventing, diagnosing, and treating health impairments, achieving age-appropriate growth and development, and attaining, maintaining, or regaining functional ability. RSNs must provide a list of 21 specific services when they are medically necessary. The MCO/RSN must provide covered services in the amount, duration, and scope required by DSHS.	14.1; *14.3*
The MCO/RSN must adopt ***practice guidelines***, disseminate them to providers, and use them in decision making for utilization management, enrollee education, service coverage, and other areas. The guidelines must be evidence-based, consider enrollee needs, be adopted in consultation with contracting professionals, and be reviewed and updated regularly.	8.7; *8.10*
The MCO/RSN must guarantee ***enrollee rights***, including the right to be treated with respect and with consideration for dignity and privacy; to be informed of available treatment options and alternatives; to participate in decisions regarding their health care; to be free from unnecessary restraint or seclusion; and to request and receive copies of their medical records and ask that they be amended. RSN enrollees must have individual service plans, developed with the participation of enrollees and their families. Each RSN must provide an independent mental health ombuds to inform enrollees of their rights and help them resolve complaints and grievances.	11.1; *10.1–10.5*
The MCO/RSN must maintain written policies and procedures for ***advance directives*** that meet state and federal requirements and must provide for staff and community education concerning these policies.	11.3; *10.6*
For physical health care, the MCO must ensure that each enrollee has an ***appropriate source of primary care*** and must allow each new enrollee to choose a PCP, to the extent possible and appropriate. For mental health care, the RSN must offer each enrollee a choice of providers.	11.4; *10.7*
Each MCO must allow ***children with special health care needs*** (SHCN) who use a specialist frequently to retain the specialist as a PCP or to be allowed direct access to specialists for needed care.	11.5
The MCO/RSN must have and maintain a ***utilization management program*** that includes mechanisms for detecting both underutilization and overutilization of services furnished to enrollees.	12.1; *11.1*
The MCO/RSN must meet state and federal requirements for ***service authorization***, including timely notification of providers and enrollees in the event that the contractor denies an authorization request. The notice must explain the reasons for denial and the procedures for filing an appeal or requesting expedited resolution.	12.2; *7.2.2*
MCO/RSN ***grievance systems*** must meet standards regarding procedures and time frames for grievances, appeals, and access to the hearing process.	13; *13*
Each MCO must provide female enrollees with ***direct access to a women's health specialist*** within the provider network as needed to provide routine and preventive care. The MCO must ensure that hospital delivery maternity care is provided in accordance with state law.	14.4–14.5

Contract provisions	Healthy Options or *MHD* contract section(s)
For physical health care, each MCO must ensure ***continuity of care*** for enrollees in an active course of treatment for a chronic or acute medical condition and must prevent the interruption of medically necessary care. For mental health care, the RSN's resource management plan must incorporate coordination and authorization of inpatient and outpatient services and regular review of the enrollee's individual service plan.	14.6; *11.2*
Each MCO must ensure ***coordination of care*** for enrollees through their PCPs, including initiating and coordinating referrals for specialty care. The MCO must identify enrollees with SHCN and ensure that they receive individualized treatment plans that ensure integration of clinical and nonclinical disciplines and services. Each RSN must help to coordinate mental health care for enrollees admitted for psychiatric inpatient services; provide follow-up care for enrollees treated in an emergency room; facilitate communication between physical and mental health providers about Early Periodic Screening, Diagnosis, and Treatment for enrollees under age 21; and have a plan for coordinating services with chemical dependency and substance abuse, criminal justice, and other allied systems.	14.7; *14.5–14.8*
Each MCO must maintain a ***quality assessment and performance improvement*** program that meets federal regulatory requirements. The program must include a Quality Improvement Committee that oversees quality functions. an annual work plan, and an annual program evaluation. Each RSN's quality management program must include an annual review of community mental health agencies within the network.	8.1; *8.1–8.9*
The MCO/RSN must conduct ***performance improvement projects*** (PIPs) designed to achieve significant sustained improvement in areas expected to have a favorable effect on health outcomes and enrollee satisfaction. Each MCO/RSN must conduct and submit to DSHS at least one clinical and one nonclinical PIP. If any of the MCO's HEDIS rates for well-child care fall below 60 percent in 2008 or 2009, the MCO must implement a clinical PIP designed to increase the rates. If the MCO's HEDIS rates for Combo 2 childhood immunizations fall below 70 percent in 2008 or below 75 percent in 2009, the MCO must implement a clinical PIP. The MCO may be required to conduct a CAHPS-related nonclinical PIP and to participate in a yearly statewide PIP. The RSN's PIPs may address topics identified by MHD for statewide improvement or identified by the RSN for local improvement.	8.2; *8.5*
For physical health care, each MCO must report ***HEDIS measures*** according to NCQA specifications. The contract specifies measures to be submitted each year. For mental health care, each RSN must show improvement on a set of performance measures specified and calculated by MHD. If the RSN does not meet MHD-defined improvement targets on any measure, the RSN must submit a performance improvement plan.	8.3; *8.7*

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

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

CFR section	Description
438.100 Enrollee Rights ***(a) General rule*** 438.100(a) General rule 438.10(b) Basic rule 438.10(c)(3) Language – non-English 438.10(c)(4) and (5) Language – oral interpretation 438.10(d)(1)(i) Format, easily understood 438.10(d)(1)(ii) and (2) Format, alternative formats 438.10(f) General information 438.10(g) Specific information 438.10(h) Basic rule 438.100(b)(2)(iii) Specific rights 438.100(b)(2)(iv) and (v) Specific rights 438.100(b)(3) Specific rights 438.100(d) Compliance with other federal/state laws	Federal regulations include comprehensive language governing enrollee rights; Healthy Options contract requirements address advance directives, enrollee choice of primary care provider, access to specialty care for enrollees with special healthcare needs, prohibition on charging enrollees for covered services, and affirmation of provider/enrollee right to communicate freely regarding needs and services.
438.226 Enrollment and Disenrollment 438.226 and 438.56(b)(1) - (3) Disenrollment requested by the MCO, PIHP 438.56(c) Disenrollment requested by the enrollee 438.56(d) Procedures for disenrollment 438.56(d)(5) MCO grievance procedures 438.56(e) Timeframe for disenrollment determinations	Establish policies, procedures, and mechanisms to ensure appropriate process for disenrollment.
438.228 Grievance Systems 438.228 Grievance systems 438.402(a) The grievance system 438.402(b)(1) Filing requirements - Authority to file 438.402(b)(2) Filing requirements - Timing 438.402(b)(3) Filing requirements - Procedures 438.404(a) Notice of action - Language and format 438.404(b) Notice of action - Content of notice 438.404(c) Notice of action - Timing of notice 438.406(a) Handling of grievances and appeals - General requirements 438.406(b) Handling of grievances and appeals - Special requirements for appeals 438.408(a) Resolution and notification: Grievances and appeals - Basic rule 438.408(b) and (c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes 438.408 (d) and (e) Resolution and notification: Grievances and appeals- Format of notice and Content of notice of appeal resolution 438.408(f) Resolution and notification: Grievances and appeals-Requirements for State fair hearings 438.410 Expedited resolution of appeals 438.414 Information about the grievance system to providers and subcontractors 438.416 Recordkeeping and reporting requirements 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending 438.424 Effectuation of reversed appeal resolutions	Meet requirements regarding a defined grievance and appeal process for enrollees, including access to the state Fair Hearing system; policies, procedures, and standard notices to enrollees; acknowledgement of grievances and investigation and resolution of all relevant issues.

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

Appendix D. PIP Review Procedures

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

TeaMonitor PIP Review Steps

ACTIVITY 1: Assess the Study Methodology
Step 1. Review the Selected Study Topic(s)
1.1. Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?
1.2. Did the PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?
1.3. Did the PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees such as those with special healthcare needs?
Step 2: Review the Study Question(s)
2.1. Was/were the study question(s) stated clearly in writing?
Step 3: Review Selected Study Indicator(s)
3.1. Did the study use objective, clearly defined, measurable indicators?
3.2. Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?
Step 4: Review the Identified Study Population
4.1. Did the plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?
4.2. If the plan studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?
Step 5: Review Sampling Methods
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?
5.2. Did the sample contain a sufficient number of enrollees?
5.3. Did the plan employ valid sampling techniques that protected against bias?
Step 6: Review Data Collection Procedures
6.1. Did the study design clearly specify the data to be collected?
6.2. Did the study design clearly specify the sources of data?
6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?
6.4. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?
6.5. Did the study design prospectively specify a data analysis plan?
6.6. Were qualified staff and personnel used to collect the data?
Step 7: Assess Improvement Strategies
7.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?

Step 8: Review Data Analysis and Interpretation of Study Results

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

8.2. Did the plan present numerical PIP results and findings accurately and clearly?

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

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

Step 9: Assess Whether Improvement Is "Real" Improvement

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

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

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

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

Step 10: Assess Sustained Improvement

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

ACTIVITY 2. Verify Study Findings (Optional)

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

ACTIVITY 3. Evaluate Overall Validity and Reliability of Study Results

Check one:

☐ High confidence in reported PIP results

☐ Confidence in reported PIP results

☐ Low confidence in reported PIP results

☐ Reported PIP results not credible

☐ Enough time has not elapsed to assess meaningful change

PIP scoring

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

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

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

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

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

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

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

Acumentra Health PIP Review Steps

Acumentra Health's PIP validation procedure consists of the following activities:

Part 1: Assessing the methodology for conducting the PIPs
Part 2: Evaluating the validity and reliability of PIP results

Part 1: Assessing the methodology for conducting PIPs

Assessing the PIP methodology consists of the following 10 steps.

Step 1: Review the study topic
Step 2: Review the study question
Step 3: Review the selected study indicator(s)
Step 4: Review the identified study population and sampling methods
Step 5: Review the data collection procedures
Step 6: Assess the improvement strategy
Step 7: Review the data analysis and interpretation of study results
Step 8: Assess the likelihood that reported improvement is "real" improvement
Step 9: Assess whether the RSN has documented additional interventions or modifications
Step 10: Assess whether the RSN has sustained the documented improvement

Each step addresses the extent to which the PIP complies with a particular standard in the CMS protocol. The specific criteria for assessing compliance with each standard are listed on the following pages.

Step 1. Review the study topic

Criterion 1.1. The topic was based on relevant information.

The topic must reflect the demographics, prevalence of diagnoses, potential risks, or service needs of the RSN's Medicaid population. Examples of relevant information from which the topic may be selected include

- utilization patterns that reflect deficiencies in service
- enrollee or provider input
- data from surveys or from grievance or appeals processes that indicate underlying issues in care or services
- data comparing the RSN's performance in standardized measures with the performance of comparable organizations

Criterion 1.2. The topic was determined through a systematic selection and prioritization process.

The topic must aim to improve care and services for a large portion of the RSN's Medicaid population. Examples of evidence for a systematic selection and prioritization process include

- descriptions of data that support the topic selection
- documentation of opportunities for soliciting enrollee or provider input

Example—clinical: Developing an algorithm to standardize prescribing patterns for specific diagnoses

Example—nonclinical: Assessing and improving the accessibility of specific services; reducing disparities in services provided to minority enrollees as compared with non-minority enrollees; designing processes to improve care coordination

Step 2: Review the study question

Criterion 2.1. The RSN has clearly defined the question the study is designed to answer. The question

- is stated so as to create a framework for data collection, analysis, and interpretation
- can be answered quantitatively or qualitatively by the PIP study

Step 3: Review the selected study indicator(s)

Each project should use at least one quality indicator for tracking performance and improvement.

Criterion 3.1. The indicator is an objective, measurable, clearly defined, unambiguous statement of an aspect of quality to be measured. The indicator statement clearly identifies

- who—the eligible population
- what—the care or service being evaluated
- when—the specific care or service time frame

The indicator description includes

- *definition of the denominator:* the eligible population, identifying inclusions and exclusions (criteria used to determine the eligible population, such as age, gender, and diagnosis and enrollment status)
- *definition of the numerator:* the outcome achieved or service rendered to the eligible population
- dates of service, procedure codes for administrative data, or acceptable medical record data
- the basis for adopting the indicators (e.g., that they are generally used in the industry—these are preferred; or if the RSN developed its own indicators either at the outset of the study or as a means of narrowing the focus for the study, a description of how the indicator was developed)

Criterion 3.2. The indicator can measure enrollee outcomes, enrollee satisfaction, or processes of care strongly associated with improved enrollee outcomes.

- Indicators for clinical care should include at least some measure of change in mental health status or functional status or process-of-care proxies for these outcomes.
- Process measures may be used as proxies for outcomes only if validity has been established in the literature or by expert consensus.

Step 4: Review the identified study population and sampling methods

Criterion 4.1. The study population is clearly defined and includes all RSN enrollees who are eligible for the study. The study population

- represents the RSN's entire Medicaid population that fits the eligibility criteria described by the indicators
- is defined in terms of enrollment time frames

If the study population is an "at risk" subpopulation,

- the RSN has clearly defined the risk and the subpopulation
- the RSN has provided a rationale for selecting the subpopulation

The RSN may use a sample for the study. *If a sample is used,* the RSN must

- provide the rationale for using a sample
- explain the sampling methodology that produced a representative sample of sufficient size (see below)

Criterion 4.2. When the study includes the RSN's entire eligible population, the data collection approach captures all eligible enrollees.

Criterion 4.3. If a sample is used, the RSN has described the method for determining the sample size.

If a clinical or service condition is being studied for first time, the true prevalence or incidence is not likely to be known. Large samples would be needed to establish a valid baseline. The sampling methodology should include the

- rationale for the size of the sample based on the RSN's eligible population
- frequency of the occurrence being studied
- confidence interval and acceptable margin of error

Criterion 4.4. The sampling methodology is valid and protects against bias.

The description establishing validity and bias protection should include

- a description of the sampling type (e.g., probability or nonprobability; stratified random or convenience)
- the rationale for selecting the sampling type

Criterion 4.5. The sample is large enough to allow calculation of statistically meaningful measures.

Step 5: Review the data collection procedures

The data collection process must ensure that the data collected on the indicator(s) are valid and reliable. Validity indicates the accuracy of the data. Reliability indicates the repeatability or reproducibility of a measurement.

Criterion 5.1. The study design clearly specifies the data to be collected.

- Data elements are defined unambiguously.
- Descriptive terms (e.g., "high," "medium," "low") are defined numerically.

Criterion 5.2. The data sources are clearly identified.

- Examples of data sources include medical records, encounter and claim systems, or surveys.
- Time frames for collecting baseline and remeasurement data are specified.

Criterion 5.3. The study design describes a systematic method of collecting valid and reliable data on all enrollees to whom the indicator(s) apply.

- *For administrative data* (claims or encounter data), the data are complete and include all data submitted by providers. If data collection is automated, the RSN has provided the data specifications and algorithms used.
- *For medical record abstraction* or review of other primary sources, the RSN has documented the steps taken to ensure that the data were consistently extracted and recorded.

Criterion 5.4. *For manual data collection*, the data collection instrument produces consistent, accurate data that are appropriate for the study indicator(s) and that can be used over the study time period.

- The data abstraction process is documented, including a data collection instrument with clear guidelines and definitions.
- Reviewer training is documented, including guidelines, definitions, instructions on how to use the instrument, and instructions on how to handle situations not covered in the documentation.
- Methods of ensuring inter-rater reliability are provided.

Criterion 5.5. The study design includes a prospective data analysis plan that specifies

- whether qualitative or quantitative data or both are to be collected
- whether data are to be collected on the entire population or a sample
- whether measures are to be compared to previous results or similar studies; if comparing measures between two or more studies, the appropriate statistical test must be identified
- whether the PIP is to compare to the performance of different sites or clinics; if comparing performance of two or more entities, the statistical design and analysis must reflect the comparisons

Criterion 5.6. *For manual data collection*, the study design includes the rationale and staff qualifications for the data abstraction. The documentation

- indicates that staff received training on the use of the data collection instrument
- indicates the inter-rater reliability of the data collection instrument

Step 6: Assess the improvement strategy

An improvement strategy is defined as an intervention or set of interventions designed to change behavior at an institutional, practitioner, or enrollee level. The effectiveness of the interventions is determined by measuring a change in performance based on the quality indicator(s).

Criterion 6.1. The RSN has reported on at least one intervention undertaken to address causes or barriers identified through the quality improvement process. The interventions were

- systemic—i.e., designed to affect a wide range of participants through long-term system change
- timed to effect change after the baseline measurement and prior to remeasurement
- effective in improving the indicator for the population(s) studied
- reasonably expected to result in measured improvement
- free of major confounding variables that were likely to affect outcomes

Step 7: Review the data analysis and interpretation of study results

The RSN calculated its performance in the indicators by adhering to appropriate statistical analysis techniques as defined in a data analysis plan.

Criterion 7.1. The analysis of the findings adheres to a data analysis plan that used an appropriate statistical methodology.

Criterion 7.2. The study results, including numerical results and findings, are presented in a manner that provides accurate, clear, and easily understood information.

Criterion 7.3. The analysis identifies

- baseline and remeasurement data
- the statistical significance of any differences between these data sets
- any factors that influenced comparability
- any factors that threatened the validity of the findings

Criterion 7.4. The analysis is based on continuous quality improvement and focused on delivery system processes.

- The interpretation of the success of the PIPs included lessons learned and identified barriers to success or presented a hypothesis about less-than-optimal performance.
- Follow-up activities addressed the barriers identified.

Step 8: Assess the likelihood that reported improvement is "real" improvement

The reported improvement represents "real" change and is not due to a short-term event unrelated to the intervention or to chance.

Criterion 8.1. The RSN has used the same methodology for measuring the baseline as for conducting remeasurement, or the RSN has described and justified a change in measurement methodology.

Criterion 8.2. The analysis discussion includes documentation of

- quantitative improvement in processes related to the study question
- improvements in associated outcomes of care

Criterion 8.3. The analysis discussion describes clearly how the interventions relate to the improvement in performance.

Criterion 8.4. The analysis includes an appropriate calculation of statistical significance, with a discussion of the test used to calculate significance. (There is no required level of significance.)

Step 9: Assess whether the RSN has documented ongoing or additional interventions or modifications

The RSN has documented sustained improvement by remeasuring performance on the initial study indicator(s) at regular intervals. (*Note:* Interventions may be modified between remeasurement periods to address barriers or to take advantage of study findings.)

Criterion 9.1. The RSN has documented ongoing or additional interventions or modifications that are based on earlier data analyses.

Step 10: Assess whether the RSN has sustained the documented improvement

Criterion 10.1. Sustained improvement is demonstrated by additional remeasurements conducted over comparable time periods.

PIP scoring

Each compliance standard has a potential score of 100 points for full compliance, with lower scores for lower levels of compliance. The scores for each standard are weighted and combined to determine the overall PIP score, as shown in Table D-1.

Table D-1. Weighting of standard scores in overall PIP score.

Standard	Criterion number(s)	Scoring weight
Demonstrable Improvement		
1 Selected study topic is relevant and prioritized	1.1, 1.2	5%
2 Study question is clearly defined	2.1	5%
3 Study indicator is objective and measurable	3.1, 3.2	15%
4 Study population is clearly defined and, if sample is used, appropriate methodology is used	4.1, 4.2, 4.3, 4.4, 4.5	10%
5 Data collection process ensures that data are valid and reliable	5.1, 5.2, 5.3, 5.4, 5.5, 5.6	10%
6 Improvement strategy is designed to change performance based on the quality indicator	6.1	15%
7 Data are analyzed and results interpreted according to generally accepted methods	7.1, 7.2, 7.3, 7.4	10%
8 Reported improvement represents “real” change	8.1, 8.2, 8.3, 8.4	10%
	Demonstrable Improvement score	**80%**
Sustained Improvement		
9 RSN has documented additional or ongoing interventions or modifications	9.1	5%
10 RSN has sustained the documented improvement	10.1	15%
	Sustained Improvement score	**20%**
	Overall PIP score	**100%**

The overall score is weighted 80 percent for demonstrable improvement in the first year (Standards 1–8) and 20 percent for sustained improvement in later years (Standards 9–10). Thus, for a PIP that has completed one remeasurement, the maximum score is 80 points (80 percent x 100 points for full compliance). If the PIP has progressed to a second remeasurement, enabling reviewers to assess sustained improvement, the maximum score is 100 points. Table D-2 shows a scoring calculation for a PIP with both demonstrable and sustained improvement.

Table D-2. Example scoring worksheet.

Standard	Compliance rating	Assigned points	Weight	Points score
Demonstrable Improvement				
1	Fully met	100	5%	5.00
2	Fully met	100	5%	5.00
3	Partially met	50	15%	7.50
4	Partially met	50	10%	5.00
5	Fully met	100	10%	10.00
6	Minimally met	25	15%	3.75
7	Partially met	50	10%	5.00
8	Partially met	50	10%	5.00
		Demonstrable Improvement Score		**46.25**
Sustained Improvement				
9	Substantially met	75	5%	3.75
10	Partially met	50	15%	7.50
		Sustained Improvement Score		**11.25**
		Overall PIP Score		**57.50**

Part 2: Evaluating the validity and reliability of PIP results

This part of the PIP review aims to establish an overall level of confidence in the validity and reliability of the PIP findings. Levels of confidence are assigned one of the ratings shown below.

High confidence in reported RSN PIP results
Confidence in reported RSN PIP results
Low confidence in reported RSN PIP results
Reported RSN PIP **results not credible**.

This portion of the assessment evaluates whether the PIP used an appropriate study design to address the project's objectives and questions of interest. Since PIPs are observational studies, the influence of bias and confounding factors on the project results must be evaluated. Bias occurs when some systematic error is introduced during study design. Reviewers evaluate the presence of selection and observation biases to assess the accuracy of reported results, as well as the presence of any confounding factors.

The review also assesses *external validity*—the extent to which the study results can be generalized or applied to other populations—and *internal validity*—whether the study measured what it was intended to measure.