# 2009 External Quality Review Annual Report

**Washington State Healthy Options**

**State Children's Health Insurance Program**

**Mental Health Division Program**

**Washington Medicaid Integration Partnership**

**December 2009**

**Presented by**

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Presented to Washington State Department of Social & Health Services,
Health and Recovery Services Administration

Acumentra Health prepared this report under contract with the Washington State Department of Social & Health Services, Health and Recovery Services Administration (Contract No. 0834-34555) and Mental Health Division (Contract No. 0835-33311).

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# Table of contents

# Index of tables and figures

## Tables

## Figures

# Acronyms used in this report

| | |
|---|---|
| ALOS | average length of stay |
| BBA | Balanced Budget Act of 1997 |
| CAHPS® | Consumer Assessment of Healthcare Providers and Systems |
| 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 |
| EPSDT | Early and Periodic Screening, Diagnosis, and Treatment |
| EQR | External Quality Review |
| EQRO | External Quality Review Organization |
| ER | emergency room |
| FFS | fee for service |
| 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 |
| MHD | Mental Health Division (merged into HRSA-DHS) |
| MHSIP | Mental Health Statistical Improvement Project |
| NCQA | National Committee for Quality Assurance |
| 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 |

Acronyms for individual RSNs and MCOs are listed on pages 14 and 77, respectively.

# Executive Summary

Federal law requires each state to implement a strategy for assessing and improving the quality of health care delivered to Medicaid enrollees through managed care. The state must provide for 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 2008. Reports from 2005 to 2007 focused on physical health services provided through the Healthy Options managed care organizations (MCOs) and overseen by HRSA's Division of Healthcare Services (HRSA-DHS). The 2008 annual report incorporated a baseline review of mental health services provided through the state's Regional Support Networks (RSNs), which then were overseen by HRSA's Mental Health Division (MHD).

HRSA's reorganization during 2009 eliminated MHD as a separate division and moved the RSN contracts and monitoring functions under HRSA-DHS. Portions of this report still refer to MHD in its capacity of oversight agency for the RSN system during 2008.

Separately, this report presents quality measurements for the Washington Medicaid Integration Partnership (WMIP), 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.

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 analysis reflects MCO and RSN performance in contract year 2008.

## State-level strengths

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

- Recent state 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 federal and state standards for coverage, authorization, and availability of services. In particular, all MCOs are complying with requirements to provide timely access to care and services.
- The RSNs typically provide timely access to outpatient care and deploy well-developed crisis and stabilization resources. They generally can provide timely access to geriatric, child, and developmental disability specialty services, although access to minority mental health specialists and child psychiatry is spotty, especially in rural areas.
- 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 and service coverage.
- The RSNs use diverse strategies to monitor the quality and appropriateness of care delivered by mental health providers.

- 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. These incentives, coupled with the requirement for MCOs to conduct improvement projects in areas where their performance measures fall below the state benchmark, constitute a "best practice" in Medicaid managed care.
- As a group, the MCOs continue to exceed the national average Medicaid performance in providing diabetes care 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.

## Recommendations

### Mental health care delivered by RSNs

**Network development.** Many RSNs have little information about the Medicaid-eligible population in their service areas. This makes it hard for the RSNs to identify barriers or gaps in service delivery, and to develop outreach to underserved people who do not present for service.

- ***HRSA needs to ensure that RSNs have accurate information about the Medicaid-eligible population in their service area, including demographic information, language needs, and geographic distribution.***

**Second opinions.** Most RSNs do not track second opinions for reasons other than denial of medical necessity. Because the RSNs do not require providers to track and report requests for second opinions, information about treatment planning, diagnoses, and medication is not readily available to RSNs for monitoring network capacity, enrollee satisfaction, and quality.

- ***HRSA needs to ensure that the RSNs track all requests for second opinions at the provider level, and require RSNs to track the timeliness of second opinions at all levels within the network.***

**Out-of-network services.** Most RSNs do not require provider agencies to report out-of-network services secured by providers on behalf of enrollees. This information is essential to determine whether the RSN needs to develop capacity within the network.

- ***HRSA needs to require the RSNs to track all out-of-network services.***
- ***HRSA's information distributed to all enrollees needs to describe how to obtain out-of-network services.***

**Routine access.** Many RSNs report a lack of consistency among their providers regarding what constitutes a request for service. A clear definition of a service request is the first step in accurately tracking timeliness of access.

- ***HRSA needs to clarify in writing the definition of a "request for service" to enable RSNs to standardize their processes for tracking enrollee access to outpatient assessments and first clinical appointments.***

The RSNs have not consistently required or implemented corrective action to address problems related to enrollee access.

- ***HRSA needs to require RSNs to follow up on issues identified through monitoring and initiate corrective action when lack of compliance to routine access is identified.***

Most RSNs authorize services for six months to a year at a time and rarely deny reauthorization for outpatient services. The RSNs have made few efforts to manage care at higher levels of care. RSNs are not always involved in authorizing hospital stays before admission, and thus cannot intervene to offer alternatives to hospitalization if appropriate.

- ***HRSA needs to establish continued-stay and discharge criteria to guide treatment and discharge planning as RSNs continue to implement the Recovery Model.***
- ***HRSA needs to work with the RSNs to implement a more robust level-of-care system with a wider array of services to meet the unique needs of enrollees.***
- ***HRSA needs to work with the RSNs to develop a system whereby the RSNs are involved in decision making before hospital admissions and in developing and providing alternatives to hospital care.***

**Timeliness issues.** Most RSNs find it hard to meet the state's timelines for providing minority mental health specialist consultations, service authorizations, and routine appointments after an enrollee's service request.

- ***HRSA needs to continue its process to redefine how RSNs are to ensure that enrollees with specialized needs have access to specialists in a timely manner.***
- ***HRSA needs to provide direction on defining authorization timelines and take steps to ensure that the RSNs meet those timelines, including requiring corrective action when noncompliance is identified.***
- ***HRSA needs to clarify the requirements for reporting on timelines for first available appointments, to ensure consistent reporting on availability of services.***

**Quality management (QM) programs.** RSNs across the state have implemented QM processes inconsistently. Only a few RSNs have robust QM plans, and four RSNs lack a current QM plan. The majority of RSNs lack comprehensive monitoring of over- and underutilization. Most RSNs do not conduct an annual evaluation of their QM program.

- ***HRSA needs to require all RSNs to submit QM plans and annual evaluations. HRSA needs to review those plans and evaluations as part of its RSN certification process.***
- ***HRSA needs to provide direction for the RSNs on expectations for monitoring for over- and underutilization of outpatient services.***

**Provider selection.** Most RSNs lack formal policies and procedures for credentialing of provider agencies, and for verifying the credentials of provider agency or RSN staff. Credentialing files at the RSNs and provider agencies do not consistently contain the required documentation.

- ***HRSA needs to provide clear direction to the RSNs regarding credentialing of RSN staff and monitoring of provider agency credentialing.***
- ***HRSA needs to clarify expectations regarding routine screening to ensure that RSN or provider staff are not excluded from participating in federal healthcare programs.***

**Oversight of delegated activities.** The RSNs are uncertain about the requirements for monitoring delegated activities—in particular, provider credentialing and screening for exclusion from federal healthcare programs. Many RSNs do not monitor their providers' subcontractors. Some do not monitor after-hours service providers, crisis clinics, and other contracted entities.

- ***HRSA needs to provide direction to the RSNs regarding the definition of delegated activities and requirements for monitoring of delegated activities.***

**Care for enrollees with specialized needs.** The RSNs lack confidence in the quality of mental health specialist consultations. Acumentra Health's review of a sample of clinical records of enrollees with specialized needs at each RSN revealed a lack of consistency in the quality of the consultations, and in incorporating the recommendations of mental health specialist consultations into enrollee treatment plans.

- ***HRSA needs to continue its process to redefine how RSNs are to ensure that enrollees with specialized needs are appropriately assessed, and that treatment plans incorporate the recommendations of mental health specialists.***

**Enrollment data.** RSNs currently have to ask enrollees to correct their enrollment information at the Community Services Office where the enrollee is active. This is an inefficient method for updating essential enrollment data.

- ***HRSA needs to provide RSNs with a process or method for removing duplicate enrollees from the eligibility files.***

## Physical health care delivered by MCOs

HRSA has taken limited action on the recommendations presented in the 2008 annual report for improving the medical managed care system. Those recommendations still apply. In addition, Acumentra Health offers the following "priority" recommendations.

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

- ***HRSA needs to require the MCOs to provide performance measure feedback to clinics and providers on a frequent and regular schedule.***

**Provider incentives.** The MCOs need to serve as a resource to support clinical quality improvement (QI) efforts.

- ***The MCOs should support and reward high-performing provider groups—e.g., those that develop medical homes for enrollees and improve their quality indicators.***

**Data completeness.** The Healthy Options MCOs should

- ***evaluate expected claims or encounter volumes by provider type to help identify missing data***
- ***monitor data submitted by vendors (e.g. pharmacy and lab data) to help ensure that the data are complete and accurate, and ensure that formal reconciliation processes are in place to ensure the integrity of data transfer between MCOs and their vendors***

HRSA requires the Healthy Options MCOs to report race and ethnicity data for all enrollees each year. However, reporting is not consistent among the MCOs, and large gaps remain the reporting of ethnicity data.

- ***HRSA either should institute corrective action for an MCO that fails to report complete race/ethnicity data, or require the MCO to conduct a PIP to improve reporting of complete race/ethnicity data.***

### Washington Medicaid Integration Partnership

The following recommendations from the 2008 EQR report continue to apply.

- ***WMIP program managers with Molina Healthcare of Washington (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 HRSA-DHS should meet with mental health program managers to discuss outcomes and explore ways to improve care processes to meet the common needs of their service populations.***
- ***MHW should discuss with 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.***

Acumentra Health offers this additional recommendation:

- ***HRSA should explore opportunities to promote the WMIP program as a model that supports the medical or health home model.***

### EQR follow-up

Last year's EQR report recommended that HRSA

- ***implement contractual requirements for all MCOs and RSNs to address the specific recommendations in this report.*** HRSA is considering this recommendation in connection with a future Healthy Options Request for Proposals, including contract revisions. HRSA has modified RSN contract provisions to address certain recommendations.
- ***merge and integrate the DHS and MHD Medicaid quality strategies to reflect a coordinated approach to managed care for physical and mental health.*** HRSA is in the process of rewriting the Medicaid Quality Strategy so that it will reflect an integrated and coordinated approach.

Following HRSA's physical/mental health merger and extensive personnel cuts in 2009, staff support for EQR program administration is underfunded and fragmented throughout HRSA's three divisions. This affects all of HRSA's quality improvement (QI) activities, and especially those that depend on a robust information technology infrastructure. The current crisis, however, offers an opportunity for HRSA to take several steps needed to ensure the continuity and long-term viability of the EQR program:

- ***convene personnel from all divisions, in conjunction with its quality oversight committee, to review the 2009 EQR recommendations and prioritize the actions that HRSA will take in response***
- ***realign HRSA's organizational structure to support the efficient administration of EQR program activities***

# 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. Roughly 1 million Washingtonians are enrolled in managed mental health services, and nearly 3,000 clients are enrolled in the Washington Medicaid Integration Partnership. HRSA administers healthcare services for these enrollees through contracts with medical MCOs and mental health RSNs, respectively. The MCOs and RSNs, in turn, contract with healthcare providers to deliver clinical services.

HRSA reorganized during 2009, eliminating MHD as a separate division and moving the RSN contracts and monitoring functions under DHS. The Division of Behavioral Health and Recovery (formerly the Division of Alcohol and Substance Abuse) now oversees block grant administration, performance measurement, and community mental health agency licensing and certification. The merger reflects HRSA's goal of further integrating medical assistance, mental health services, and chemical dependency treatment.

Under new DSHS leadership, HRSA has announced a focus on integrating primary care and mental health services, building community partnerships, and reducing client risk, with statewide implementation of a medical home or health home model. HRSA's vision calls for the delivery of patient-centered, integrated, and coordinated care, founded on prevention, early intervention, treatment, and resiliency and recovery.

## EQR requirements

The federal Balanced Budget Act (BBA) of 1997 requires that every state Medicaid agency that contracts with managed care plans must evaluate and report on specific EQR activities. Acumentra Health, as the external quality review organization (EQRO) for 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 recommendations from the previous year's review.

This report contains information collected from MCOs and RSNs through activities based on protocols of the Centers for Medicare & Medicaid Services (CMS):

- **compliance monitoring**—site reviews of the Medicaid managed care plans to determine whether they meet regulatory and contractual standards governing managed care
- **validation of performance improvement projects (PIPs)** to determine whether the health plans meet standards for conducting these required 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

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

- statewide performance measures used to monitor the delivery of mental health services by RSNs, including an Information Systems Capabilities Assessment (ISCA) for each RSN

For the MCOs, 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, validates PIPs, and conducts the ISCA.

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 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. Current state law extends Medicaid coverage to all children in families with incomes up to 250 percent of the Federal Poverty Level (FPL)—as of 2009, $55,125 for a family of four—and requires premiums for families with incomes above 200 percent of the FPL, or $44,100 for a family of four.

### 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 550,000 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 RSNs cover roughly 1 million enrollees in managed mental health care, including more than 100,000 enrollees in Pierce County. (In 2008 and part of 2009, Medicaid recipients in Pierce County received state-administered FFS mental health services. As a result, Acumentra Health did not review Pierce County RSN operations as part of the 2009 EQR.)

### Washington Medicaid Integration Partnership (WMIP)

This Medicaid 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 2009, almost 3,000 clients were enrolled in WMIP.

## State quality improvement activities

HRSA-DHS conducts and oversees 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 complied with the majority of BBA standards regarding managed care. MHD's Quality Strategy, last updated in April 2007, incorporates quality assurance and performance improvement (QAPI) activities and expectations for the RSNs.

HRSA is in the process of drafting a combined physical/mental health Quality Strategy that will reflect an integrated and coordinated approach to managed health care.

### 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 current Healthy Options contract requires each MCO to conduct at least one clinical and one nonclinical PIP. An MCO must conduct a PIP to improve immunization and/or WCC rates if the MCO's rates fall below established benchmarks. HRSA-DHS validates the PIPs' compliance with CMS standards through the TEAMonitor reviews.

In addition to these required PIPs, each MCO participated in the Washington State Collaborative to Improve Health, which concluded in May 2009. This group learning project, funded primarily by HRSA-DHS, the Department of Health (DOH), and the MCOs, was 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 2009, targeting improvements in care and nonclinical services. All projects were carried over from 2007, including two contractually required PIPs on chemical dependency topics.

Each RSN is required to conduct one clinical and one nonclinical PIP annually. Acumentra Health validates the PIPs using a review protocol adapted from the CMS protocol. The RSNs

have established a topic for a statewide nonclinical PIP: improving the timeliness of outpatient appointments following a client's discharge from inpatient psychiatric care. For 2009, 8 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

The Healthy Options contract incorporates NCQA accreditation standards related to quality management and improvement, utilization management, and enrollee rights and responsibilities. Specific contract provisions apply to 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 2009, 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

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. HRSA funded the 2009 HEDIS audit for the Healthy

Options plans to fulfill the federal requirement for validation of performance measures. For the WMIP program, MHW underwent a certified HEDIS audit that incorporated HEDIS validation of performance measures and the CMS 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 CAHPS survey for 2009 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. Report findings are summarized in the WMIP section of this report.

#### Mental health performance measures

Each RSN is required by contract to demonstrate improvement on a set of performance measures calculated and reviewed by the state each quarter. If the RSN does not meet defined improvement targets on any measure, the RSN must submit a performance improvement plan. For 2009, two performance measures were in effect, related to providing timely appointments for routine care and timely follow-up care after an enrollee's discharge from psychiatric hospitalization.

In 2008, Acumentra Health's performance measure validation included a review of the methodology and code used to calculate the measure of timely follow-up after hospitalization. MHD did not calculate other performance measures. In 2009, Acumentra Health reviewed the methodology and code and conducted a full state-level ISCA, as well as an ISCA for each RSN, including a review of their contracted vendors, to evaluate the extent to which the information technology infrastructure supported the production and reporting of valid and reliable measures. As a part of this review, Acumentra Health evaluated the response of the state and RSNs to findings from the previous EQR report.

### Compliance monitoring

HRSA participates in TEAMonitor with DOH, the state Health Care Authority, and the Aging and Disability Services Administration to oversee medical 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 2009, 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 adapted from the CMS protocol. The 2009 reviews addressed provisions related to QAPI programs, network adequacy, care coordination, provider selection, and other compliance areas. The previous round of reviews in 2008 addressed enrollee rights and grievance systems.

### 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 2009, the state paid $996,871to MHW, $879,742 to Community Health Plan (CHP), and smaller amounts to other plans. MHW and CHP have received the highest performance bonuses since 2005. Of $8 million disbursed by HRSA since the onset of this program, MHW has received almost $3.8 million and CHP has received almost $2.7 million.

## CMS audit

CMS's most recent onsite audit of HRSA occurred in August 2007. The audit found that HRSA complied with federal requirements in 9 of 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: client liability for payment and supplemental payments to Federally Qualified Health Centers and rural health centers.

## Quality oversight

HRSA's quality oversight committee reviews RSN and TEAMonitor results, recommends actions, and follows up on issues within the state's quality program. DHS's Office of Quality and Care Management focuses on quality monitoring, managed care, and care management. During 2008–2009, HRSA has convened regular 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 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 | Performance measure validation and ISCA 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 by EQRO | MHSIP survey |

# Methods

This annual report combines results from individual EQR activities to present a composite picture of care delivered to Washington Medicaid enrollees. In aggregating and analyzing the data for this report, Acumentra Health drew on elements from the following reports:

- 2009 HEDIS report of MCO performance in key clinical areas[2]
- 2009 TEAMonitor reports on MCOs' compliance with BBA regulations and state contractual requirements
- Acumentra Health reports on individual RSNs' regulatory and contractual compliance, PIP validation, and ISCA, submitted throughout 2009

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

BBA regulations require the EQRO to describe how conclusions were drawn about 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 care delivery (e.g., through evidence-based practices) 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 the patient's experience *before* care is delivered. Access depends on many factors, including availability of appointments, the patient's ability to see a specialist, adequacy of the healthcare network, and availability of transportation and translation services.[3,4,5] Access to care affects a patient's experience as well as outcomes.

**Timeliness,** a subset of access, refers to the time frame in which a person obtains needed care. Timeliness of care can affect utilization, including both appropriate care and over- or underutilization of services. The cost of care is lower for enrollees and health plans when diseases are prevented or identified early. 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 1 illustrates the relationship of these components for quality assessment purposes.

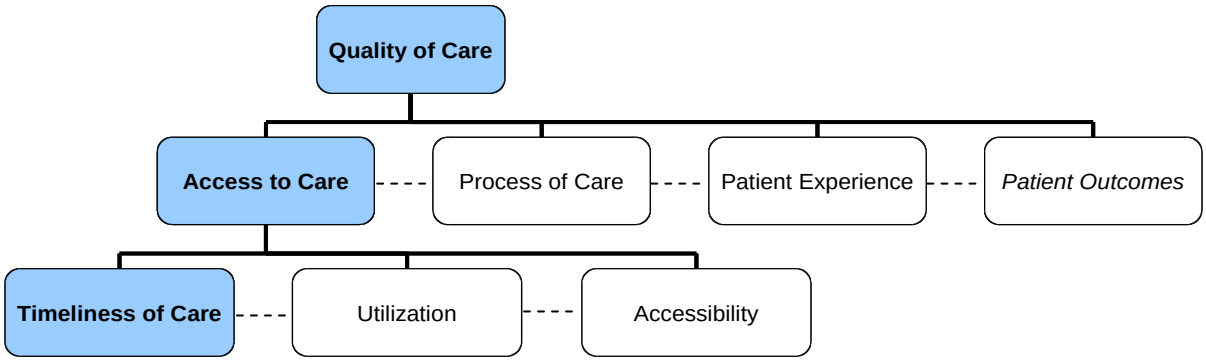



**Figure 1. Components in measuring the quality of health care.**

Certain performance measures lend themselves directly to the analysis of quality, access, and timeliness. For example, in analyzing physical health care, Acumentra Health used NCQA reporting measures and categories (HEDIS data) to define each component of care. In addition, the degree of a health plan's compliance with certain regulatory and contractual standards can 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 and part of 2009, HRSA contracted with 12 RSNs to deliver mental health services for Medicaid enrollees through managed care. Medicaid enrollees in Pierce County received state-administered FFS mental health services through June 30, 2009, when the Pierce County RSN resumed managing those services for 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.

All RSNs are required to contract with an independent Ombuds service to 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 HRSA 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 2008.

**Table 2. Mental health Regional Support Networks and enrollees, December 2008.[a]**

| Health plan | Acronym | Number of enrollees | % of all enrollees |
|---|---|---|---|
| Chelan-Douglas RSN | CDRSN | 22,941 | 2.1 |
| Clark County RSN | CCRSN | 69,433 | 6.4 |
| Grays Harbor RSN | GHRSN | 17,214 | 1.6 |
| Greater Columbia Behavioral Health | GCBH | 167,772 | 15.5 |
| King County RSN | KCRSN | 226,151 | 20.8 |
| North Central Washington RSN | NCWRSN | 62,568 | 5.8 |
| North Sound Mental Health Administration | NSMHA | 154,337 | 14.2 |
| Peninsula RSN | PRSN | 49,102 | 4.5 |
| Pierce County (FFS in 2008) | | 128,747 | 11.9 |
| Southwest RSN | SWRSN | 22,845 | 2.1 |
| Spokane County RSN | SCRSN | 93,548 | 8.6 |
| Thurston-Mason RSN | TMRSN | 45,272 | 4.1 |
| Timberlands RSN | TRSN | 22,024 | 2.0 |
| **Total** | | **1,084,916** | **100.0** |

[a] Source: Washington Mental Health Performance Indicator System.

Figure 2 shows the counties served by each RSN.

**RSN Service Areas 2009**

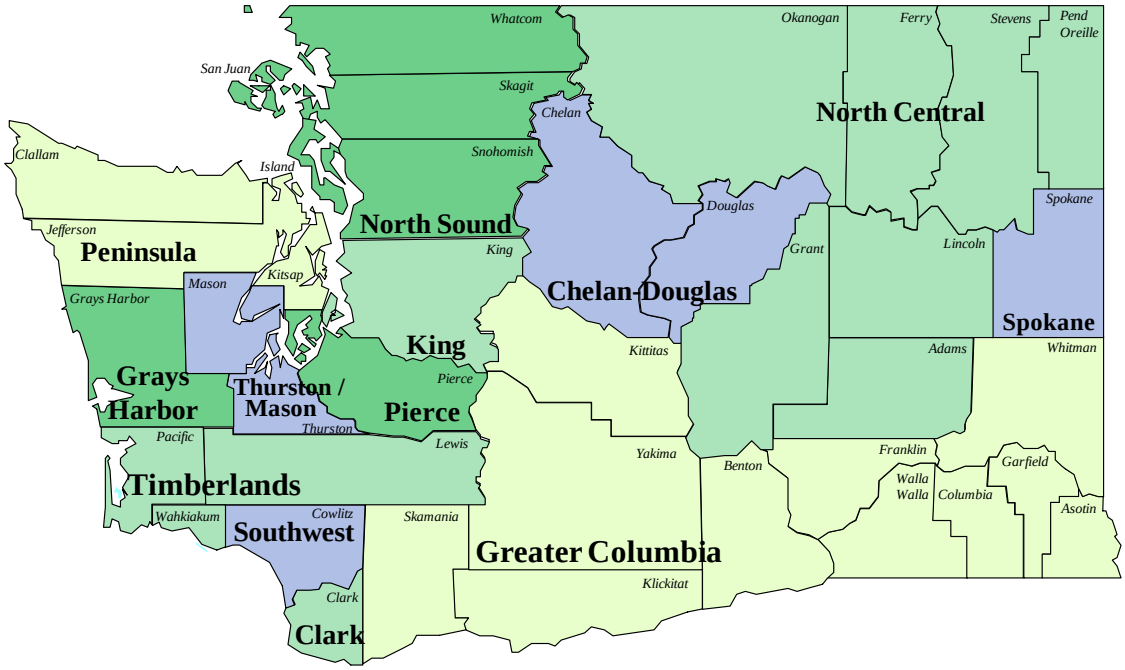



**Figure 2. Geographical coverage of RSNs.**

In 2009, Acumentra Health conducted the compliance review, PIP validation, and ISCA for each RSN (excluding Pierce County). 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. Does the RSN's information technology infrastructure support the production and reporting of valid and reliable performance measures?

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
- *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. The RSN received a written copy of all interview questions and documentation requirements prior to onsite interviews.
2. The RSN submitted the requested documentation to Acumentra Health for review.
3. Acumentra Health staff visited the RSN to conduct onsite interviews and provided each RSN with an exit interview summarizing the results of the review.
4. Acumentra Health staff conducted interviews and reviewed documentation of up to four provider agencies and other contracted vendors for each RSN.
5. Acumentra Health scored the oral and written responses to each question and compiled results.

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

The following sections summarize the results of individual EQR reports for 12 RSNs completed in 2009. These results represent established measurements against which HRSA 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 and recommendations regarding access to mental health care arose from Acumentra Health's site reviews of the Washington RSNs during 2009.

### Strengths

- **Crisis and stabilization resources:** Most RSNs had well-developed crisis and stabilization resources available to enrollees, including evaluation and treatment (E&T) centers; mobile crisis teams that can intervene at the enrollee's home or in the community 24 hours a day, seven days a week; crisis respite beds; children's hospital diversion programs; and hospital discharge planning. Most RSNs monitored their enrollees' use of crisis services to ensure that crises were not related to lack of appropriate outpatient services.

### Opportunities for improvement

- **Network development:** Many RSNs have little information about the Medicaid-eligible population in their service areas. This makes it difficult for the RSNs to determine whether they meet the needs of the Medicaid-eligible people they receive capitation to serve. Without comparing the entire Medicaid eligible population with those enrolled in services, the RSNs cannot identify barriers or gaps in service delivery systems, and they cannot fully develop outreach efforts to the underserved populations who do not present for service.
    - ***HRSA needs to ensure that RSNs have accurate information about the Medicaid-eligible population in their service area, including demographic information, language needs, and geographic distribution.***
- **Second opinions:** Most RSNs do not track second opinions for reasons other than denial of medical necessity. Because the RSNs do not require provider agencies to track and report requests for second opinions, information about treatment planning, diagnoses, and medication is not readily available to RSNs for monitoring network capacity, enrollee satisfaction, and quality.
    - ***HRSA needs to ensure that RSNs track all requests for second opinions at the provider level.***
- **Out-of-network services:** Several RSNs lacked mechanisms to track out-of-network referrals. Most RSNs do not require provider agencies to report out-of-network services secured by providers on behalf of enrollees. This information is essential to determine whether the RSN needs to develop capacity within the network. One RSN initiated an extensive provider training program for eating disorders to address a gap in its delivery system as a result of tracking out-of-network service requests.
    - ***HRSA needs to require the RSNs to track all out-of-network services.***

    All Medicaid enrollees have the right to request services outside the network if medically necessary services are not available within the network. However, HRSA's Benefits Booklet for People Enrolled in Medicaid omits information on how enrollees may obtain out-of-network services.

- ***HRSA's information distributed to all enrollees needs to describe how to obtain out-of-network services.***

- **Routine access:** Many RSNs report a lack of consistency among their providers regarding what constitutes a request for service. A clear definition of a service request is the first step in accurately tracking timeliness of access. To begin to address this, HRSA clarified verbally in October 2009 that only an enrollee or the enrollee's guardian can make a request for service. A referral from an ancillary service provider, such as a PCP, from a family member of an adult enrollee, or from the criminal justice system does not constitute a request for service.

  - ***HRSA needs to clarify in writing the definition of a "request for service" to enable RSNs to standardize their processes for tracking enrollee access to outpatient assessments and first clinical appointments.***

  None of the RSNs met all federal and state access standards. Most of the RSNs that had identified access problems had implemented improvement strategies, such as fine-tuning data collection to capture all requests for service. The RSNs had not consistently required or implemented corrective action.

  - ***HRSA needs to require RSNs to follow up on issues identified through monitoring and initiate corrective action when lack of compliance to routine access is identified.***

  Because capacity is limited in the publicly funded mental health system, the RSNs need to work with providers to serve enrollees appropriately and effectively at the least restrictive level of care.

  Routine reauthorization of outpatient services, without evaluating whether services are needed, limits overall access to mental health care. Most RSNs authorize services for six months to a year at a time and rarely deny reauthorization for outpatient services. The RSNs have made few efforts to manage care at higher levels of care, and have not required justification to continue treatment at the higher reimbursement rate.

  The high rate and high cost of hospital utilization also can limit overall access to care. RSNs are not always involved in authorizing hospital stays before admission, and thus cannot intervene to offer alternatives to hospitalization if appropriate.

  - ***HRSA needs to establish continued-stay and discharge criteria to guide treatment and discharge planning as RSNs continue to implement the Recovery Model.***
  - ***HRSA needs to work with the RSNs to implement a more robust level-of-care system with a wider array of services to meet the unique needs of enrollees.***
  - ***HRSA needs to work with the RSNs to develop a system whereby the RSNs are involved in decision making before hospital admissions and in developing and providing alternatives to hospital care.***

## Timeliness of mental health care

The following observations and recommendations regarding the timeliness of mental health care arose from Acumentra Health's site reviews of the Washington RSNs during 2009.

### Strengths

- **Timeliness of specialist consultations:** Since most provider agencies have internal resources for geriatric, child, and developmental disability mental health specialists, the RSNs were able to provide those services in a timely manner. In general, the RSNs monitored their provider agencies to determine whether they offered timely access to specialist consultations.
- **PIPs addressing timeliness:** The RSNs are pursuing various projects aimed at improving the timeliness of care delivery.
    - Nine of the 12 RSNs are studying ways to improve the timeliness of outpatient follow-up appointments for enrollees discharged from psychiatric hospitalization.
    - NSMHA began a PIP in 2009 that aims to improve the timeliness of enrollees' access to medication evaluation appointments.
    - CCRSN and NCWRSN are conducting PIPs aimed at ensuring access to routine mental health services within 14 days of a service request.

### Opportunities for improvement

- **Timeliness of minority consultations:** Most RSNs had difficulty consistently meeting the 30-day requirement for minority mental health specialist consultations. Scheduling difficulties often delayed access to outside consultations. HRSA is re-examining the requirement for mental health specialist consultations. Modifying the qualifications for becoming a mental health specialist could help resolve timeliness issues.
    - ***HRSA needs to continue its process to redefine how RSNs are to ensure that enrollees with specialized needs have access to specialists in a timely manner.***
- **Timeliness of authorization:** HRSA data show only one RSN meeting the contract requirement limiting the time between a request for service and authorization of service to 14 days. Also, the majority of RSNs (those not contracting with Behavioral Health Options to perform service authorization) do little monitoring or tracking of the time it takes to complete an authorization after the provider submits an authorization request to the RSN. Nevertheless, provider agencies and RSN staff who perform authorizations report a quick response time.
    - ***HRSA needs to provide direction on defining authorization timelines and take steps to ensure that the RSNs meet those timelines, including requiring corrective action when noncompliance is identified.***
- **Second opinions:** Because most RSNs had no mechanism to track second opinions performed at the provider level, they had no way of knowing whether second opinions were delivered in a timely manner.

- ***HRSA needs to require RSNs to track the timeliness of second opinions at all levels within the network.***

- **Lag between initial request and first routine service:** HRSA reports that in 2008, only one RSN met the requirement to provide the first routine service within 28 days of an enrollee's request. The RSNs lack a clear understanding of this standard, resulting in confusion and inaccurate reporting. Factors behind inaccurate reporting include:
  - Enrollees do not always select the first available appointment, but choose one outside the required time limit.
  - "No show" rates for initial intakes exceed 30 percent.
  - Intakes may be scheduled only one day per week and enrollees are asked to call back the following week. The time reported is calculated from the time the call resulting in an appointment is made.
  - Initial services may not be available on a timely basis from the requested provider, whereas another provider can provide timely services. This is not considered a "waiting list" or an access issue, but rather a consequence of enrollee choice.

  - ***HRSA needs to clarify the requirements for reporting on timelines for first available appointments, to ensure consistent reporting on availability of services.***

## Quality of mental health care

A 2009 survey of 87 publicly funded mental health providers by the Washington Institute for Mental Health Research and Training revealed that two-thirds of the agencies were implementing at least one evidence-based practice (EBP), and more than half were implementing more than one EBP. The most frequently used adult EBP was Medication Management, and the most frequently used children's EBP was Functional Family Therapy.[7]

Many providers within the RSN system have implemented EBPs approved by the U.S. Substance Abuse and Mental Health Services Administration. Several RSNs have implemented the Program for Assertive Community Treatment (PACT), a recovery-oriented mental health service delivery model in which transdisciplinary teams provide intensive outreach-oriented services for people with severe and persistent mental illnesses and co-occurring disorders. Recent funding cutbacks have reduced the availability of Supported Employment, another EBP.

This assessment of the RSNs' compliance with quality standards emerged from the 2009 site reviews and from a review of clinical records of enrollees who met special-population criteria.

### Strengths

- **Quality monitoring:** The RSNs used diverse strategies to monitor the quality and appropriateness of care delivered by provider agencies. Most RSNs monitored quality through methods such as annual administrative audits, clinical record review, grievance reports, and enrollee surveys conducted by QRTs.
- **Clinical record review:** Almost all RSNs performed clinical record review of provider agencies. However, most RSNs that performed such reviews focused on technical assistance related to individual cases, rather than on trends or system-wide quality of care. Since 2008, the RSNs have made progress in adjusting their oversight activities to incorporate federal regulatory and state contractual requirements; previously, the primary focus of auditing was compliance with state regulations. Most RSNs have required provider agencies to perform corrective action when quality-of-care concerns were identified.
- **Practice guidelines:** All RSNs had implemented at least one clinical practice guideline. As part of clinical record reviews, many RSNs monitored their providers' fidelity in applying the practice guidelines. GHRSN focused its clinical PIP on implementation of its guideline for treating Major Depressive Disorder. KCRSN monitored for developmentally appropriate treatment and recovery/resiliency, its adopted practice guidelines, and provided a performance incentive for providers who demonstrate adherence to the guidelines.
- **Cultural competency:** Several RSNs contract with SeaMar, a federally qualified health center that specializes in services for Latino enrollees. Several RSNs have collaborated successfully with the tribes in their service areas to coordinate care. NSMHA holds an annual tribal conference and meets regularly with local tribes.
- **Clinical quality PIPs:**
  - CDRSN, KCRSN, and PRSN focused their clinical PIPs on identifying and screening enrollees who are at risk for developing metabolic syndrome as a result of taking atypical anti-psychotic medications.

- GCBH and SWRSN focused their clinical PIPs on using the PACT team—an evidence-based approach to caring for adult enrollees with serious and persistent mental illness—to reduce hospital utilization.
- TMRSN focused its clinical PIP on implementing Multisystemic Therapy, a family-centered intervention for enrollees under 18 with chronic violent and/or substance-abusing behaviors.

### Opportunities for improvement

- **Quality management (QM) programs:** The EQR site visits revealed inconsistent implementation of QM processes across the state. Six RSNs had comprehensive QM programs in place. Six RSNs had implemented QM processes but needed to improve them; several of those RSNs were reviewing and implementing new QM programs. Most did not conduct an annual evaluation of their QM program.

  Although WAC 388-865-0280 requires each RSN to submit a QM plan to the state biennially, the RSNs did not routinely submit such plans to the state. Only a few RSNs had robust QM plans that included indicators, performance goals, and benchmarks. Four RSNs lacked a current QM plan in 2008.

  The majority of RSNs lacked a comprehensive program for monitoring for over- and underutilization of services. In general, RSNs monitored less for underutilization because the RSNs lacked access to accurate and timely data on Medicaid enrollees assigned to their systems.

  The majority of RSNs had not described methods to measure outcomes or progress toward recovery—for example, using results of the Mental Health Statistical Improvement Project (MHSIP) survey to address symptom reduction, improvement in functioning, and satisfaction with services. Other outcome measures might include successful employment and stable housing.

  - ***HRSA needs to require all RSNs to submit QM plans and annual evaluations.***
  - ***HRSA needs to review QM plans and evaluations as part of its RSN certification process.***
  - ***HRSA needs to provide direction for the RSNs on expectations for monitoring for over- and underutilization of outpatient services.***

- **Provider selection:** Most RSNs lacked formal policies and procedures for credentialing of provider agencies, and for verifying the credentials of provider agency or RSN staff. In addition, most of the RSN and provider agency staff credentialing files lacked documentation of having verified providers' credentials through primary sources, such as DOH or national accreditation bodies. In particular, the RSNs that relied on county personnel departments to screen applicants and to check references before employment lacked complete documentation. The same was true for provider agencies that had a central office.

  Although the majority of RSNs required providers to screen their staff members for exclusion from participating in federal healthcare programs, half of the RSNs did not consistently monitor their provider agencies for exclusion. In addition, eight RSNs did not monitor their own staff members for exclusion.

- ***HRSA needs to provide clear direction to the RSNs regarding credentialing of RSN staff and monitoring of provider agency credentialing.***
- ***HRSA needs to clarify the expectations regarding routine screening to ensure that RSN or provider agency staff are not excluded from participating in federal healthcare programs***

- **Oversight of delegated activities:** The RSNs were uncertain about the kind of monitoring needed for delegated activities—in particular, provider credentialing and screening for exclusion from federal healthcare programs. The majority of RSNs had no process to assess a contractor's ability to perform delegated activities before initiating a contract. Some RSNs did not consider contracts to be delegation agreements. Many RSNs did not monitor the community mental health agencies' processes for overseeing work performed by subcontractors. Some RSNs did not monitor after-hours service providers, crisis clinics, and other contracted entities.

  - ***HRSA needs to provide direction to the RSNs regarding the definition of delegated activities, the need to assess subcontractors' ability to perform activities before contracting, and requirements for monitoring of delegated activities.***

- **Care for enrollees with specialized needs:** The RSNs reported lack of confidence in the quality of mental health specialist consultations. Acumentra Health's review of a sample of clinical records of enrollees with specialized needs at each RSN revealed a lack of consistency in the quality of the consultations. Some consultations were specific to the enrollee's individualized needs, but most were generic. Many of the consultants' recommendations were the same for all enrollees of a particular special population. RSNs in urban areas seemed to have access to a wider range of minority consultants.

  The clinical record review also revealed inconsistency in incorporating mental health specialists' recommendations into enrollee treatment plans. This problem appeared to involve both lack of understanding of how to incorporate recommendations and lack of specificity in the recommendations as to the enrollee's individualized needs. Sometimes, when the consultation occurred by telephone, the consultant's lack of awareness of local resources made acting on the recommendations difficult.

  Clinical staff members who were members of a specific minority population or who were bicultural sometimes were required to seek consultations from specialists who had the necessary training but were not members of the special population. HRSA may need to develop a process whereby clinicians who are members of a special population or are bicultural can qualify as mental health specialists.

  Certain populations—for example, Ukrainians and Russians—do not qualify for mental health specialty consultations despite having special cultural needs. Other subgroups of minorities have specialized needs—for example, Laotian refugees' needs differ greatly from those of South Korean immigrants—but the same consultant would serve both subgroups. The mental health system has not addressed these issues adequately.

  - ***HRSA needs to continue its process to redefine how RSNs are to ensure that enrollees with specialized needs have access to specialists and are appropriately assessed, and that treatment plans incorporate the recommendations of mental health specialists.***

- **Quality monitoring:** HRSA's Medicaid waiver identifies the entire RSN network as specialty providers and considers that the requirements in the federal protocol for enrollees with specialized needs apply to all RSN enrollees.

  One major approach for monitoring quality of care is to conduct clinical record review of all providers. However, the clinical protocols used by the RSNs did not always address items from the federal protocol in a complete manner. For example:

  - The RSNs did not monitor enrollee treatment plans to ensure that relevant physical health needs were addressed.
  - The RSNs rarely monitored treatment plans to ensure that the treatment goals reflected the recommendations of mental health specialists. Treatment goals did not routinely reflect input from specialists such as psychiatrists and prescribers.
  - Progress notes rarely addressed the enrollee's progress on treatment goals.

  The RSNs need direction regarding monitoring the overall quality of care in their service areas. The focus of clinical review currently addresses individual needs on a case-by-case basis. The RSNs need to establish a method to incorporate the results of clinical review into system-wide QI efforts.

  - ***HRSA needs to provide direction to the RSNs regarding how to incorporate clinical quality monitoring into their QM plans and annual evaluations.***

## Mental health regulatory and contractual standards

During 2009, Acumentra Health's compliance review of the RSNs addressed regulatory and contractual provisions in eight major areas of managed care operations:

1. Delivery Network
2. Coordination and Continuity of Care
3. Coverage and Authorization of Services
4. Provider Selection
5. Subcontractual Relationships and Delegation
6. Practice Guidelines
7. Quality Assessment and Performance Improvement (QAPI) Program
8. Certification and Program Integrity

The previous round of reviews in 2008 addressed Enrollee Rights and Grievance Systems.

The compliance review followed a protocol adapted from the CMS protocol for this activity. The provisions of Washington's Medicaid waiver and the RSN contract are such that some parts of the federal protocol do not apply directly to RSN practices. For example, because all Washingtonians with mental illness are defined as having "special healthcare needs," the criteria for serving RSN enrollees differ from the criteria for serving people with special healthcare needs as defined by federal regulations.

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

Each section of the RSN compliance review protocol 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 individual 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 2009 compliance review results

**Delivery Network:** As shown in Figure 3, six RSNs fully met this standard, five RSNs substantially met the standard, and TRSN partially met the standard.

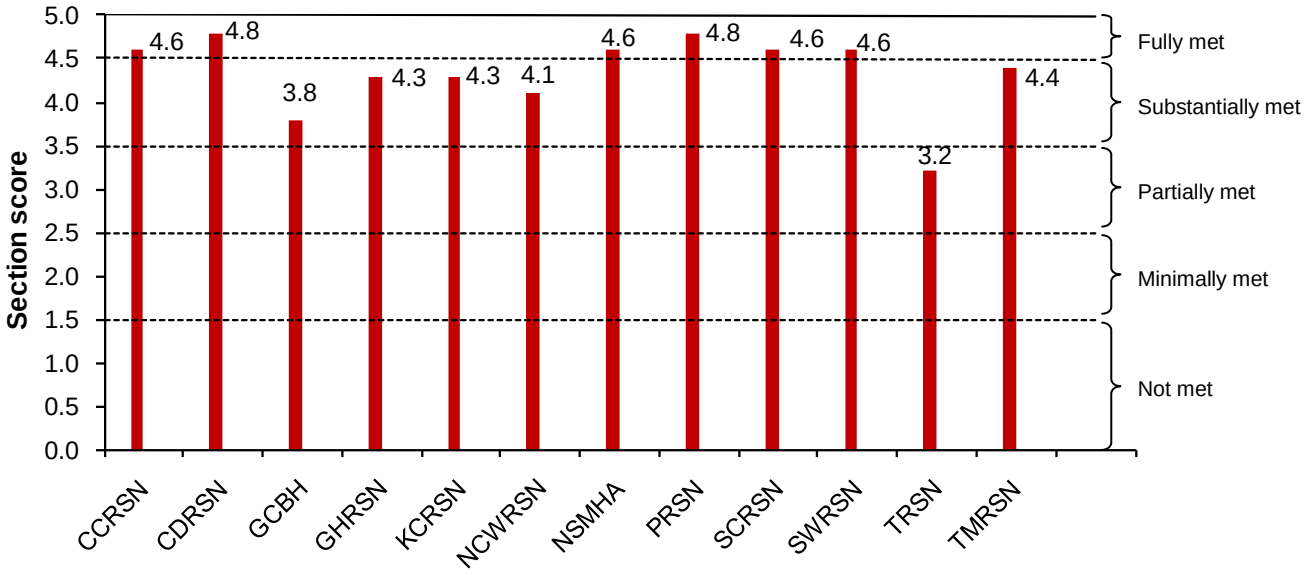



**Figure 3. RSN compliance scores: Delivery Network.**

### Strengths

- Eight of the 12 RSNs reviewed their network capacity annually, and some reviewed it quarterly. The RSNs analyzed various inputs to determine network adequacy, such as service utilization by age, ethnicity, and gender; service penetration rates by zip code; geo access reports; use of crisis and stabilization services; complaints and grievances; satisfaction surveys; clinician mix; and prescriber hours.
- Five RSNs (TMRSN, SCRSN, SWRSN, CCRSN, NSMHA) had mechanisms in place to track enrollee requests for second opinions from providers.
- Six RSNs (SWRSN, PRSN, CDRSN, KCRSN, CCRSN, NSMHA) tracked out-of-network service authorizations and used the data in gap analysis.
- Five RSNs (SCRSN, SWRSN, TRSN, KCRSN, CCRSN) monitored enrollee access to services by reviewing clinical records and complaints.
- NCWRSN, a rural RSN, used teleconferences with Spokane Children's Hospital to facilitate enrollee access to psychiatric services.
- Four RSNs (TMRSN, NSMHA, SCRSN, PRSN) had coordinated programs of outreach to tribes.
- Four RSNs (TMRSN, GCBH, GHRSN, CCRSN) monitored enrollee access to culturally competent services.

### Opportunities for improvement

- More than half of the RSNs reported routine problems with enrollee access; some had identified a lack of consistency in how providers documented initial contacts with enrollees. RSNs in rural areas reported access delays, although NCWRSN had taken corrective action. Several rural RSNs reported limited access to psychiatric services.
- Three RSNs (TRSN, NCWRSN, GCBH) did not monitor their network capacity. Some had delegated that function to their contracted providers, but had not defined criteria by which to measure adequacy.
- Many RSNs lacked data on second opinions conducted at the provider level. Some did not monitor enrollee requests for second opinions.
- Three RSNs (TRSN, SCRSN, GCBH) did not track out-of-network services.

### Recommendations for HRSA

- ***Clarify HRSA's expectations of the RSNs related to***
  - ***network development and monitoring.*** The RSNs need access to complete eligibility files to determine whether they are serving all potential clients and to determine unmet needs.
  - ***enrollee access to second opinions for reasons other than denial of medical necessity***
  - ***ensuring enrollee access to out-of-network services.*** HRSA's benefits booklet for Medicaid enrollees, upon which most RSNs rely, should present information on how to obtain out-of-network services.
- ***Continue to work with the RSNs to standardize mechanisms to track enrollee access to outpatient assessments and first clinical appointments. This is the first step to accurately determine access needs and barriers.***

**Coordination and Continuity of Care:** As shown in Figure 4, eight RSNs fully met this standard; three RSNs substantially met the standard; and TRSN partially met the standard.

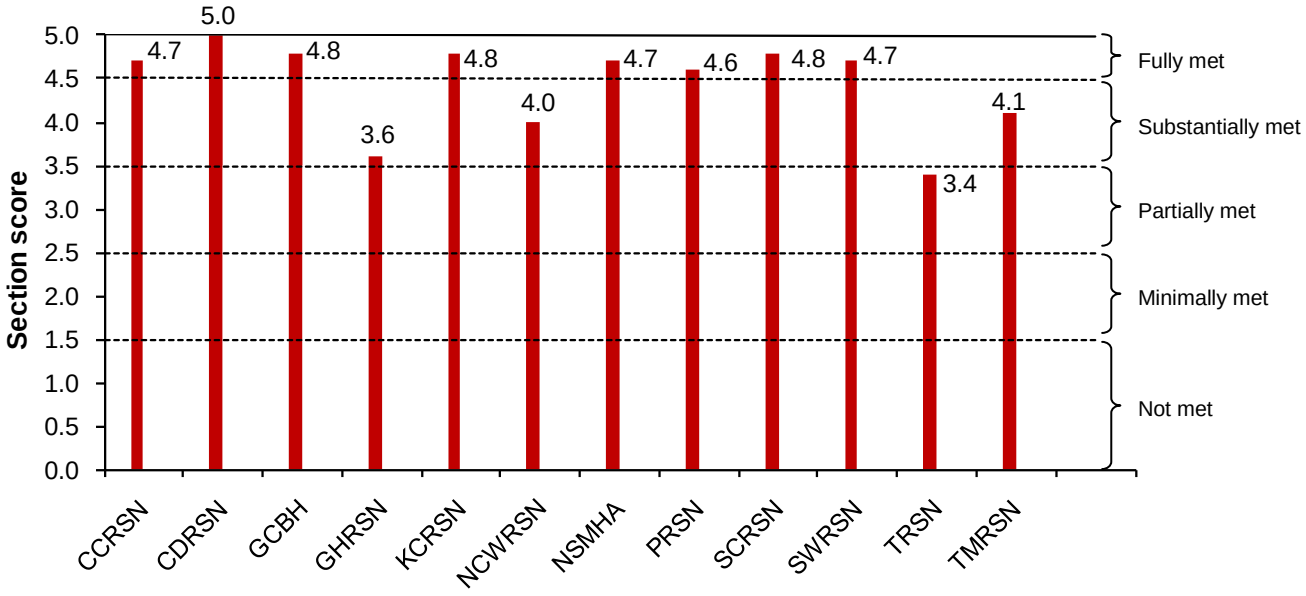



**Figure 4. RSN compliance scores: Coordination and Continuity of Care.**

### Strengths

- Nine of the 12 RSNs conducted clinical record review to determine whether assessments were conducted by qualified mental health professionals and whether treatment plans incorporated the recommendations of mental health specialists.
- The records audited by CDRSN demonstrated incorporation of mental health specialist recommendations into treatment plans.
- Five RSNs (SWRSN, NCWRSN, PRSN, CDRSN, CCRSN) had processes in place to ensure that enrollees had access to PCPs. SWRSN monitored for access to dental care, and KCRSN monitored for coordination of care for enrollees with co-occurring disorders. NCWRSN required its providers to refer to PCPs all enrollees over 60 years of age who seek mental health and substance abuse services. For NSMHA, a psychiatrist from a large provider agency met twice a month with a pediatric clinic to discuss child psychiatry issues, including medication management.
- Five RSNs (NCWRSN, KCRSN, GHRSN, CCRSN, NSMHA) used monitoring tools that included questions about coordination with other healthcare providers. NCWRSN coached provider agency staff to facilitate coordination of care.
- CCRSN's care managers facilitated coordination of care for enrollees with specialized needs. Care Managers at NSMHA coordinated services when enrollees were admitted to an acute care or long-term care facility, or for other types of healthcare needs requiring long-term planning.

- NSMHA prepared a specialized needs study that identified enrollees requiring specialized care by age, ethnicity, and language.
- PRSN addressed findings from the 2008 EQR report by incorporating indicators of care coordination with PCPs into its chart audit.

### Opportunities for improvement

- Most RSNs had difficulty in ensuring that enrollees' treatment plans incorporated the recommendations of mental health specialists.
- Six RSNs (TMRSN, SCRSN, PRSN, KCRSN, GHRSN, NSMHA) reported difficulty in meeting access requirements for mental health specialist consultations.
- Records of three RSNs (TMRSN, TRSN, GHRSN) reviewed by Acumentra Health revealed missed opportunities for coordinating care with PCPs and other managed care plans.
- Staff of two RSNs (GHRSN, TRSN) did not know which managed physical health plans were active in their service area.

### Recommendations for HRSA

- ***Continue to encourage the RSNs to build relationships with physical healthcare providers and other managed care plans to ensure that enrollees have access to primary care services and that their care is coordinated.***

**Coverage and Authorization of Services:** As shown in Figure 5, five RSNs fully met this standard, and the remaining RSNs substantially met the standard.

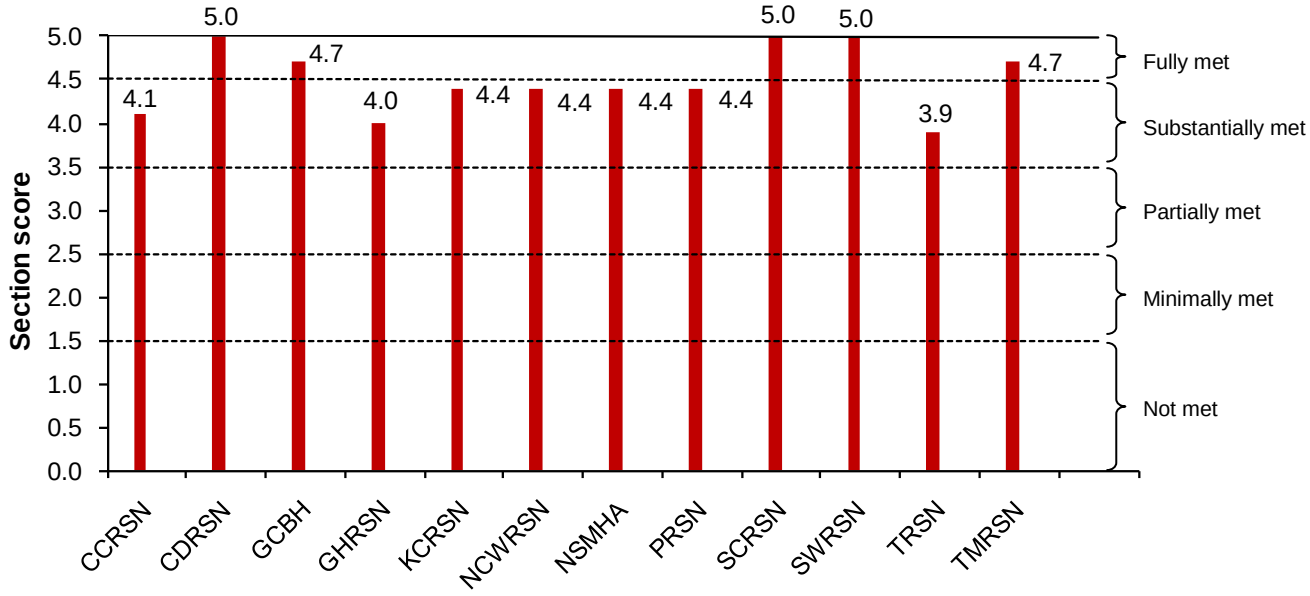



**Figure 5. RSN compliance scores: Coverage and Authorization of Services.**

### Strengths

- Nine of the 12 RSNs had developed extensive arrays of crisis and stabilization services. RSNs across the state used 18 evaluation and treatment (E&T) centers. During 2008, SCRSN implemented an array of "stepdown" resources, including a new E&T, as an alternative to inpatient hospitalization.
- Six RSNs (CCRSN, CDRSN, GHRSN, NCWRSN, SWRSN, NSMHA) reported timely service authorizations and consistent application of utilization management criteria.
- Three RSNs (CCRSN, KCRSN, SWRSN) audited their providers to ensure consistent application of authorization review criteria and timely completion of authorizations by staff with the appropriate credentials.
- Six RSNs (KCRSN, NSMHA, GHRSN, SWRSN, TMRSN, CCRSN) used levels of care as a framework for determining intensity of services.
- KCRSN implemented a performance incentive program for providers related to furnishing developmentally appropriate and resiliency services.
- Three RSNs (PRSN, NCWRSN, TRSN) examined a percentage of crisis services when monitoring clinical records.
- KCRSN and NCWRSN monitored all inpatient authorization requests and had implemented enhanced coordination of care prior to discharge.
- Several RSNs took corrective action in response to the 2008 EQR report:

- NCWRSN revised its Client Rights and Responsibility booklet to inform enrollees how to obtain crisis and stabilization services.
- PRSN initiated a stratified chart as a mechanism to monitor initial authorization and reauthorization decisions.
- GHRSN completed a corrective action plan regarding medical necessity training for providers in October 2008.

### Opportunities for improvement

- Many RSNs did not monitor the turnaround time for authorization of service requests.
- Four RSNs (NCWRSN, TMRSN, KCRSN, NSMHA) lacked formal mechanisms to ensure that authorization decisions were based on consistent review criteria.
- PRSN and TRSN needed to monitor their contracted administrative service organizations to determine whether authorization review criteria were applied consistently, providers were consulted, and decisions to deny services, or to authorize services in amount, scope, or duration less than requested, were made by professionals with appropriate clinical experience.
- PRSN discovered 100 service authorizations that were not approved, although the enrollees received services.

### Recommendations for HRSA

- ***Clarify HRSA's expectations of the RSNs related to***
  - ***ensuring that authorization review criteria are applied consistently and that authorization decisions are made by appropriate personnel***
  - ***monitoring crisis and hospital stays to determine whether these services are related to lack of access to routine care or to inappropriate management at an outpatient level***
- ***Work with the RSNs to implement a more robust level-of-care system with a wider array of services to meet the unique needs of enrollees.*** Most RSNs approve authorizations solely on the basis of Global Assessment of Functioning scores and the Access to Care standards. An additional process is needed within the RSNs to manage enrollees' care to ensure providing an appropriate level of care based on the enrollee's functional status, and developing treatment approaches to build resiliency and progress toward recovery.

**Provider Selection:** As shown in Figure 6, four RSNs fully met this standard; six RSNs substantially met the standard; and two RSNs partially met the standard.

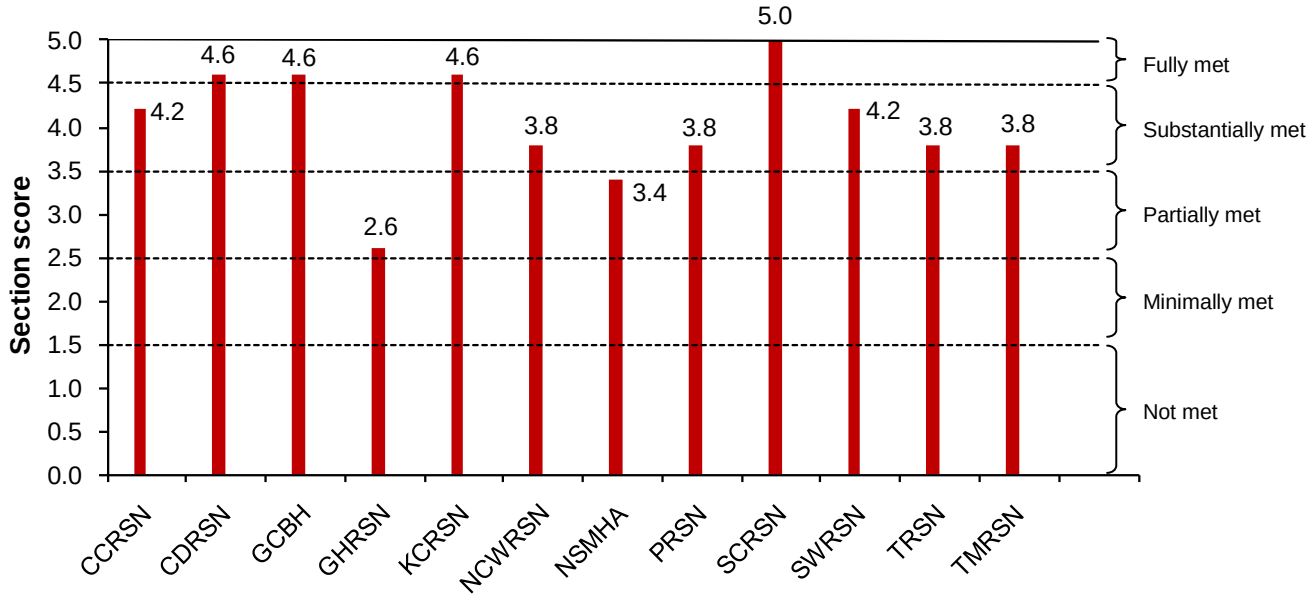



**Figure 6. RSN compliance scores: Provider Selection.**

### Strengths

- Nine of the 12 RSNs addressed credentialing requirements in their policies and provider contracts, and reviewed credentialing during provider site visits.
- Four RSNs (CCRSN, PRSN, NCWRSN, SCRSN) conducted annual credentialing site visits during which they reviewed providers' use of practice guidelines, policies and procedures, authorization decisions, data integrity, credentialing, and performance improvement initiatives.
- Two RSNs (SWRSN, SCRSN) had formal policies and procedures for credentialing.
- The credentialing files at SCRSN contained documentation of primary source verification and screening for exclusion.

### Opportunities for improvement

- Most RSNs lacked formal policies and procedures for credentialing of providers.
- Most RSNs' credentialing files lacked documentation of having verified providers' credentials through primary sources, such as the DOH website. In particular, RSNs that relied on county personnel departments to screen applicants and to check references before employment lacked complete documentation in their credentialing files.
- Five RSNs (GHRSN, GCBH, PRSN, NCWRSN, TMRSN) lacked policies and procedures for verifying the credentials of provider agency or RSN staff.
- Although the majority of RSNs required providers to screen their staff members for exclusion from participating in federal healthcare programs, half of the RSNs did not

consistently monitor their provider agencies for exclusion. In addition, eight RSNs did not monitor their own staff members for exclusion.

- Three RSNs (NCWRSN, SWRSN, NSMA) lacked formal processes for determining whether providers were excluded from participating in federal healthcare programs, and relied on the state to notify them of newly excluded providers or agencies.

### Recommendations for HRSA

- ***Provide clear direction to the RSNs regarding***
  - ***credentialing of RSN staff and monitoring of provider agency credentialing.*** The RSNs need to ensure that all provider agencies have licenses in good standing, and need to track corrective action required by the state until issues are resolved. Provider agency credentialing files need to contain documentation of licensing, corrective actions, and current liability insurance.
  - ***the expectation for routine screening to ensure that no RSN or provider agency staff are excluded from participating in federal healthcare programs***

**Subcontractual Relationships and Delegation:** As shown in Figure 7, two RSNs fully met this standard; eight RSNs substantially met the standard; and two RSNs partially met the standard.

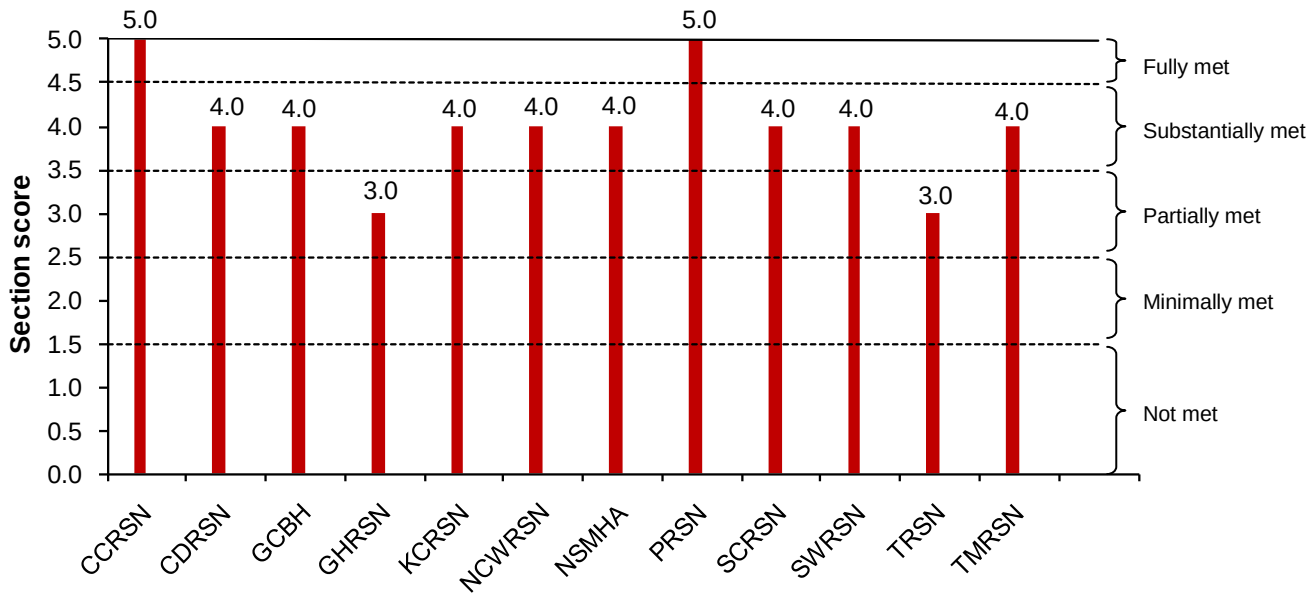



**Figure 7. RSN compliance scores: Subcontractual Relationships and Delegation.**

### Strengths

- Half of the RSNs addressed delegation in their policies and provider contracts, and routinely monitored the performance of delegated functions. CDRSN and NSMHA reviewed the performance of delegated activities quarterly.
- PRSN required each provider to complete a detailed report on how the provider met the previous year's expectations for activities outlined in the delegation agreement. PRSN and NCWRSN took action to correct deficiencies identified through monitoring.

### Opportunities for improvement

- Four RSNs (TRSN, SCRSN, GHRSN, CDRSN) performed incomplete monitoring of their subcontractors. Four RSNs (SCRSN, GHRSN, GCBH, SWRSN) had in place incomplete delegation agreements that did not address all activities.

### Recommendations for HRSA

- ***Define HRSA's expectations of the RSNs related to delegated activities, such as***
  - ***defining detailed contractual specifications***
  - ***monitoring all delegated activities, including those delegated to subcapitated providers, administrative service organizations, third-party administrators, and after-hours crisis services***
  - ***assessing potential subcontractors' ability to perform delegated activities before entering into contracts***

**Practice Guidelines:** As shown in Figure 8, eight RSNs fully met this standard; three RSNs substantially met the standard; and SCRSN partially met the standard.

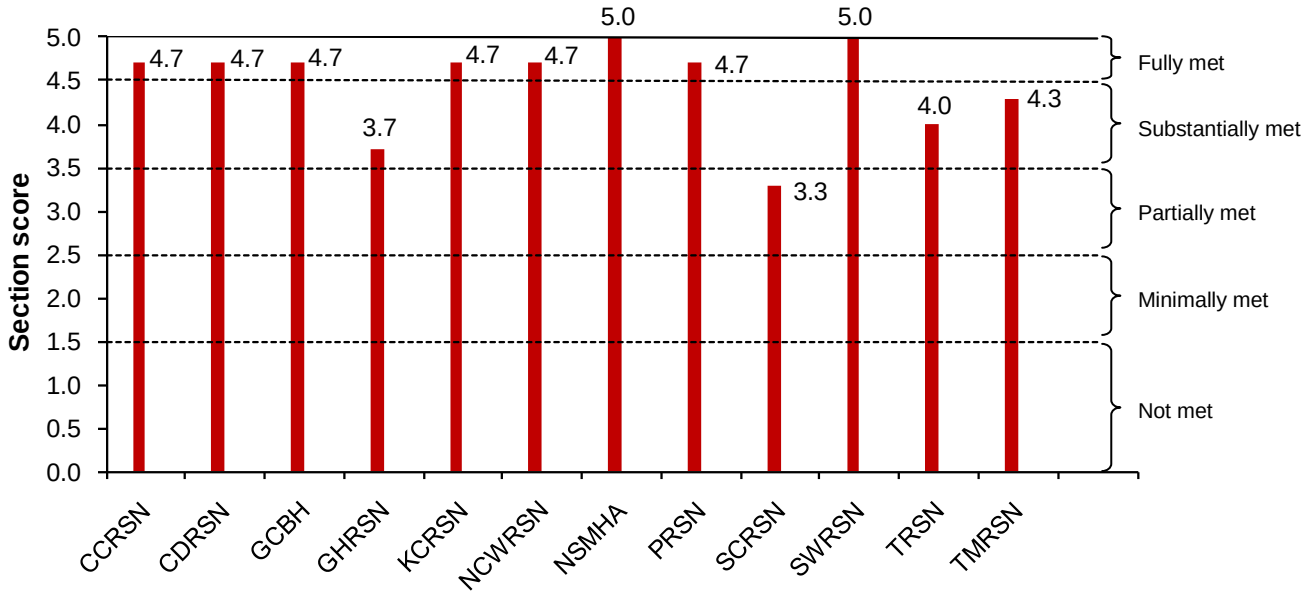



**Figure 8. RSN compliance scores: Practice Guidelines.**

### Strengths

- All RSNs had implemented at least one clinical practice guideline. The majority of RSNs had developed their guidelines in cooperation with network providers and medical directors. TMRSN's committee charged with developing practice guidelines included consumers and family representatives as well as providers.
- Six RSNs (SWRSN, PRSN, CDRSN, CCRSN, NCWRSN, NSMHA) had guidelines based on those of nationally recognized organizations.
- TMRSN reviewed service utilization data to assess enrollee needs as a guide in developing practice guidelines. KCRSN, in developing its guidelines for schizophrenia and for other specific diagnoses, had an internal workgroup analyze prevalent diagnoses, solicit feedback from providers, and research evidence-based practices.
- Nine of the 12 RSNs used clinical record review to monitor providers' implementation of their practice guidelines.
- CCRSN conducted provider education and training on its guidelines.

### Opportunities for improvement

- GHRSN and TMRSN each needed to adopt a second practice guideline to meet contractual obligations.
- GCBH and SCRSN did not monitor providers' use of practice guidelines.
- CDRSN and KCRSN lacked policies on the dissemination of guidelines.

### Recommendations for HRSA

- ***Provide clarification for RSNs as to how they can meet the requirement for practice guidelines by adopting evidence-based practices.***

**QAPI Program:** As shown in Figure 9, seven RSNs fully met this standard; NSMHA substantially met the standard; and the remaining RSNs partially met the standard.

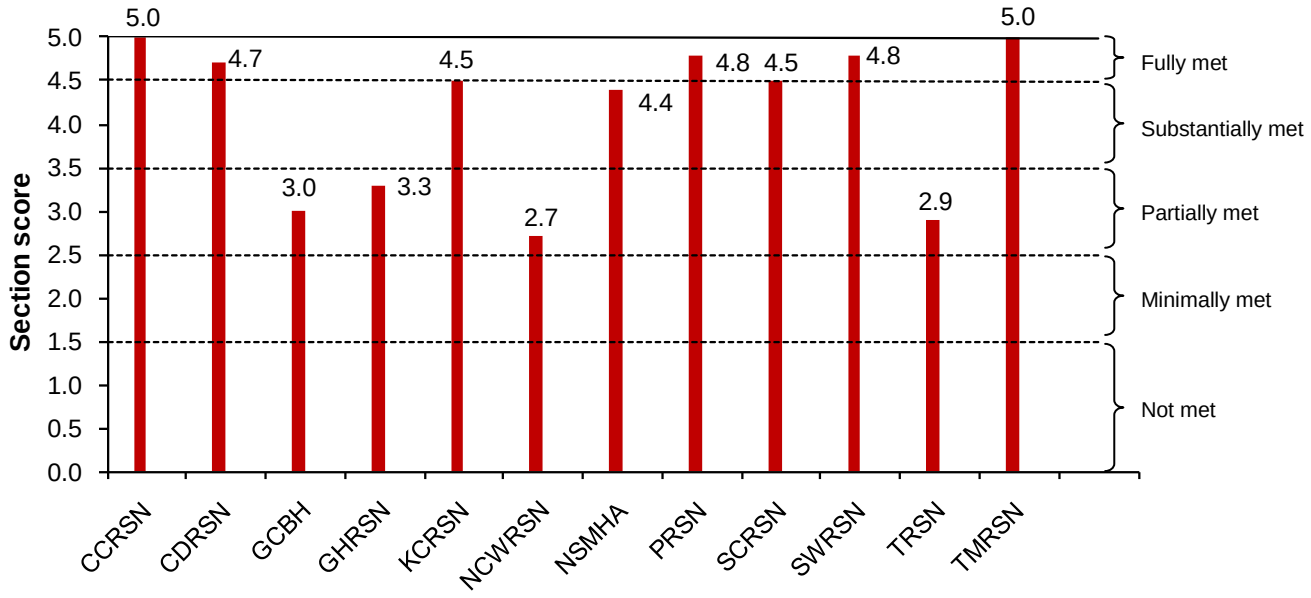



**Figure 9. RSN compliance scores: QAPI Program.**

### Strengths

- Four RSNs (TMRSN, SWRSN, PRSN, KCRSN) had extensive utilization management plans that involved performance monitoring through review of complaints and appeals, surveys, focused studies, service performance, and service trends.
- Five RSNs (SWRSN, PRSN, KCRSN, GHRSN, NSMHA) monitored for over- and underutilization through discussions with the clinical team and analysis of utilization by zip code and level of care. The RSNs had strategies in place to address overutilization and had conducted training for providers. KCRSN hired a consultant to study hospital utilization. NSMHA adjusted capitated payments to providers quarterly based on utilization and performance.
- Almost all RSNs assessed quality and appropriateness of care by methods such as onsite audits, weekly team meetings, and analysis of authorization data, complaints and appeals, and enrollee surveys. The RSNs took corrective action when deficiencies were identified.
- CDRSN's provider contracts specified expectations for quality and process improvement. GHRSN required its providers to perform an annual QI self-evaluation.
- Four RSNs (SCRSN, GCBH, CCRSN, NSMHA) had current QM plans. CCRSN's plan was robust, including key indicators, performance goals, target population, rationale, responsible party, and report schedule.
- Five RSNs (TMRSN, SWRSN, KCRSN, CDRSN, NSMHA) had quality management committees (QMCs) that met regularly.

- Four RSNs (SWRSN, PRSN, KCRSN, CDRSN) had QM programs that went above and beyond contract requirements by outlining lines of authority, clinical monitoring, incident reporting, utilization management, review of network capacity and service utilization, and solicitation and use of satisfaction data and stakeholder input.
- Four RSNs (TMRSN, SWRSN, CCRSN, NSMHA) conducted annual evaluation of their QM programs. TMRSN updated its annual QM plan by evaluating the previous year's activities. CCRSN's evaluation addressed achievements and effectiveness, fidelity to practice guidelines, and recommendations for the upcoming year.

**Information systems**

- Six RSNs (TMRSN, PRSN, KCRSN, CDRSN, GHRSN, CCRSN) had information systems that could track enrollee needs, identify concerns, and inform management decisions. These RSNs routinely generated extensive reports from encounter data. CCRSN met with providers monthly to discuss utilization and ensure data integrity.
- Seven RSNs (TMRSN, SCRSN, SWRSN, PRSN, KCRSN, CDRSN, GHRSN) conducted encounter data validation.

### Opportunities for improvement

- TRSN and CDRSN lacked methodologies, policies, or criteria to monitor for over- and underutilization.
- Four RSNs (GHRSN, KCRSN, GCBH, GHRSN) lacked criteria for underutilization. GCBH focused solely on overutilization of inpatient services.
- TRSN submitted no PIPs in 2009, and CDRSN submitted only one PIP.
- Four RSNs (SCRSN, GHRSN, NCWRSN, GCBH) lacked QM programs during 2008. Most RSNs that had QM programs failed to conduct a program evaluation in 2008.
- Three RSNs (TRSN, NCWRSN, GCBH) lacked processes to ensure taking action when quality-of-care issues were identified.
- GHRSN and NCWRSN suspended their QMCs during 2008.

**Information systems**

- Four RSNs (TRSN, NCWRSN, GCBH, GHRSN) generated data reports but did not use them to identify unmet needs or to inform management decisions.
- SWRSN and NCWRSN either did not have reporting systems or did not generate reports that could inform management decisions.
- Three RSNs (NCWRSN, TRSN, GHRSN) either did not conduct encounter data validation, or their data sample was too small to characterize current practices of the provider agencies.
- NCWRSN failed to transmit timely encounter data to the state during 2008.

### Recommendations for HRSA

- ***Clarify HRSA's expectations of the RSNs related to QM program implementation and evaluation.*** HRSA needs to enforce the contractual requirement for RSNs to maintain QM programs and to conduct an annual program evaluation for HRSA's review and approval.
- ***Provide direction for the RSNs on expectations for monitoring for underutilization of outpatient services.***
- ***To address overutilization, work with the RSNs to develop a system whereby the RSNs are involved in decision making before hospital admissions and in providing alternatives to hospital care.***

See also recommendations in the sections of this report that discuss PIPs, performance measure validation, and ISCA results.

**Certification and Program Integrity:** As shown in Figure 10, ten RSNs fully met this standard, and two RSNs substantially met the standard.

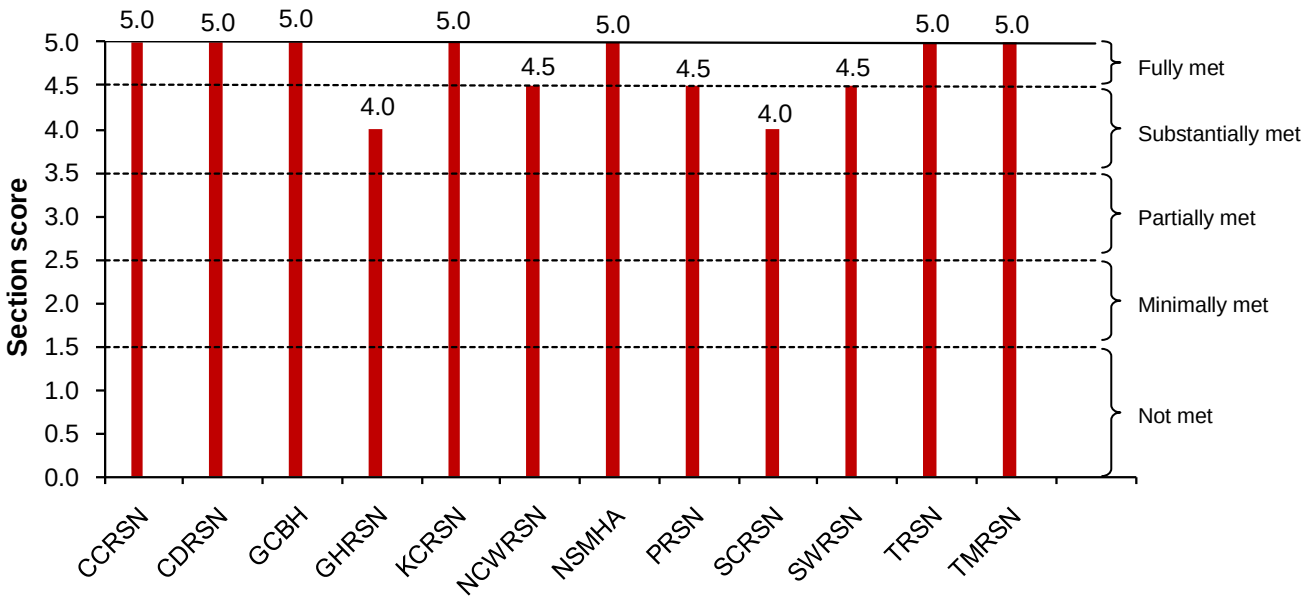



**Figure 10. RSN compliance scores: Certification and Program Integrity.**

### Strengths

- Nine RSNs had administrative and management procedures in place to guard against fraud and abuse. These RSNs had comprehensive compliance plans. They required their providers by contract to maintain administrative and management arrangements to guard against fraud and abuse, and monitored providers' compliance with those provisions.
- Ten RSNs provided training to staff related to fraud and abuse.
- Eight RSNs had compliance committees.
- Five RSNs (GHRSN, GCBH, KCRSN, PRSN, NSMHA) had tested their fraud and abuse detection and response systems. The RSNs investigated allegations and, when warranted, took action to recoup funds.
- CCRSN and KCRSN operated hotlines for reporting fraud and abuse.

### Opportunities for improvement

- Compliance officers at four RSNs (PRSN, NSMHA, SWRSN, SCRSN) needed fraud and abuse training or refresher courses.
- GHRSN had not fully implemented an internal auditing process.

### Recommendations for HRSA

- ***Work with RSNs to identify opportunities and resources to provide for training for RSN compliance officers in detecting and preventing fraud and abuse.***

## Corrective action plans

For 2009, HRSA required RSNs to submit corrective action plans (CAPs) to address findings of noncompliance with regulatory and contractual requirements. Table 3 shows the issues identified in compliance areas where corrective action was required.

**Table 3. Issues in RSN corrective action plans.**

| Compliance area | 42 CFR citations (see Appendix C) | Number of issues | Number of RSNs with issues |
|---|---|---|---|
| **Quality Assessment/Performance Improvement** | | | |
| Availability and timely access to services | *438.206 (b) & (c)(1)* | 12 | 7 |
| Cultural considerations | *438.206(c) (2)* | 1 | 1 |
| Coordination and continuity of care | *438.208(b)* | 6 | 3 |
| Authorization of services | *438.210* | 2 | 2 |
| Compensation for UM activities | *438.210 (c)* | 1 | 1 |
| Credentialing and recredentialing | *438.214(a)-(b)* | 9 | 8 |
| Excluded providers | *438.214(d)* | 7 | 7 |
| Contractual and subcontractual relationships, delegation, monitoring | *438.230* | 6 | 6 |
| Practice guidelines | *438.236* | 3 | 3 |
| QAPI program | *438.240* | 22 | 6 |
| **Information Systems Capabilities Assessment** | | | |
| | | 69 | 12 |

### Follow-up on CAPs from 2008

Table 4 on the following page shows the status of CAPs required of RSNs following the 2008 EQR cycle. CAPs were required for fewer than half of the RSNs regarding enrollee rights, grievances and appeals, and encounter data validation. CAPs were required for RSNs reviewed earlier in 2008, but not for those reviewed later in the year.

In addition, several of the RSNs have addressed recommendations from the individual EQR reports:

- PRSN added monitoring for coordination of care to its chart audit tool, and initiated a process to monitor authorization decisions.
- GHRSN provided training for agency staff on determining medical necessity.
- NCWRSN revised its Client Rights and Responsibility booklet to inform enrollees how to obtain crisis and stabilization services.

**Table 4. Status of corrective actions identified in 2008.**

| Compliance area | 42 CFR citations (see Appendix C) | Number of issues | RSN | Status of corrections |
|---|---|---|---|---|
| Enrollee Rights—policy | *438.100(a)* | 2 | GHRSN, SCRSN | resolved |
| Enrollee Rights—non-English materials | *438.100(b), 438.10(b-d)* | 1 | GHRSN | resolved |
| Enrollee Rights—advance directives | *438.100(b)(2), 438.128* | 3 | GHRSN, CCRSN, SCRSN | resolved |
| Enrollee Rights—seclusion and restraint | *438.100(b)(2)(v)* | 1 | GHRSN | resolved |
| Enrollee Rights—free choice | *438.10* | 1 | SCRSN | resolved |
| Grievances—mechanisms to monitor | *438.403(a)(b)* | 1 | GHRSN | resolved |
| Grievances—notice of action | *438.404* | 1 | CCRSN | resolved |
| Encounter data validation[a] | | 1 | GHRSN | resolved |
| Retention of authorization records | | 1 | SWRSN | resolved |

[a]This issue was identified during encounter data validation. MHD investigated the issue and requested a corrective action plan. GHRSN implemented acceptable corrective action, resolving the issue.

## 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 and again in 2009.

Because RSNs begin their PIPs at different times, and because PIPs are typically multi-year projects, the studies may be in different stages at the time of the EQR evaluation. Per the protocol approved by MHD, Acumentra Health scores all PIPs according to the same criteria, regardless of the stage of completion. As ongoing QI projects, the PIPs may not meet all standards the first year, but a PIP is expected to achieve better scores as project activities progress, eventually reaching full compliance.

### 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 5.

**Table 5. 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 2009 were scored on the 80-point scale. At the time of review, not all RSNs had begun their planned interventions, and the majority of 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 6 shows the compliance ratings and associated scoring ranges for PIPs graded on the 80-point scale. Appendix D presents a sample scoring worksheet.

**Table 6. 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 2009 PIP validation results

Table 7 shows the topics of the PIPs submitted by each RSN.

**Table 7. PIP topics by RSN, 2009.**

| 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: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder |
| | 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: Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization |
| | Nonclinical: Improved Access to Services—Intakes Provided Within 14 Days of a Service Request |
| NSMHA | Clinical: Decrease in the Days to First Prescriber Appointment After Request for Service |
| | 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: Implementing an Evidence-Based Practice |
| | Nonclinical: Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines |
| SWRSN | Clinical: Using Assertive Community Treatment to Decrease Consumer Hospital Utilization |
| | Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization |
| TMRSN | Clinical: Multisystemic Therapy |
| | Nonclinical: Improved Rate of Medicaid Adults Seen for a Non-Crisis Outpatient Appointment Within 7 Days of Discharge from a Psychiatric Inpatient Level of Care |
| TRSN | Clinical: Not submitted |
| | Nonclinical: Improving Coordination of Care with Primary Care Providers |

During 2009, most RSNs continued the same projects that Acumentra Health reviewed during the first EQR round in 2008. However, NCWRSN and TRSN began work on new nonclinical PIP topics, and NSMHA and SWRSN began work on new clinical topics.

**Progress on statewide PIP topic:** Nine of the 12 RSNs continued to study ways of improving the timeliness of outpatient follow-up appointments after discharge from psychiatric hospitalization. The 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, during 2006–2007, all RSNs performed below that benchmark.

In 2008 and 2009, MHD and the RSNs worked to resolve issues with the study data files provided to each RSN by MHD. Primarily, the RSNs noted a mismatch between MHD data and local RSN data in terms of which enrollees were seen for follow-up within seven days. These discrepancies caused significant variations in the RSNs' performance levels based on the data source. During 2008, the EQRO advised RSNs that they needed to continue making progress with the PIP regardless of the status of the MHD data. Ultimately, four RSNs elected to use the data provided by MHD to calculate their study indicators, and five others elected to use local or other data sources (e.g., MHD intranet files).

Most intervention strategies involved designating a clinical person or entity to conduct and monitor discharge planning and/or to contact the enrollee to schedule an outpatient appointment within seven days. As of 2009:

- 6 RSNs had developed an intervention strategy
- 7 RSNs had reported baseline data
- 4 RSNs had reported remeasurement data and results of a statistical analysis
- GHRSN and NSMHA had concluded that the PIP achieved statistical improvement
- GHRSN had concluded that the PIP achieved statistical *and* clinical improvement

Overall, a majority of the RSNs made important progress toward determining whether a given intervention strategy could improve the timeliness of outpatient follow-up. Four RSNs indicated that they would likely continue this PIP in 2010.

**PIP scores by validation standard:** Figure 11 shows the change in average scores by individual validation standard for all RSNs' PIPs from 2008 to 2009.

Across most standards, the RSNs considerably improved their study documentation and, thus, their scores. As a group, the RSNs *substantially* met Standards 1–3, addressing the study topic, question, and indicators, and *partially* met Standards 4–6, addressing the study population, data collection and analysis plan, and intervention goals and strategies. However, the RSNs only *minimally* met Standards 7 and 8, which involve reporting baseline and remeasurement data and analyzing the results of each intervention.

These patterns generally reflect the stage of the PIPs in terms of the performance improvement cycle. A PIP is considered complete after two remeasurements of sustained improvement and is then scored on a total of 10 standards. As of the 2009 reviews, none of the PIPs had progressed to the stage at which they would be scored on 10 standards. Fewer than half had progressed to a first remeasurement, a necessary step in order to report fully on Standards 7 and 8.

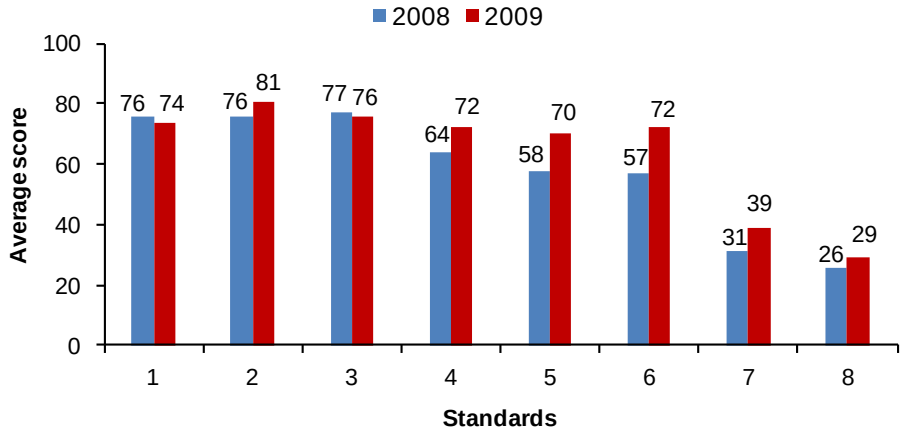



**Figure 11. Average scores by PIP validation standard, 2008 vs. 2009.**

**Overall PIP scores:** Figures 12 and 13 depict the change in overall scores for the RSNs' clinical and nonclinical PIPs, respectively, from 2008 to 2009. As shown, nine RSNs improved their clinical PIP scores and three RSNs scored worse. CDRSN, KCRSN, and TMRSN earned Fully Met scores.

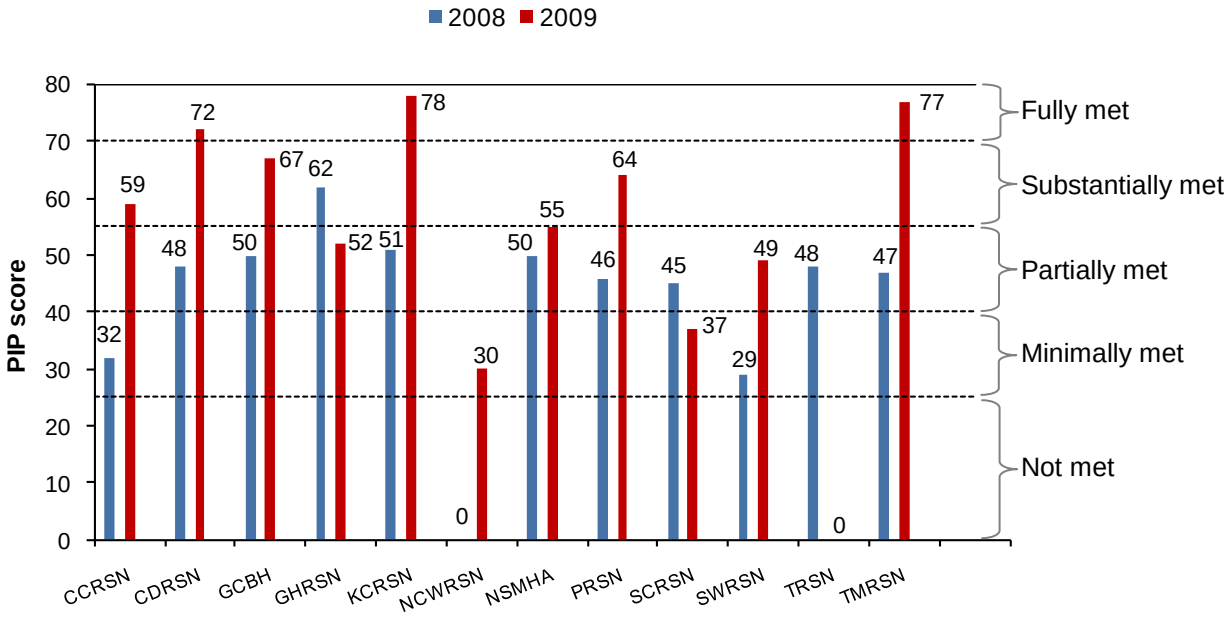



**Figure 12. RSN scores on clinical PIPs, 2008 vs. 2009.**

Looking at the nonclinical PIPs, seven RSNs improved their scores and five RSNs scored worse. GCBH, GHRSN, NSMHA, and TMRSN earned Fully Met scores.

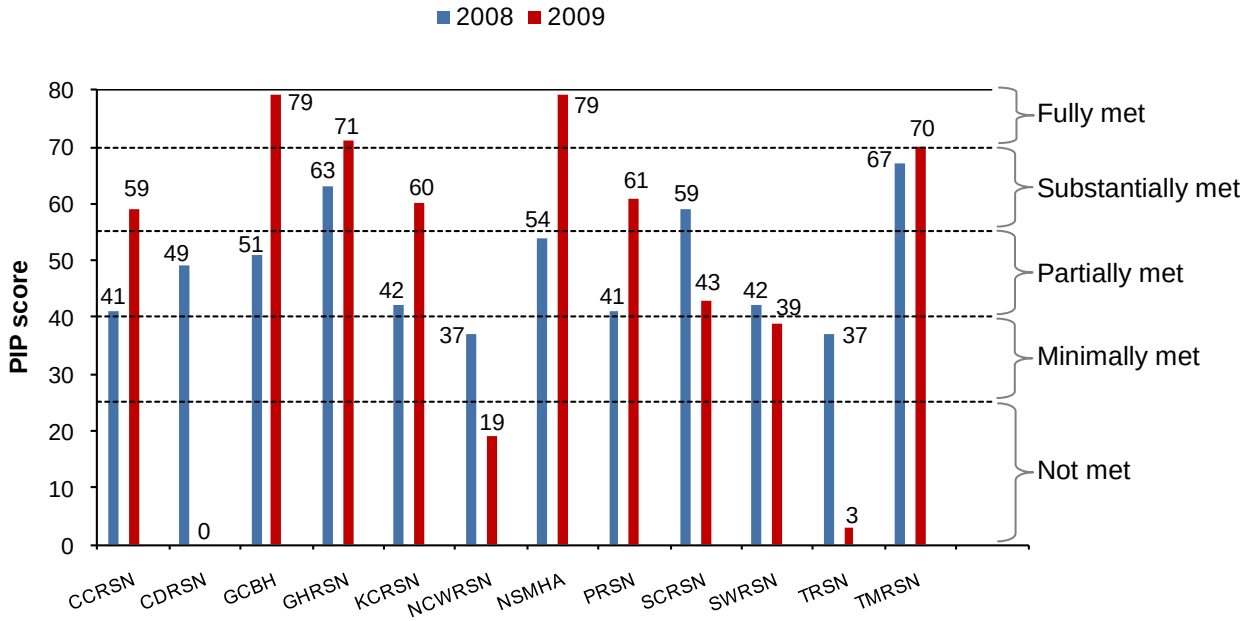



**Figure 13. RSN scores on nonclinical PIPs, 2008 vs. 2009.**

One reason why RSNs scored worse in 2009 was that they submitted little or no documentation for the current year, or submitted new documentation that did not address the standard(s) adequately. A second reason is that the expectations for PIP documentation increased because of PIP training and explicit recommendations in the 2008 EQR report that the RSNs needed to address. In addition, RSNs received no credit in 2009 for reporting planning efforts for Standards 7 and 8. To receive credit on Standard 7, the RSNs at a minimum had to present baseline data. To receive credit on Standard 8, RSNs had to be able to conclude whether the PIP had achieved statistical and/or clinical improvement, based on the results of an analysis comparing baseline and remeasurement data.

In general, ***RSNs need to take the following steps to achieve further improvement in their PIP scores and in their overall PIP programs.***

- Use local quantitative and qualitative data (e.g., enrollee complaints or grievances, focus group results) and barrier analyses to identify the highest-priority QI topics in the RSN system.
- Identify the precise barriers to improvement, and develop effective and targeted intervention strategies to address those barriers.
- Describe clearly the data validation procedures used to ensure that only enrollees who meet the study inclusion criteria are captured in the study population; this includes validating enrollees' Medicaid eligibility status.
- Describe clearly the data validation procedures for the study numerator, including why the data are considered accurate and reliable (e.g., corroboration against a second data source).
- Provide specific details of the data analysis plan, including the rationale for selecting a given statistical test and the probability level used to determine statistical significance.
- Describe how the intervention strategy is expected to improve the study indicator (e.g., how the intervention targets a specific barrier identified in the system, how the literature connects a strategy to specific outcomes).
- Monitor, track, and report on the implementation of the intervention strategy. 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.

## PIP descriptions and discussion

### Clark County RSN

**Clinical: Employment Outcomes for Adult Consumers.** The goal of this PIP is to increase the rate of employment among adult enrollees receiving routine outpatient services. CCRSN has implemented an employment campaign to advocate for employment of mental health consumers. The campaign targets consumers, providers, and community employers to increase awareness of this population's ability to be competitively employed. CCRSN has done well in designing and documenting all aspects of this PIP. At the time of review, however, CCRSN had not reported its baseline enrollee employment rate and had not completed its first remeasurement, as intervention activities began in mid-December 2008.

**Nonclinical: Timeliness of Access to Outpatient Services.** The goal of this project, initiated in 2006, is to improve the timeliness of enrollees' access to intake for routine mental health services. The goal for 2009 was to measure whether a network-wide notification and referral process can increase the percentage of enrollees offered an intake appointment within 10 days of a service request. CCRSN has done a good job of documenting many features of this PIP. However, CCRSN needs to be able to capture all enrollee requests for routine outpatient services. Because the real access issue may be provider agency capacity to conduct intakes, CCRSN plans to modify its intervention strategy to address capacity in the next phase of this PIP.

### Chelan-Douglas RSN

**Clinical: Metabolic Syndrome Screening and Intervention.** This PIP aims to reduce the risk of developing metabolic syndrome in enrollees with schizophrenia who use atypical antipsychotic medications. CDRSN screened eligible enrollees for symptoms and, where deemed necessary, intervened with a range of strategies that included educating enrollees about a healthy lifestyle, diet, exercise, and tobacco use, and linking them with PCPs. After collecting and analyzing remeasurement data, CDRSN concluded that it did not achieve significant improvement, and identified several barriers to improvement. CDRSN reported that it may modify the PIP by refining the study indicator, increasing the population size, and refocusing the PIP on increasing the number of enrollees successfully screened for metabolic syndrome.

**Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization.** In 2008, CDRSN submitted documentation of its work on this "statewide" PIP. For 2009, CDRSN submitted a template that the RSN PIP Workgroup had drafted for all RSNs to adapt in conducting the PIP. The template document contained none of the work reflected in CDRSN's 2008 documentation, nor did it update the RSN's progress since 2008. Although Acumentra Health extended the submission deadline, CDRSN provided no written or verbal documentation before the new deadline. CDRSN eventually submitted its nonclinical PIP, demonstrating that the RSN plans to address this deficiency in the upcoming review year, but it was not possible to include the results of the evaluation in this annual report.

### Grays Harbor RSN

**Clinical: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder.** The first phase of this PIP aimed to encourage the use of a standardized questionnaire, the PHQ-9, to measure symptoms of major depressive disorder (MDD) before and after treatment. The second phase aims to determine whether implementing

the MDD practice guideline and training clinicians to use it can reduce clinical symptomology for enrollees, as indicated by PHQ-9 scores. At the time of the 2009 review, GHRSN was collecting data to answer the study's second aim. The RSN had reported data for the first phase of the PIP, regarding use of the PHQ-9 questionnaire, but had not yet measured clinical outcomes for the expected improvement.

**Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization.** This PIP seeks to determine whether GHRSN can increase the percentage of enrollees who receive timely non-crisis outpatient appointments following discharge from a psychiatric hospital by assigning a discharge oversight clinician at the time of hospital admission to arrange follow-up care. GHRSN reported a significant improvement from baseline to first remeasurement in the number of enrollees receiving timely follow-up care. The RSN needs to conduct a barrier analysis to determine whether the intervention worked as planned and/or what other factors may have contributed to improvement in the study indicator, and document the results to demonstrate that the observed improvement was due to the intervention.

### Greater Columbia Behavioral Health

**Clinical: Impact of Implementing the PACT Model on the Use of Inpatient Treatment.** GCBH implemented the PACT model in October 2007 in Benton and Franklin counties, using a multidisciplinary team to offer intensive services to high-risk enrollees. The PIP aims to determine whether PACT reduces the number of inpatient psychiatric hospital days for Medicaid enrollees in the program. Preliminary study data indicate that 29 of the 40 enrollees spent fewer days in inpatient treatment, 5 spent more days, and 6 stayed the same. Overall, PACT enrollees averaged 70 inpatient days during the 12 months before PACT admission and 21 days during the 12 months following admission. These preliminary data suggest that the PACT model has succeeded, but data collection will not be complete until the end of December 2009.

**Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization.** GCBH's barrier analysis of baseline data revealed that 27 percent of enrollees with hospital discharges were not connected with a specific provider, and thus were less likely to receive timely follow-up services. GCBH focused its intervention strategy on this barrier by assigning care coordinators to notify a designated provider agency about the enrollee's hospitalization. However, the intervention did not involve a follow-up contact to determine whether the agency actually contacted the enrollee. GCBH reported that the strategy did not significantly improve the study indicator for the RSN as a whole or for the group of enrollees with no previous provider connection. GCBH plans to discontinue this PIP.

### King County RSN

**Clinical: Metabolic Syndrome Screening and Intervention.** This PIP aims to reduce the risk of developing metabolic syndrome in enrollees with schizophrenia who use atypical antipsychotic medications. KCRSN's provider agencies screened eligible enrollees for symptoms and, where necessary, intervened by educating enrollees about a healthy lifestyle and linking them to primary care. Initial results suggest that the interventions developed by providers were not strong enough to reduce the occurrence of metabolic syndrome symptoms. Following barrier analysis, KCRSN likely will refocus this PIP on increasing the rate of enrollees successfully screened for metabolic syndrome, rather than on trying to influence clinical outcomes directly.

**Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization.** To improve the timeliness of outpatient appointments following hospitalization, KCRSN formed a Centralized Diversion Team to review discharge planning, identify needed resources, and ensure continuity of care between inpatient and outpatient services. A pilot intervention with the largest inpatient service provider began in September 2009, and KCRSN may expand the intervention to other network hospitals if successful. KCRSN needs to collect and analyze its baseline and remeasurement data, test any changes for statistical significance, and determine whether the intervention succeeded in improving the study indicator.

### North Central Washington RSN

**Clinical: Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization.** NCWRSN submitted this PIP as its nonclinical PIP during 2008, but chose to modify the PIP and submit it as a clinical PIP for 2009. Baseline data for this PIP indicate that NCWRSN is performing well above the statewide average on follow-up after psychiatric hospitalization. The RSN should determine whether it needs to conduct a PIP on this topic or if its resources would be better used to address another quality issue.

**Nonclinical: Improved Access to Services—Intakes Provided Within 14 Days of a Service Request.** The goal of this PIP is to improve the timeliness of enrollees' access to routine outpatient care. However, NCWRSN's documentation does not establish that timely access to routine care represents a significant quality issue in the RSN's service area. According to MHD data, during 2008, 86 percent of NCWRSN's Medicaid enrollees were seen within 14 days of a service request, with an average of 10.7 days between the request and intake service.

For both PIPs, NCWRSN described its intervention strategy as "feedback to provider agencies and local data monitoring." However, NCWRSN provided no details about the interventions and did not describe how they represent new practices aimed at improving service delivery.

### North Sound MHA

**Clinical: Decrease in the Days to First Prescriber Appointment After Request for Service.** NSMHA began a new clinical PIP aimed at reducing the time between an enrollee's request for service and the first medication evaluation appointment. In 2008, enrollees waited an average of 94 days for their first such appointment following a service request. After a barrier analysis and examination of initial contacts with the mental health system, NSMHA decided to intervene at an enrollee's first ongoing outpatient appointment. The RSN plans to ask clinicians to follow a "decision tree" to determine whether an enrollee needs a medication evaluation appointment and, if so, to make a referral. At the time of review, the intervention had not yet received approval by NSMHA's Quality Management Oversight Committee. NSMHA plans to complete baseline data collection in 2009 and collect remeasurement data in 2010.

**Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization.** Baseline data show that only about half of NSMHA's enrollees received outpatient services within seven days of discharge from the hospital in 2008. The intervention, which began in July 2008, involved the RSN's provider agencies making contact with enrollees who were affiliated with the agencies, and the RSN's utilization management vendor contacting enrollees not affiliated with an agency, prior to hospital discharge. NSMHA determined that the intervention did not succeed since the vendor contacted only 1 percent of hospitalized enrollees. Following a barrier analysis, NSMHA made minor modifications to the intervention that

ultimately did not increase its effectiveness. Although NSMHA's follow-up rate showed a statistically significant improvement, the RSN concluded that because the intervention was not implemented successfully, the improvement was not clinically significant.

### Peninsula RSN

**Clinical: Metabolic Syndrome Screening and Intervention.** This PIP aims to reduce the risk of developing metabolic syndrome in enrollees with schizophrenia who use atypical antipsychotic medications. PRSN has screened eligible enrollees for symptoms of metabolic syndrome and, where deemed necessary, intervened with strategies that include educating enrollees on a healthy lifestyle, diet, exercise, and tobacco use, and linking them with PCPs. PRSN reported on its baseline study indicators and will complete collection of remeasurement data at the end of December 2009.

**Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization.** Baseline data showed that 79 percent of enrollees discharged from inpatient facilities received timely follow-up care. However, after careful analysis of the data, PRSN determined that 83 percent of enrollees discharged from E&T facilities were seen timely, versus only 67 percent of enrollees discharged from community hospitals. PRSN asked each provider agency to assign a hospital liaison to coordinate discharge planning for enrollees. Agency interventions have been in place since January 2009, and PRSN plans to compile remeasurement data in January 2010.

For both PIPs, PRSN thoroughly documented its topic selection process and the study questions, indicators, population, and data collection methods. The intervention strategies can reasonably be expected to improve the study indicators. PRSN needs to collect and analyze its remeasurement data, and interpret the results in terms of whether the interventions succeeded in producing the targeted improvement.

### Southwest RSN

**Clinical: Using Assertive Community Treatment to Decrease Consumer Hospital Utilization.** SWRSN initiated this PIP in 2008 to evaluate the success of the PACT model in reducing psychiatric hospital utilization. The RSN provided data on hospitalizations for PACT enrollees, as well as some data indicating that using PACT has saved costs. However, SWRSN did not calculate its study indicators or perform a planned statistical analysis to answer the study questions and determine whether its intervention resulted in performance improvement. To substantiate a link between PACT and a reduction in hospitalizations and cost, SWRSN needs to clearly define its study indicators, calculate them, compare baseline and remeasurement data, and discuss how any improvement is related to the intervention strategy.

**Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization.** SWRSN submitted this PIP in 2008 and 2009 but has made little progress toward identifying the RSN's baseline performance or appropriate intervention strategies. SWRSN has identified a barrier stemming from communication between the hospital discharge planner and the provider agency responsible for outpatient care. However, at the time of the PIP review, SWRSN still had not fully defined the study question, indicators, and population, the data collection and analysis plan, or the intervention by which it expects to improve the timeliness of outpatient follow-up.

### Spokane County RSN

**Clinical: Implementing an Evidence-Based Practice.** Feedback from the families of children in SCRSN's system indicated that the families perceived a lack of respect from providers. SCRSN responded by training its providers on the Motivational Interviewing (MI) technique, designed to increase clinical skills and engender more respectful and collaborative approaches to care. The goal of this PIP is to train 50 network clinicians to achieve and sustain competency in the MI approach. SCRSN needs to strengthen its documentation of technical aspects of this PIP, such as by explaining more thoroughly how the intervention is expected to increase enrollees' feelings of respect and their involvement in treatment. Baseline and remeasurement data were not available at the time of the PIP review.

**Nonclinical: Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines.** SCRSN has worked with its provider agencies to refine instructions for service encounter reporting. This PIP seeks to reduce reporting errors associated with the use of codes for reporting Rehab Case Management and Crisis Services encounters. SCRSN reported an initial reduction in coding errors as a result of its interventions, but the RSN has not clearly linked improved service reporting with better enrollee outcomes. In addition, because Rehab Case Management is not a Medicaid-funded service, the validity of the PIP topic is problematic. To adhere to the federal PIP protocol, SCRSN needs to focus the PIP exclusively on Medicaid enrollees and/or Medicaid services.

### Thurston-Mason RSN

**Clinical: Multisystemic Therapy.** This PIP aims to improve mental health outcomes for young enrollees served by multiple systems—e.g., mental health, juvenile justice, and chemical dependency services—through Multisystemic Therapy (MST), a community-based, family-centered care model. TMRSN collected data on school attendance, suicide attempts, substance abuse, and arrests to determine whether MST improved outcomes for 25 young enrollees. Very likely because of the small study population, TMRSN found no statistical significance between baseline and remeasurement data, but noted improvements ranging from 25 to 75 percent on three of the four outcome measures. On the basis of community team feedback, high fidelity scores on MST implementation, and preliminary data from the second remeasurement period, TMRSN believes that the intervention is improving outcomes for enrollees.

**Nonclinical: Improved Rate of Medicaid Adults Seen for a Non-Crisis Outpatient Appointment Within 7 Days of Discharge from a Psychiatric Inpatient Level of Care.** This PIP seeks to determine whether TMRSN can improve the timeliness of outpatient appointments following discharge by assigning a hospital liaison to work with enrollees during hospital stays and facilitate linkage to outpatient services. TMRSN reported performance rates of 51 percent at baseline and 53 percent at remeasurement after six months. The RSN concluded that the intervention did not result in statistical or clinical improvement, most likely because the hospital liaison position remained unfilled during part of the remeasurement period. TMRSN believes that since the position is now filled, the intervention is likely to improve performance in the coming year.

### Timberlands RSN

**Clinical: Not submitted.** For the 2008 EQR, TRSN submitted a clinical PIP focused on supported employment services for Medicaid enrollees. However, TRSN decided not to continue that PIP in 2009, citing "1915(b)(3) waiver constraints." At the time of the 2009 review, TRSN had not selected a replacement topic for its clinical PIP and had submitted no supporting documentation for the 2009 EQR.

**Nonclinical: Improving Coordination of Care with Primary Care Providers.** TRSN identified this topic after discontinuing its 2008 nonclinical PIP. Evidence from the 2008 EQR report and from internal studies showed that fewer than half of the clinical records for TRSN enrollees documented care coordination between mental healthcare providers and PCPs. Also, treatment plans rarely contained goals related to coordination of care. TRSN only submitted documentation to support Standard 1 of this PIP. Consequently, at the time of the 2009 review, TRSN had not defined the technical aspects of its study (e.g., study question, indicator, or population), nor the intervention it will use to improve performance.

## Mental health performance measure validation

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

Looking Glass Analytics, an Olympia-based consulting firm, contracts with the state to calculate the measures according to state-supplied methodology. Data for the calculations are collected through regular encounter data submissions from the RSNs.

Four statewide performance measures were in effect for 2008:

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.

For 2009, the state eliminated the two performance measures related to administering the Consumer Outcome Assessment.

During 2009, Acumentra Health assessed the completeness and accuracy of state performance measures and the procedural integrity of the information system for collecting, processing, and analyzing the data used in calculating the measures. The performance measure validation 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 the state use the measures to monitor the RSNs' performance over time and to compare their performance with health plans in other states?

### Validation results

The 2008 review found that data challenges had prevented MHD from calculating valid performance measures and assigning the measures to RSNs. Looking Glass Analytics calculated 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 did not meet CMS criteria because the calculation was based on a denominator of all patients discharged from state hospitals and E&T facilities, without regard to each patient's Medicaid eligibility.

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 and exclusion criteria. The details provided were insufficient to calculate the performance measures. In addition, discussions with MHD staff revealed that MHD had no documented routine process to monitor or verify the calculation of performance measures by Looking Glass Analytics.

As MHD made no substantive changes to the performance measures in 2008, the finding and recommendations reported in the 2008 EQR report remain valid.

**Table 8. Performance measure validation ratings, 2008.**

| 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 | 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 |

### 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.

## Follow-up on 2008 recommendations

The 2008 EQR report presented the following recommendations for MHD.

1. 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.

   ***2009 status:*** MHD reported having resolved this issue but submitted no documentation of its methodology for the EQRO to review. MHD incorporated a new data element, "Medicaid eligibility status," in all performance measures.

2. 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.

   ***2009 status:*** The 2009–2011 RSN contract, Section 8.3.1.5, sets improvement targets for the Core Performance Measures by reference to Exhibit E. The performance measure documentation specifies performance targets but does not present the rationale for using these targets or data to support their use.

3. Develop instructions for calculating each performance measure, including inclusion and exclusion criteria, source data tables, field names, and, when appropriate, codes (e.g., diagnostic, procedure, Medicaid eligibility, etc.).

   ***2009 status:*** MHD produced a document entitled "Final Draft PI Documentation Grid" that describes the formula for calculating each performance measure, including the inclusion and exclusion criteria and the source database. However, the document does not include source data tables or field names. Except for one measure, the descriptions do not report the procedure codes included in the measures. Although the procedure codes used to generate performance measure reports were attached to those reports, it was not possible to validate that the calculation of the performance measure occurred correctly without documentation of the procedure codes within the methodology.

   The descriptions of the numerator and denominator for each measure correctly describe a percentage, but the formula incorrectly divides that percentage. For example, in the first performance measure, MHD needs to eliminate the phrase "divided by the total number of discharges…" from the formula statement.

4. Develop and document a data archiving system to support future validations and additional analysis. A frozen data set would be the ideal solution.

   ***2009 status:*** As recommended, MHD now requires Looking Glass Analytics to freeze all data sets used to calculate the performance measures.

5. Develop and document a routine procedure to monitor or verify the calculation of performance measures.

   ***2009 status:*** MHD has made no progress with regard to this recommendation.

## Status of state performance measures

For 2009, MHD eliminated two performance measures and revised the two remaining measures, related to providing timely appointments for routine services and timely follow-up care after an enrollee's discharge from psychiatric hospitalization. MHD calculated these measures using 2008 data.

For 2010, the state will require RSNs to meet the following performance measures.

1. A routine outpatient service must be offered to a Medicaid client within 7 days of discharge from a psychiatric inpatient hospital or E&T facility.
2. Time from a request for service to a routine service offered shall be within 28 days.
3. Time from a service request to an intake service shall be within 14 days.
4. Consumer periodic data [such as activities concerning employment, current living situation, etc.] shall be submitted to the state on a timely basis, as defined in the RSN contract.
5. Outpatient encounters shall be submitted to the state within 60 days of the close of the month in which the services were provided (i.e., service month).

MHD revised the inclusion and exclusion criteria for the first three performance measures listed above. The most significant revision—limiting the population for each measure to Medicaid enrollees—would resolve the Finding presented on page 57. (See Recommendation #1 from 2008, above.) Acumentra Health reviewed these revisions and provided feedback. That process will continue as the state develops these measures further.

Near the end of 2009, MHD submitted the SAS code used by Looking Glass Analytics to calculate these measures. Acumentra Health received the revised code too late to incorporate a review of the code in this year's annual report.

## Information Systems Capabilities Assessment

Acumentra Health examined MHD's 2008 information systems and data processing and reporting procedures, and those of the individual RSNs, to determine the extent to which they supported the production of valid and reliable state performance measures and the capacity to manage the health care of RSN enrollees.

Assessment procedures, adapted from the CMS protocol for this activity, consisted of the following four phases.

1. Before the onsite reviews, Acumentra Health collected standard information about information systems from the ISCA data collection tool (ISCA-T) completed by MHD and the RSNs. Acumentra Health also asked MHD and the RSNs to submit other relevant documents at that time.
2. Acumentra Health reviewed the completed ISCA-T tools and accompanying documents. Where an answer seemed incomplete or indicated an inadequate process, Acumentra Health marked that section for follow-up and further review onsite.
3. Acumentra Health conducted a data center security walkthrough and a series of in-depth onsite and telephone interviews with key MHD and RSN staff members who completed the ISCA-T, as well as with other knowledgeable staff. The site visits provided additional information for assessing the integrity of information systems and data processing and reporting procedures. For the RSN reviews, Acumentra Health also interviewed provider agencies regarding their information systems, encounter/claims processing, and handling of enrollment data.
4. Following the site visits, Acumentra Health compiled and analyzed the findings about the information systems and the implications of the findings in terms of:
    a. the completeness and accuracy of any claims and encounter data collected and submitted to MHD
    b. the capacity of MHD and the RSNs to conduct QAPI initiatives
    c. the capacity of MHD and the RSNs to oversee and manage the delivery of mental health care to Medicaid enrollees
    d. the calculation of mental health performance measures

### Scoring scheme

Acumentra Health's ISCA review was organized in two main sections—(1) Data Processing Procedures and Personnel and (2) Data Acquisition Capabilities—with eight subsections. Each section contained review elements corresponding to relevant federal standards.

Within each section, Acumentra Health used the information collected in the ISCA-T, responses to interview questions, and results from the security walkthrough to score performance on each element on a scale from 1 to 3 (see Table 9 on next page).

After scoring the individual elements, Acumentra Health combined the scores and used a predetermined weighting system to calculate a weighted average score for each subsection. The detailed criteria for scoring are available from Acumentra Health upon request.

**Table 9. Scoring scheme for ISCA elements.**

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

## MHD information systems

In 2007, APS Healthcare, MHD's previous EQRO, conducted a state-level ISCA to evaluate the extent to which the state's information technology (IT) infrastructure supported the production and reporting of valid and reliable performance measures. APS Healthcare's report identified several state-level strengths, challenges, and recommendations.[8] Acumentra Health reviewed those findings for the 2008 EQR report and summarized the steps MHD had taken in response. In 2009, Acumentra Health conducted a full ISCA for MHD, the results of which follow.

During the review year (January–December 2008), MHD used a Microsoft SQL Server database management system, the Mental Health Division-Consumer Information System (MHD-CIS), to collect and process encounter data submitted by the RSNs.

MHD subcontracted with Looking Glass Analytics of Olympia to maintain and administer the web-based Performance Indicator (MHD-PI) system, which uses Looking Glass Analytics' proprietary query tool system to perform statistical analysis and generate reports from MHD-CIS encounter data.

The 2009 ISCA results reflect MHD's and Looking Glass Analytics' information systems and data processing procedures, as well as MHD's oversight and monitoring of Looking Glass Analytics and RSN-contracted activities.

Acumentra Health's review found that in 2008, MHD *partially met* federal standards related to data processing procedures and personnel, and *partially met* the data acquisition capabilities standards. Table 10 summarizes the ISCA scores and ratings.

**Table 10. Weighted average scores and ratings on state-level ISCA sections, 2009.**

| Review section/subsection | Score | Compliance rating |
|---|---|---|
| **Section 1: Data Processing Procedures and Personnel** | | |
| A. Information Systems | 2.5 | Partially met |
| B. Staffing | 2.5 | Partially met |
| C. Hardware Systems | 3.0 | Fully met |
| D. Security | 2.5 | Partially met |
| **Section 2: Data Acquisition Capabilities** | | |
| A. Administrative Data | 2.5 | Partially met |
| B. Enrollment Systems | 2.0 | Not met |
| C. File Consolidation | 3.0 | Fully met |

### State data processing procedures and personnel

MHD uses the MHD-CIS to collect and process encounter data submitted by the RSNs. The database runs on a Dell PowerEdge6850/Microsoft Windows Server 2003 rack server, with redundant array of independent disks (RAID) configuration. The database server is about four years old and still under vendor warranty.

MHD's IT services are located in the centralized Division of Systems and Monitoring (HRSA-DSM), which shares services, resources, and dedicated Structured Query Language (SQL) developers and database administrators. HRSA-DSM administers and maintains the MHD-CIS. HRSA-DSM employs three full-time, experienced programmers. However significant staff turnover has created a deficiency regarding long-term institutional memory. HRSA-DSM does not use established quantitative methods to measure the effectiveness of its programmers; instead, HRSA-DSM measures quality in terms of user satisfaction results.

HRSA-DSM has no formal Systems Development Life Cycle (SDLC) quality assurance process, including code auditing, to assist in reducing programming errors before the software is released into production. HRSA-DSM uses Visual SourceSafe for software configuration and source code (version control) management.

HRSA-DSM programmers use SAS, Transact SQL, Visual Basic for Applications, and Microsoft Excel for additional data analysis and reporting of Medicaid encounter data. The SAS application server and reporting data reside on Dell PowerEdge/Windows Server 2003 rack servers, with RAID configuration.

The MHD-CIS system is located in two separate locations: the Cherry Street Plaza building and the OB2 building. The entrance to both locations is secured at all times, and access is limited to personnel with a legitimate need for access to perform their jobs. HRSA-DSM performs daily differential backups and weekly full backups to a tape backup system. The backup tapes are transported in a locked container to an offsite location. HRSA-DSM performs regular restoration testing of backup tapes to ensure that data are readily available for production.

HRSA-DSM maintains a current Disaster Recovery Plan that is frequently audited and tested to ensure that information systems will be maintained, resumed, and/or recovered as intended. However, HRSA-DSM lacks a formal IT control framework—i.e., a set of generally accepted measures, indicators, processes, and best practices that help an organization ensure a sustainable information security compliance program.

HRSA-DSM and MHD representatives regularly attend data management meetings, such as the monthly Information Systems Data Evaluation Committee (ISDEC) meetings, which bring together state and RSN staff to review IT issues and data submissions.

Looking Glass Analytics maintains and administers the web-based MHD-PI system and provides SAS programming expertise for the benefit of HRSA-DSM programmers. The MHD-PI system uses Looking Glass Analytics' proprietary query tool system to perform statistical analysis and generate reports using data extracted from the MHD-CIS system.

MHD-PI web servers are located at Looking Glass Analytics' facility. Data are transmitted to and from Looking Glass Analytics via secure File Transfer Protocol (FTP) connection.

Looking Glass Analytics performs daily backups to a tape backup system. The backup tapes are transported offsite and stored at a personal residence. Looking Glass Analytics does not perform

regular restoration testing of backup tapes to ensure that data are readily available for production, nor does the contractor maintain a current Disaster Recovery Plan that is audited and tested.

MHD lacks effective monitoring and oversight of Looking Glass Analytics-contracted activities. MHD does have written policies in place that establish how Looking Glass Analytics should access, store, transport, and delete (upon termination of MHD's contract with Looking Glass Analytics) Medicaid encounter data residing on Looking Glass Analytics systems. However, MHD has no process to verify that these policies are being adhered to.

## Section 1A: Information Systems Score: 2.5 (Partially met)

This section of the ISCA protocol assesses the state's systems development life cycle (SDLC) and supporting environments, including database management systems and/or billing software, programming languages, and training for programmers.

A data storage and processing system that facilitates valid and reliable performance measurement would have the following characteristics:

- flexible data structures
- no degradation of processing with increased data volume
- adequate programming staff
- reasonable processing and coding time
- ease of interoperability with other database systems
- data security via user authentication and permission levels
- data locking capability
- proactive response to changes in encounter and enrollment criteria
- adherence to the federally required format for electronic submission of encounter data

To ensure accurate and complete performance measure calculation, best practices in computer programming include:

- good documentation
- clear, continuous communication between the client and the programmers on client information needs (e.g., analysis needs, reports)
- a quality assurance process
- version control
- continuous professional development of programming staff

### Strengths

- HRSA-DSM and MHD representatives regularly take part in data management meetings, such as the monthly ISDEC meetings.
- HRSA-DSM uses software configuration and source code (version control) management software.

- HRSA-DSM's and Looking Glass Analytics' software programming and IT staff are highly trained and experienced.

**Opportunities for improvement**

- MHD lacks effective monitoring and oversight of Looking Glass Analytics-contracted activities.

**Recommendations**

- MHD needs to monitor and oversee Looking Glass Analytics-contracted activities on the basis of written policies and instructions as to how Looking Glass Analytics should access, store, transport, and delete (upon termination of MHD's contract with Looking Glass Analytics) Medicaid data residing on Looking Glass Analytics systems.

## Section 1B: Staffing Score: 2.5 (Partially met)

This section of the protocol assesses the physical access by the MHD's staff to IT assets, as well as specific training requirements for programmers and new staff.

Best practices for sustaining quality in processing encounter data include

- adequately trained staff for processing and tracking errors in encounter data submission
- a comprehensive, documented formal training process for new hires and experienced professionals
- refresher courses for staff when updates occur and when new systems are implemented
- established and monitored productivity goals
- low staff turnover

**Strengths**

- HRSA-DSM provides programmers with formal training that includes mentoring by senior programmers.

**Opportunities for improvement**

- HRSA-DSM lacks adequate written policies and procedures describing its accepted productivity standards for IT staff who process encounter data.
- HRSA-DSM reports high turnover among its programming staff, which has created a deficiency regarding long-term institutional memory.

**Recommendations**

- HRSA-DSM needs to develop written policies and procedures describing its productivity standards for programming staff, to ensure timely and accurate data processing.
- HRSA-DSM needs to examine the reason(s) for high turnover among its programming staff, and develop knowledge-sharing tools to help preserve and manage institutional memory.

## Section 1C: Hardware Systems Score: 3.0 (Fully met)

This section assesses MHD's network infrastructure and hardware systems.

Best practices for sustaining quality hardware systems include

- infrastructural support that includes maintenance and timely replacement of computer equipment and software, disaster recovery procedures, adequate training of support staff, and a secure computing environment
- redundancy or duplication of critical components of a hardware system with the intention of increasing reliability of the system, usually in the case of a backup or fail-safe

### Strengths

- HRSA-DSM maintains current premium-level hardware, software, and network vendor service contracts.
- HRSA-DSM's data center facilities and hardware systems are well designed and maintained.
- HRSA-DSM takes full advantage of redundant software and hardware designs that include RAID configuration, and dual NIC and switch configuration.

## Section 1D: Security Score: 2.5 (Partially met)

This section assesses MHD's information systems for integrity and the capacity to prevent data loss and corruption. Acumentra Health conducts a security walkthrough of the computer area and/or data center to assess the possibility of a breach in security measures.

Best practices for securing data are summarized below.

- A well-run security management program includes IT governance, risk assessment, policy development, policy dissemination, and monitoring. Each of these activities should flow into the next in a cycle of activity to ensure that policies remain current and that important risks are addressed.
- Computer systems and terminals should be protected from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates.
- Paper-based claims and encounters should be in locked storage facilities when not in use.
- Data transferred between systems/locations should be encrypted.
- A comprehensive backup plan includes, but is not limited to, scheduling, rotation, verification, retention, and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.
- To ensure integrity, backups should be verified periodically by performing a "restore" and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite climate-controlled facility.

- Databases and database updates should include transaction management, commits, and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
- Formal controls in the form of batch control sheets or assignment of a batch control number should be used to ensure a full accounting of all claims received.

**Strengths**

- HRSA-DSM performs daily differential backups and weekly full backups of MHD-CIS data to a tape backup system. Backup tapes are stored offsite.
- HRSA-DSM's backup and restoration processes are well documented and tested.
- HRSA-DSM has a current Disaster Recovery Plan that is frequently audited and tested to ensure that information systems will be maintained, resumed, and/or recovered as intended.
- HRSA-DSM maintains current "Antivirus Guidelines" policies and up-to-date antivirus protection on all computers and servers.

**Opportunities for improvement**

- HRSA-DSM's IT security policies and procedures, although well documented, are not managed within an organized control framework (a set of generally accepted measures, indicators, processes, and best practices that help an organization improve its security posture). This makes it difficult for Acumentra Health to affirm that HRSA-DSM's current information security policies and procedures are adequate.
- Looking Glass Analytics does not have a current IS Disaster Recovery Plan in place.
- Looking Glass Analytics does not store backup tapes of MHD's data in a secure offsite location.

**Recommendations**

- HRSA-DSM needs to adopt an IT control framework to help build control structure and ensure a sustainable information security compliance program.
- Looking Glass Analytics needs to develop an IS Disaster Recovery Plan that includes a formal process for auditing and testing the plan. Looking Glass Analytics should conduct periodic table-top audits and onsite practice drills to determine the plan's effectiveness and identify needed changes.
- Looking Glass Analytics should store backup tapes of MHD's data in a secure offsite location. Storing backup tapes offsite at a secure location is a crucial component of a Disaster Recovery Plan.

### State data acquisition capabilities

HRSA-DSM oversees and monitors Medicaid encounter data submission. HRSA-DSM accepts encounter data from the RSNs in ANSI X12N 837 electronic format only. At least monthly, the RSNs connect to the MHD-CIS via a secure FTP service on the Inter-Governmental Network (IGN) to transmit batched encounter data. The Washington State Department of Information Services monitors and manages the security of the IGN network environment.

MHD-CIS processes encounter data using Microsoft BizTalk Server and BizTalk Accelerator for HIPAA to ensure HIPAA transactional compliance. Encounter data submissions run through an automated, rules-based edit system in MHD-CIS to screen the data, identify potential input errors, and ensure compliance with MHD-CIS Data Dictionary and Service Encounter Reporting requirements. If an error occurs, an exception report is created and sent to the RSN to enable the RSN to examine possible encounter errors and to make corrections. HRSA-DSM manages and monitors RSN encounter data certifications for accuracy and completeness.

HRSA-DSM performs monthly reconciliation activities to verify the authorization status of each encounter service, provider credentials, member-month eligibility files, member ID codes, and income source and program codes. HRSA-DSM supplies monthly summaries of encounter data submissions, error reports, and certification reports to MHD for review.

HRSA-DSM and MHD representatives regularly attend data management meetings, such as the monthly Performance Data Group (PDG) meetings, at which MHD, RSN, provider, and consumer members review performance indicators, consumer outcomes, and data quality reports to develop reports for all levels of the state's mental health system.

Although MHD requires the RSNs by contract to perform encounter data validation audits of contracted provider agencies, MHD does not adequately enforce RSN compliance with this contract requirement.

MHD's Medicaid eligibility files are updated once a month. MHD downloads a flat fixed-length file from the MMIS system and then imports the data into the MHD-CIS for further processing, which includes assigning the enrollee to an RSN. The RSNs are responsible for removing duplicate enrollees from the system.

MHD's performance measurement and report production system lacks sufficient documentation and relies heavily on the expertise of Looking Glass Analytics. While RSNs are responsible for meeting performance targets, they do not calculate the performance measures. Looking Glass Analytics calculates the measures using the state-supplied methodology.

MHD does not document the entire process for producing performance measures, including steps for importing data, building tables, creating reports, and archiving data; data sources; edit and validation routines; a current data dictionary; and the person or position responsible (including team or unit) for each part of the production process.

MHD facilitates the Performance Indicator Workgroup, a statewide workgroup representing MHD, the RSNs, and provider agencies, whose members work on improving methodology to clarify the interpretation of performance targets and results.

## Section 2A: Administrative Data Score: 2.5 (Partially met)

This section of the ISCA protocol assesses the MHD's submission of accurate information, process for describing differences when verifying accuracy of submitted claims, and data assessment and retention.

To ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, it is important to have documented standards, a formal quality assurance of input data sources and transactional systems, and readily available historical data. Best practices include:

- automated edit and validity checks of procedure and diagnosis code fields, timely filing, eligibility verification, authorization, referral management, and a process to remove duplicate claims and encounters
- a documented formal procedure for rectifying encounter data submitted with one or more required fields missing, incomplete, or invalid. Ideally, the data processor would not alter the data until receiving written notification via a paper claim or from the provider.
- periodic audits of randomly selected records conducted internally and externally by an outside vendor to ensure data integrity and validity. Audits are critical after major system upgrades or code changes.
- multiple diagnosis codes and procedure codes for each encounter record, distinguishing clearly between primary and secondary diagnoses
- efficient data transfer (frequent batch processing) to minimize processing lags that can affect data completeness

### Strengths

- Encounter data submitted electronically by the RSNs pass through a stringent screening process to ensure data accuracy and validity.
- HRSA-DSM performs automated pre- and post-adjudication edits and verification checks in MHD-CIS to ensure the completeness and correctness of submitted encounter data.
- HRSA-DSM provides exception reports to RSNs to enable them to examine possible encounter errors and to make corrections.

### Opportunities for improvement

- Although MHD requires the RSNs by contract to perform encounter data validation audits of contracted provider agencies, MHD does not adequately enforce RSN compliance with this contract requirement.

### Recommendations

- MHD needs to ensure that RSNs perform encounter data validation audits of contracted provider agencies to ensure completeness and correctness of encounter data.

## Section 2B: Enrollment Systems Score: 2.0 (Not met)

This section assesses the MHD's Medicaid enrollment systems pertaining to enrollment and disenrollment processes, tracking claims and encounter data, Medicaid enrollment data updates, Medicaid enrollment code, and data verification.

Timely and accurate eligibility data are paramount in providing high-quality care and for monitoring services reported in utilization reports.

Best practices are summarized below.

- Access to up-to-date eligibility data should be easy and fast.
- Enrollment data should be updated daily or in real time.
- The enrollment system should be capable of tracking an enrollee's entire history within the MHD, further enhancing the accuracy of the data.

### Strengths

- HRSA-DSM performs frequent audits of MHD's eligibility enrollment files to ensure that they are free of anomalies.

### Opportunities for improvement

- Although HRSA-DSM requires each RSN to remove duplicate enrollees from the eligibility files, HRSA-DSM provides no process or method to accomplish this.

### Recommendations

- HRSA-DSM needs to provide the RSN with a process or method for removing duplicate enrollees from the eligibility files.

### Finding

MHD does not provide the RSNs with a method for updating enrollee eligibility information reported to them by contracted provider agencies. A method to track, monitor, and resolve duplicate and/or erroneous enrollment information in a timely manner is necessary to deter and detect possible Medicaid fraud and duplication of benefits.

## Section 2C: File Consolidation Score: 3.0 (Fully met)

This section assesses the structural components of MHD's information systems, focusing on the collection of administrative, encounter, and clinical data and the consolidation or coordination of those data files for use in performance measurement and QI activities.

An ideal file consolidation system includes:

- use of appropriate data, including linked data from separate data sets
- procedures to avoid or eliminate double-counting enrollees or numerator events

- procedures for frequent review of the programming logic or for demonstration of the program, to confirm that non-standard codes are mapped to standard codes in a consistent, complete, and reproducible manner
- adherence to the parameters required by the specifications of the performance measure
- assurance that the process of integrating administrative and medical record data for the purpose of determining the numerator is consistent and valid

### Opportunities for improvement

- Data reporting limitations prevent MHD from properly calculating the required statewide performance measures.
- The performance measurement and report production system lacks sufficient documentation and relies heavily on the expertise of Looking Glass Analytics.

### Recommendations

- MHD needs to work with state hospitals, RSNs, and vendors to correct any data reporting limitations that prevent calculation and validation of the required performance measures.
- MHD needs to document the entire process for producing performance measures, including steps for importing data, building tables, creating reports, and archiving data; data sources; edit and validation routines; a current data dictionary; and the person or position responsible (including team or unit) for each part of the production process.

### RSN information systems

In addition to the state-level ISCA, Acumentra Health conducted a full ISCA for each RSN during 2009, identifying strengths, challenges, and recommendations at the RSN level. These reviews (examining the status of RSNs' information systems during 2008) revealed the following major themes.

Fully Met scores generally reflected the following strengths.

- Stringent screening process to verify data accuracy and validity
  - The RSN performed automated edits and verification checks to ensure completeness and correctness of submitted encounter data, including provider identification, diagnosis and procedure codes, eligibility verification, and service authorization.
- Frequent encounter data validation
  - The RSN performed regular audits of encounter claims to ensure data integrity and validity.
- The RSN's enrollee data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care.
- The RSN showed evidence demonstrating that encounter claims submitted by providers were processed accurately and within the state's required time frame.
- Data center facilities and hardware systems were well designed and maintained, and included up-to-date, premium-level vendor service contracts.

Scores of less than Fully Met generally reflected the following deficiencies.

- Inadequate oversight
  - The RSN lacked elements of IT governance, such as an IT control framework, an IT steering committee, or management reports.
  - The RSN performed inadequate oversight of third-party administrators, application service providers, and/or vendors.
- Inadequate basic IT security procedures
  - The RSN lacked a Disaster Recovery Plan or had not tested its plan.
  - RSN and/or provider personnel transported backup media by unsecure means—e.g., using unlocked cases and unencrypted backups.
  - The RSN performed no formal restoration testing of backup media.
  - The RSN maintained no technical documentation, including for network schematics.
  - Data sets for essential reports were not frozen.
- Inadequate administrative controls for encounter data
  - The RSN lacked formal policies and procedures for encounter data processing and submission.
  - The RSN had not implemented batch controls.
- Incomplete or absent provider profile directory. Such a directory can help enrollees to make informed choices among network providers.

During 2008, six RSNs contracted with Behavioral Healthcare Options (BHO), a third-party administrative services organization, for utilization management, including initial service authorization and enrollee eligibility verification. Although GCBH performed an audit of BHO on behalf of these RSNs in June 2008, the RSNs lacked effective monitoring and oversight of BHO-contracted activities.

BHO collected and warehoused Medicaid enrollment and service utilization data in its Facets system without express permission from any RSN to do so. The RSNs had no written policies in place to establish how BHO should access, store, transport, and delete Medicaid enrollment and service utilization information residing on BHO systems. In addition, BHO denied Acumentra Health's request to perform a security walkthrough of BHO's data facilities. Therefore, Acumentra Health could not affirm BHO's compliance with relevant federal standards regarding the security of RSN Medicaid data.

The following pages present the scores for individual RSNs on each subsection of the ISCA review protocol. The subsections and criteria for the RSN reviews are similar to those used for the state-level ISCA, except that the RSNs are not evaluated for File Consolidation, but for these elements of the RSN information system:

- The **Vendor Data Integrity** subsection assesses how the RSN integrates vendor data with administrative data for completeness of data and quality of data.
- The **Provider Data** subsection examines whether the RSN's compensation structure balances contractual expectations, enrollees' needs, and capitation rates set by the state. It also assesses whether the RSN provides an accessible database of qualified providers, ideally with current information on clinicians' gender, credentials, treatment specialties, languages spoken, and whether the provider's office meets accessibility standards of the Americans with Disabilities Act.

**Information Systems:** As shown in Figure 14, five RSNs fully met the criteria for this subsection; six RSNs partially met the criteria; and NCWRSN failed to meet the criteria.

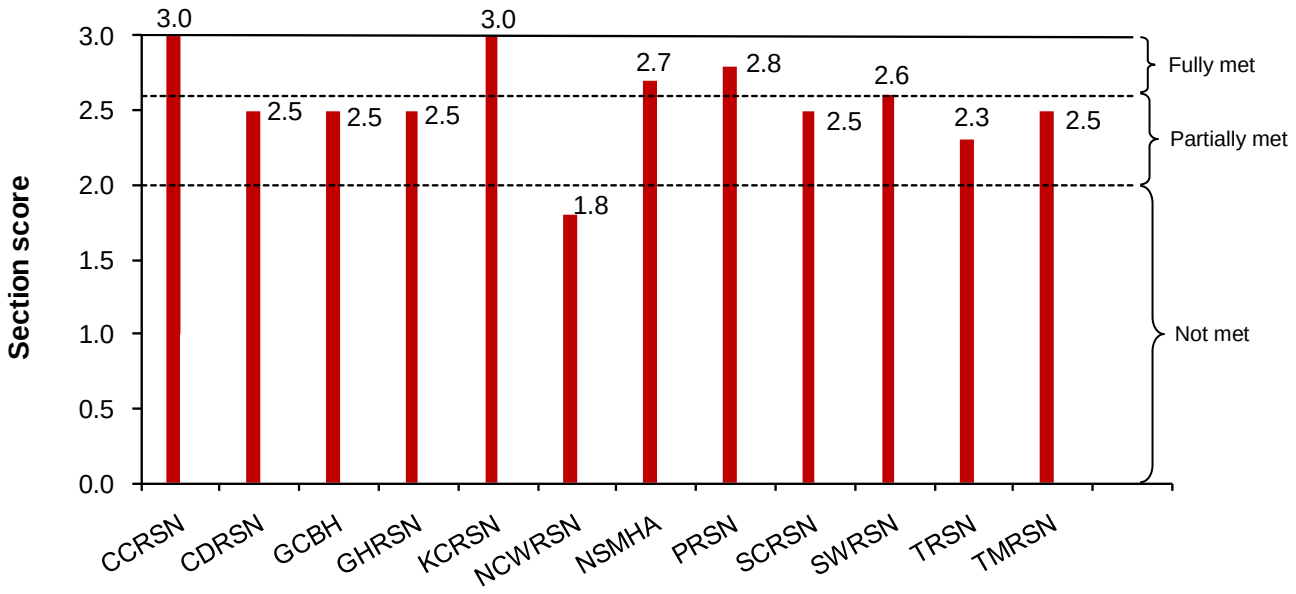



**Figure 14. RSN ISCA scores: Information Systems.**

**Staffing:** As shown in Figure 15, six RSNs fully met the criteria for this subsection; five RSNs partially met the criteria; and NCWRSN failed to meet the criteria.

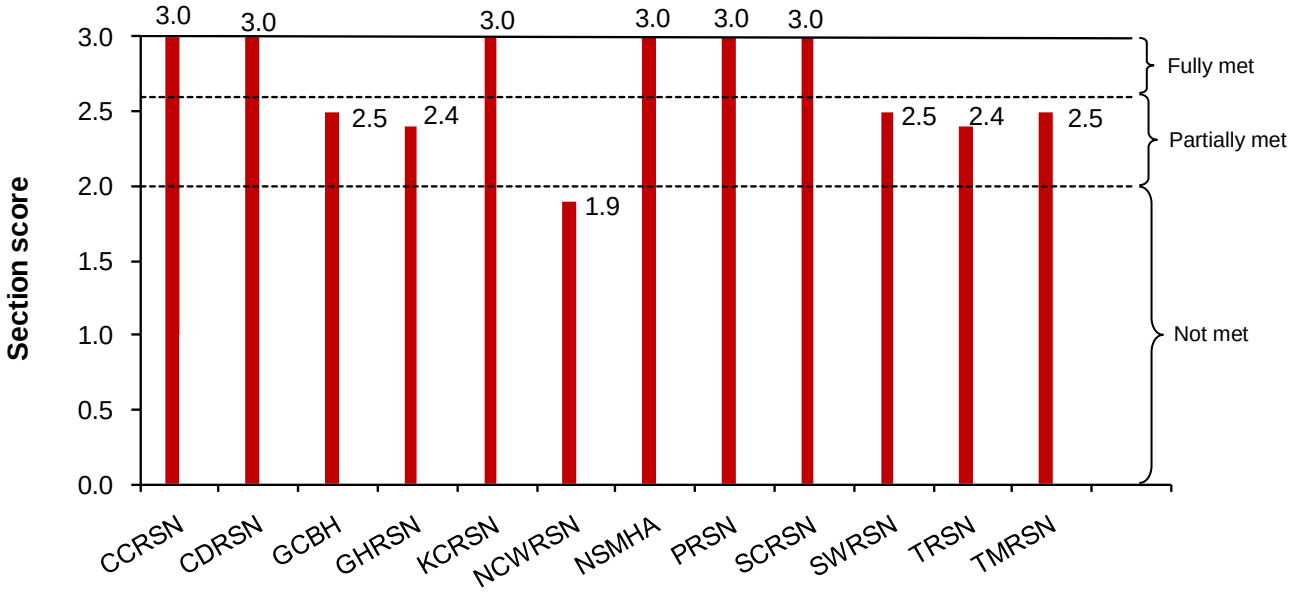



**Figure 15. RSN ISCA scores: Staffing.**

**Hardware Systems:** As shown in Figure 16, seven RSNs fully met the criteria for this subsection; four RSNs partially met the criteria; and PRSN failed to meet the criteria.

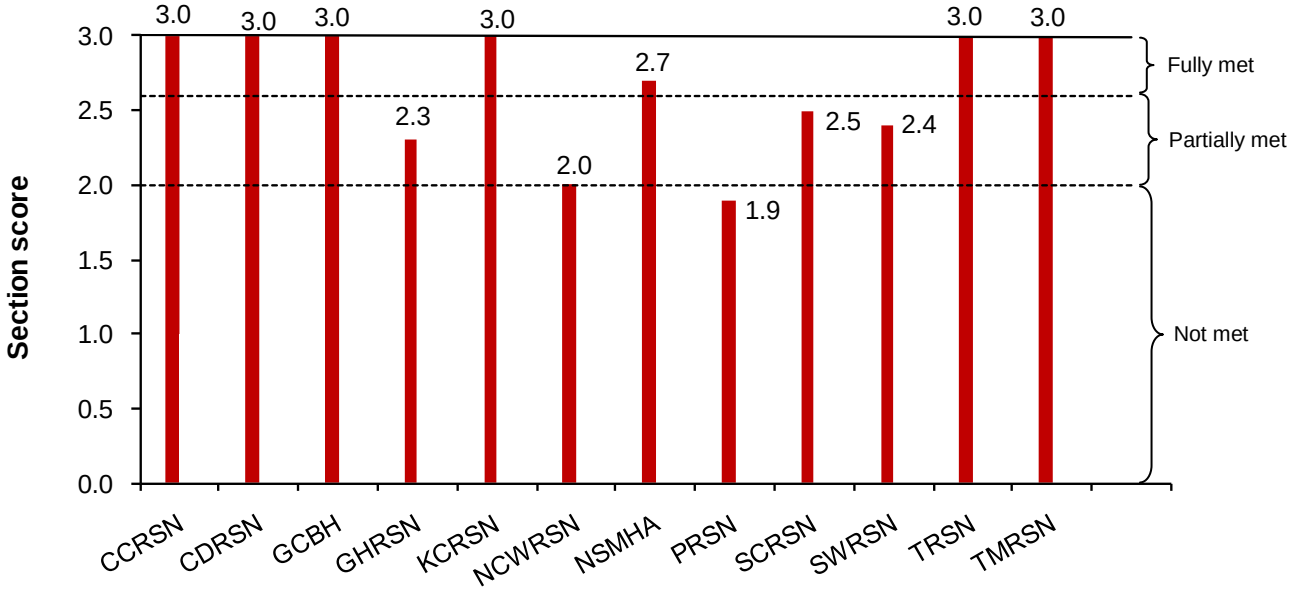



**Figure 16. RSN ISCA scores: Hardware Systems.**

**Security:** As shown in Figure 17, three RSNs fully met the criteria for this subsection; eight RSNs partially met the criteria; and NCWRSN failed to meet the criteria.

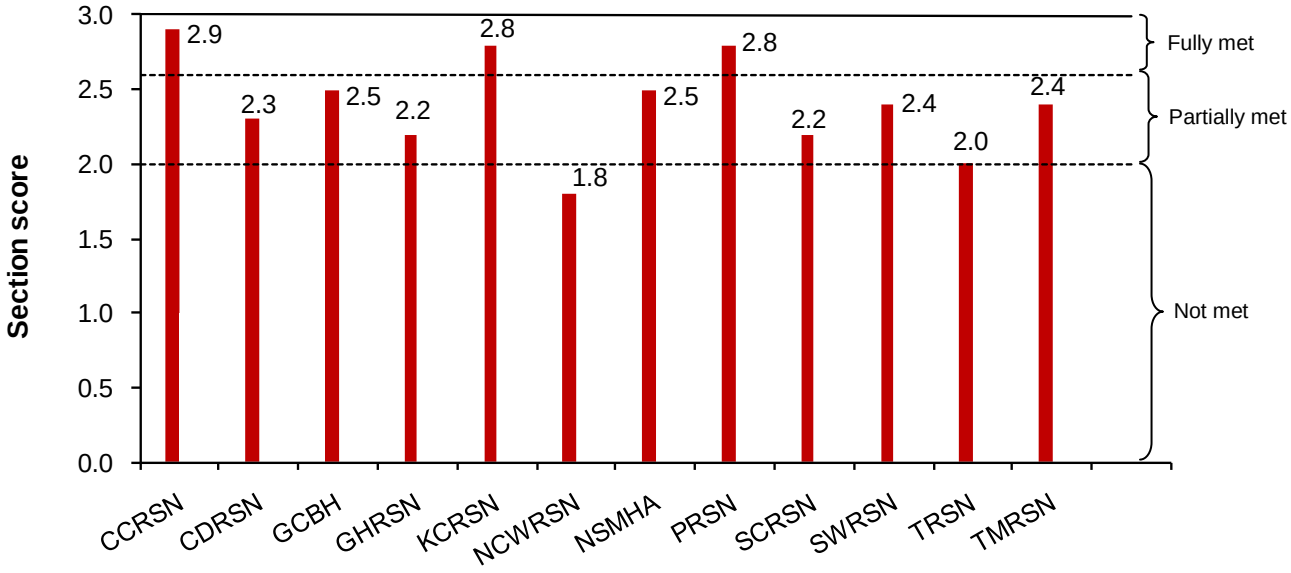



**Figure 17. RSN ISCA scores: Security.**

**Administrative Data:** As shown in Figure 18, ten RSNs fully met the criteria for this subsection, and two RSNs partially met the criteria.

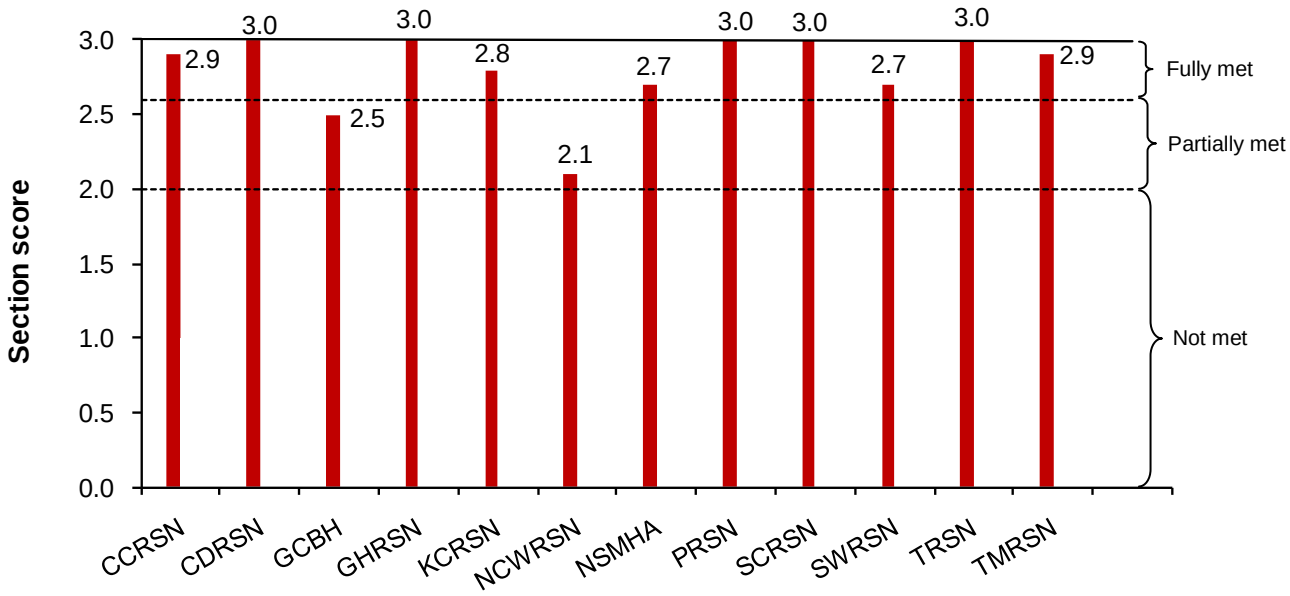



**Figure 18. RSN ISCA scores: Administrative Data.**

**Enrollment System:** As shown in Figure 19, all RSNs except NSMHA fully met the criteria for this subsection.

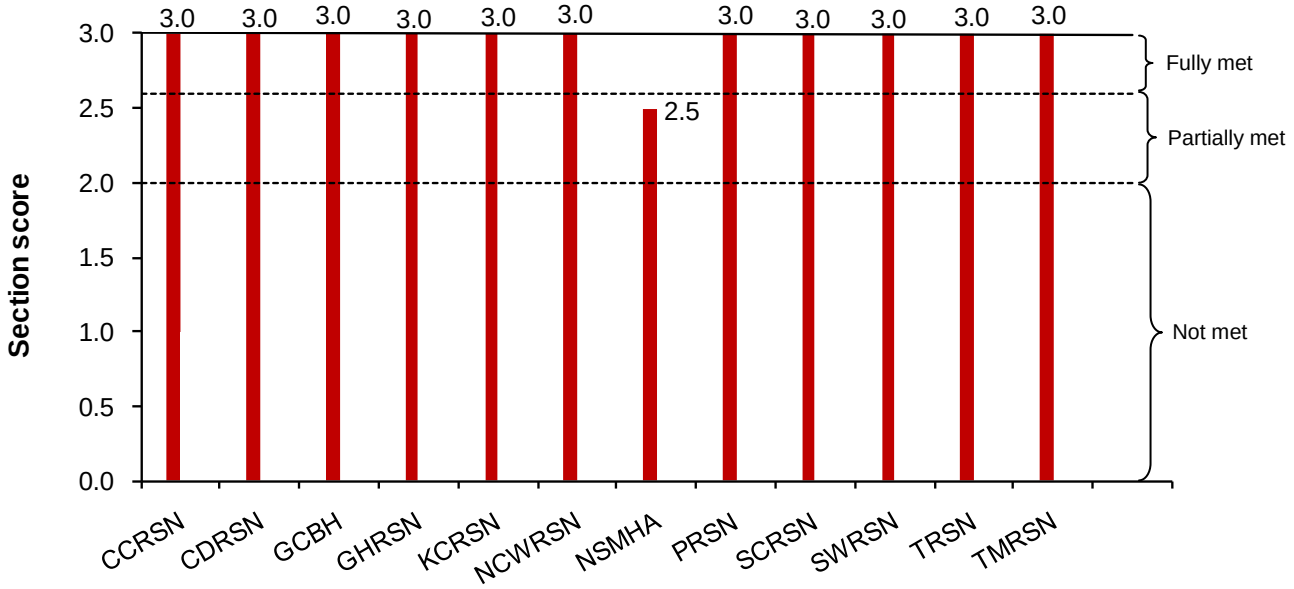



**Figure 19. RSN ISCA scores: Enrollment System.**

**Vendor Data Integrity:** As shown in Figure 20, all RSNs fully met the criteria for this subsection.

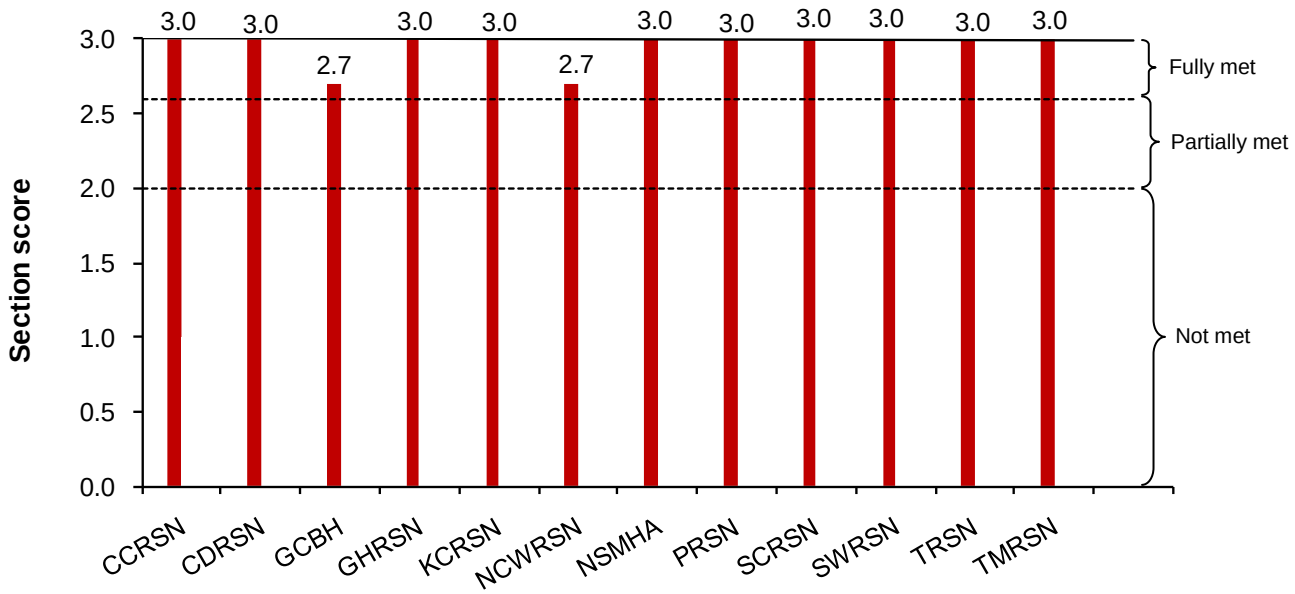



**Figure 20. RSN ISCA scores: Vendor Data Integrity.**

**Provider Data:** As shown in Figure 21, all RSNs except CDRSN and NCWRSN fully met the criteria for this subsection.

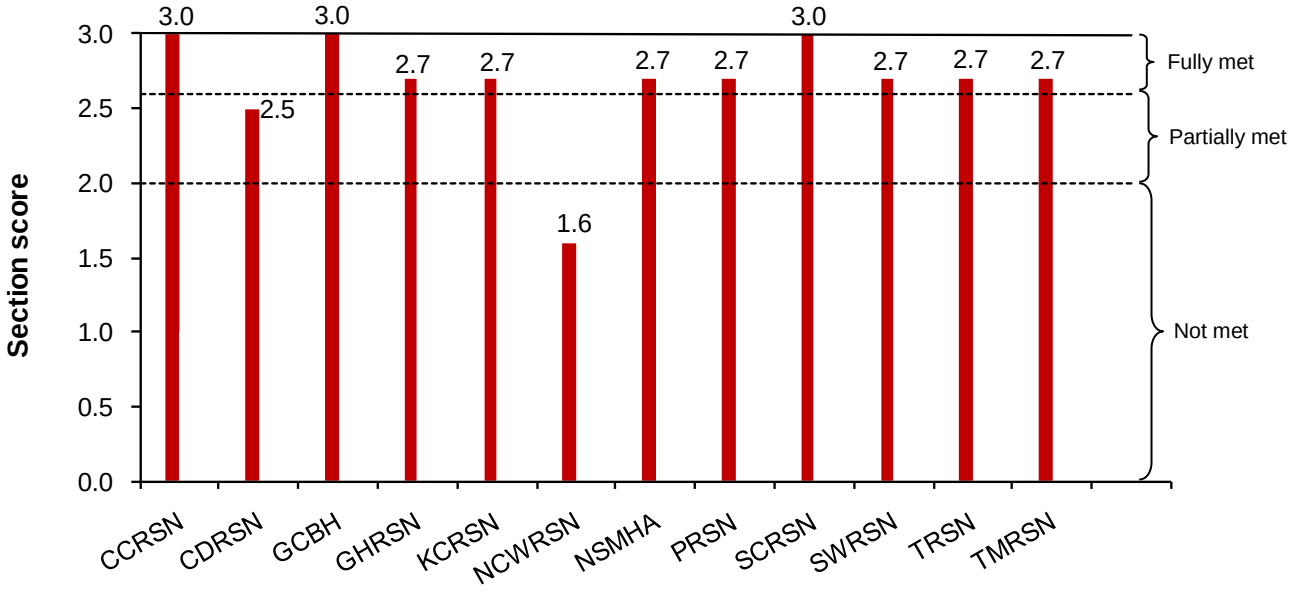



**Figure 21. RSN ISCA scores: Provider Data.**

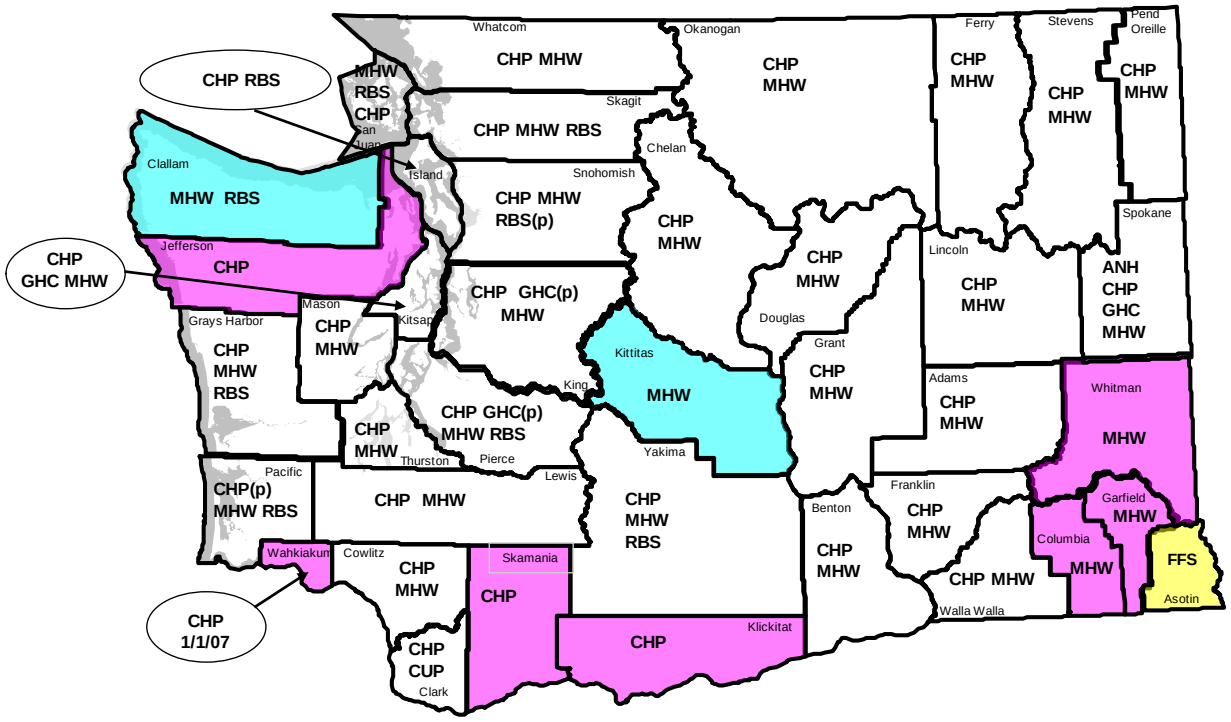
# Physical health care delivered by MCOs

HRSA contracts with seven MCOs to deliver physical healthcare services to Medicaid managed care enrollees. Table 11 shows the approximate number and percentage of enrollees assigned to each health plan as of December 2008. Figure 22 shows the counties served by each plan.

**Table 11. Healthy Options MCOs and enrollees served, December 2008.**

| Health plan | Acronym | Number of enrollees | % of all enrollees |
|---|---|---|---|
| Asuris Northwest Health | ANH | 1,786 | <1 |
| Community Health Plan | CHP | 161,082 | 32 |
| Columbia United Providers | CUP | 31,999 | 6 |
| Group Health Cooperative | GHC | 16,767 | 4 |
| Kaiser Permanente Northwest | KPNW | 751 | <1 |
| Molina Healthcare of Washington | MHW | 260,098 | 51 |
| Regence BlueShield | RBS | 33,961 | 6 |

**Healthy Options/S-CHIP Service Areas 2009**




Counties represent areas where enrollment in managed care is voluntary as plan(s) do not have enough capacity to serve all eligibles. Clients are assigned fee for service with plan option.

Counties represent areas where enrollment in managed care is voluntary with only one plan. The plan has capacity to serve all eligibles. Clients are assigned to the plan with fee for service as an option.

Asotin is FFS with no plans participating. **(p)** Indicates plan is not serving the entire county, only certain zip codes.

**Figure 22. Geographical coverage of Healthy Options MCOs.**

During 2008, 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. For the 2009 review, TEAMonitor requested preassessment documentation from each health plan supporting the plans' compliance with specific regulatory and contractual provisions. Following a desk audit of these materials, TEAMonitor performed a one- to two-day site visit for 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. The sections reporting statewide results present analysis 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 average percentages 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 2009 Medicaid averages from the NCQA *Quality Compass*.[9]

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 23 shows the stars and the percentile ranges.

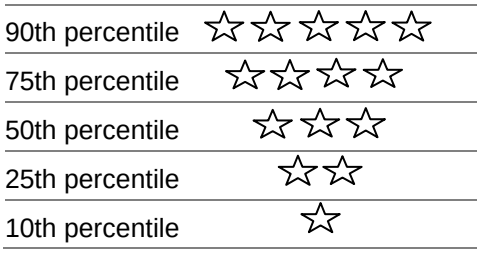



**Figure 23. Percentiles and star ratings used for this report.**

## 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.

### 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 2009 review:

- As a group, the MCOs improved their compliance with standards related to Availability of Services, Furnishing of Services, and Emergency and Post-stabilization Services.
- Some MCOs remained out of compliance with regard to aspects of Primary Care and Coordination, Coverage and Authorization of Services, and QAPI Program. Some plans lacked systematic processes to identify enrollees with special needs, and/or lacked complete documentation related to grievances.

### Performance on access measures

Three 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 12 compares access to WCC in Washington with the national Medicaid averages. The Healthy Options plans' average rate of delivering WCC visits for infants rose significantly in 2009, nearly matching the national average. About 57 percent of Healthy Options infants received at least six visits in the first 15 months of life. However, child and adolescent WCC visit rates in Washington, at 60 percent and 37 percent, respectively, remained significantly below the national averages.

**Table 12. Washington scores and national averages for physical health access measures, 2009.**

| Measure | National average | Washington score | Washington rating |
|---|---|---|---|
| **Prevention** | | | |
| Infant WCC Visits (6 or more) | 59% | 57% | ☆☆ |
| WCC Visit, 3–6 years | 70% | 60% | ☆☆ |
| Adolescent WCC Visit | 46% | 37%* | ☆ |

Stars represent Washington's performance compared with the 2009 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:** The percentages of WCC visits for enrollees in all three age groups varied considerably by health plan (see Table 13). Overall, MHW was the highest performing plan, with WCC visit rates significantly exceeding the state aggregates for children and adolescents.

*Infants:* Almost 75 percent of infants enrolled in CUP received at least six WCC visits, significantly above the state average. In contrast, CHP's and GHC's proportions of infants with the recommended number of WCC visits (47 percent and 49 percent, respectively) were significantly below average.

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

*Adolescents:* MHW, at 45 percent, was the best performer in getting adolescents seen for a WCC visit. GHC, at 40 percent, also exceeded the state average.

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 13. MCO and state scores for access measures, 2009.**

| Measure | ANH | CHP | CUP | GHC | KPNW | MHW | RBS | State |
|---|---|---|---|---|---|---|---|---|
| **Prevention** | | | | | | | | |
| Infant WCC (6+ visits) | — | 47% ▼ | 74% ▲ | 49% ▼ | — | 56% | 58% | 57% |
| Child WCC, 3 to 6 Years | 50% ▼ | 63% | 51% ▼ | 60% | 63% | 68% ▲ | 62% | 60% |
| Adolescent WCC Visit | 32% | 36% | 33% | 40% | 36% | 45% ▲ | 37% | 37% |

▲ 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.

### 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 all MCOs demonstrated full compliance with state and federal requirements for timely access to care and services.

### 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 14 shows that nearly two-thirds of Healthy Options women are receiving timely postpartum care. In 2009, the statewide average score for postpartum care was essentially the same as in 2008. 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 14. Washington scores and national averages for physical health timeliness measure, 2009.**

| Measure | National average | Washington score | Washington rating |
|---|---|---|---|
| **Prevention** | | | |
| Postpartum Care | 63% | 63% | ☆☆☆ |

Stars represent Washington's performance compared with the 2009 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.

**MCO results:** Table 15 compares the performance of individual health plans with the statewide score on the timeliness measure.

Among GHC's female enrollees, 72 percent of those who delivered a live birth received timely postpartum care, a significantly higher percentage than the state average of 63 percent. KPNW (at 79 percent) and RBS (at 68 percent) also exceeded the state average, while CHP and CUP and were below average.

Scores improved slightly for GHC and RBS from 2008 to 2009, while scores for CHP, CUP, KPNW, and MHW fell slightly.

**Table 15. MCO and state scores for timeliness measure, 2009.**

| Measure | CHP | CUP | GHC | KPNW | MHW | RBS | State |
|---|---|---|---|---|---|---|---|
| **Prevention** | | | | | | | |
| Postpartum Care | 57% ▼ | 56% ▼ | 72% ▲ | 79% | 60% | 68% | 63% |

▲ Health plan percentage is significantly higher than state average ($p<0.05$).
▼ Health plan percentage is significantly lower than state average ($p<0.05$).

# 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.

## Compliance with quality standards

Quality standards are embedded in the portions of the compliance review protocol addressing Primary Care and Coordination, Provider Selection, Practice Guidelines, QAPI, Enrollee Rights, and Grievance Systems, as well as in contractual requirements to ensure continuity and coordination of care.

TEAMonitor's 2009 review found that all MCOs fully or partially met requirements to:

- ensure that their enrollees received appropriate primary care and ongoing coordination of healthcare services
- ensure that their policies and procedures for selection of providers were based on NCQA guidelines
- maintain formal utilization management programs and practice guidelines based on reliable and valid clinical practice
- ensure that their oversight of delegated and subcontractual relationships was consistent with federal regulations

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 no MCO fully met these requirements. CHP and KPNW met 80 percent of the requirements, while GHC and RBS met 60 percent of the requirements.

## 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 glucose 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 glucose) 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 16 compares Washington's performance on these quality measures with the nationwide performance.

Washington's Combo 2 immunization rates in 2009 (averaging 71 percent) remained below the national average, although the statewide average has risen significantly over the past 5 years. The federal benchmarking report, *Healthy People 2010*, sets 80 percent as the target for health plans to achieve by 2010 for DTaP, IPV, MMR, HiB, and HepB, and 90 percent as the target for PCV. Currently, three antigen rates are at or above 90 percent—IPV, MMR, and HiB—while the rates for Hep B and VZV rate are slightly below 90 percent.

The statewide PCV immunization rate, averaging 81 percent in 2009, has risen significantly since 2006, when this measure was introduced. As a result, the statewide Combo 3 average also has risen significantly and now slightly exceeds the national average.

With regard to the diabetes care measure, the statewide average has varied slightly around 80 percent over the past five years. The 2009 average rate of HbA1c testing, about 82 percent; was slightly higher than the national average.

**Table 16. Washington scores and national averages for physical health quality measures, 2009.**

| Measure | National average | Washington score | Washington rating |
|---|---|---|---|
| **Prevention** | | | |
| Childhood Immunizations (Combo 2) | 74% | 71% | ☆☆ |
| Childhood Immunizations (Combo 3) | 68% | 68% | ☆☆ |
| **Treatment** | | | |
| Diabetes Care (annual HbA1c test) | 80% | 82% | ☆☆☆ |

Stars represent Washington's performance compared with the 2009 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:** Table 17 compares the performance of individual health plans with the statewide scores on the quality measures.

*Combo 2 immunizations:* CHP and GHC performed significantly better than the state average of 71 percent, while CUP scored significantly below the state average.

*Combo 3 immunizations*: CHP scored significantly above the state average of 68 percent, while CUP scored significantly below average.

*Diabetes care:* Plan performance on HbA1c testing ranged from a low of 78 percent (RBS) to a high of 86 percent (CUP). All plans except RBS and MHW outperformed the national average. Significance testing was not feasible at the plan level because of small sample sizes for this measure.

**Table 17. MCO and state scores for quality measures, 2009.**

| Measure | CHP | CUP | GHC | KPNW | MHW | RBS | State |
|---|---|---|---|---|---|---|---|
| **Prevention** | | | | | | | |
| Child Immunizations (Combo 2) | 77% ▲ | 56% ▼ | 76% ▲ | —% | 74% | 73% | 71% |
| Child Immunizations (Combo 3) | 75% ▲ | 53% ▼ | 72% | —% | 70% | 68% | 68% |
| Diabetes Care (HbA1c test) | 82% | 86% | 84% | —% | 81% | 78% | 82% |

▲ 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 2009, TEAMonitor reviewers scored MCOs on their compliance with more than 60 required elements in 17 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)
- Program Integrity
- Timely Claims Payment
- Primary Care and Coordination
- Additional Services for Enrollees with Special Healthcare Needs (SHCN)
- Patient Review and Restriction
- Coverage and Authorization of Services
- Emergency and Post-Stabilization Services
- Enrollee Rights
- Enrollment and Disenrollment
- Grievance Systems
- Performance Improvement Projects
- Practice Guidelines
- Provider Selection (Credentialing)
- 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 program contractor's compliance with selected regulations and contract provisions (see page 102).

### 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 18 and in the MCO Profiles in Appendix B. The scores were calculated as follows.

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

**Numerator:** the number of scored elements that received a Met score. Compliance 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 18 breaks out the 2009 compliance scores assigned by TEAMonitor for each of 16 standards (excluding PIPs) by health plan. (Note: TEAMonitor combines its review of RBS and ANH, since the two plans share administrative functions and resources.) Figure 24 shows the change in compliance scores on selected standards from 2007 through 2009.

The 2009 scores indicate continuing improvement in compliance with the Availability of Services, Furnishing of Services, Claims Payment, Enrollee Rights, Provider Selection, and Subcontractual Relationships and Delegation standards. As a group, the health plans met at least 83 percent of all elements in those standards. The plans demonstrated perfect compliance with Furnishing of Services and Enrollment/Disenrollment.

Overall compliance scores fell in 2009 for four standards: Primary Care and Coordination, Coverage and Authorization of Services, Grievance Systems, and QAPI. Compliance scores remained the same for Program Integrity, Additional Services for Enrollees with SHCN, and Practice Guidelines.

Patient Review and Restriction is a new review standard added by TEAMonitor for 2009. MCOs must meet contractual requirements of this program to control overutilization and inappropriate use of medical services by Medicaid enrollees. An enrollee who has used services at a frequency or amount that is not medically necessary is restricted to one physician, one pharmacy, and one hospital, and only those assigned providers may be reimbursed for services. On average, the Healthy Options plans complied with only about two-thirds of the elements of this new standard, although KPNW fully met the standard.

Many of the Partially Met or Not Met ratings relate to deficiencies in the MCOs' documentation to support compliance. HRSA required the MCOs to address these standards through corrective action plans following the TEAMonitor review. Therefore, the scores shown in Table 18 may not reflect the status of plan performance as of December 2009.

**Table 18. MCO compliance scores for physical health regulatory and contractual standards, 2009.[a]**

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

| | CHP | | | CUP | | | GHC | | | KPNW | | | MHW | | | RBS/ANH | | | State average | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Standard (# of elements) | 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) | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **60** | 40 | 0 | **93** | 7 | 0 |
| Furnishing of Services (2) | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 |
| Program Integrity (2) | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **50** | 0 | 50 | **50** | 50 | 0 | **83** | 8 | 8 |
| Claims Payment (2) | **50** | 0 | 50 | **50** | 50 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **83** | 8 | 8 |
| Primary Care and Coordination (1) | **0** | 100 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **0** | 100 | 0 | **100** | 0 | 0 | 0 | 100 | 0 | **50** | 50 | 0 |
| Additional Services for Enrollees with SHCN (4) | **0** | 100 | 0 | **25** | 75 | 0 | **25** | 0 | 75 | **75** | 25 | 0 | **25** | 0 | 75 | **25** | 75 | 0 | **29** | 46 | 25 |
| Patient Review and Restriction (8) | **63** | 12.5 | 25 | **50** | 50 | 0 | **63** | 25 | 13 | **100** | 0 | 0 | **63** | 12 | 25 | **50** | 38 | 12 | **64** | 23 | 13 |
| Coverage and Authorization of Services (4) | **100** | 0 | 0 | **75** | 25 | 0 | **50** | 50 | 0 | **75** | 25 | 0 | **75** | 25 | 0 | **75** | 25 | 0 | **75** | 25 | 0 |
| Emergency and Post-stabilization Services (1) | **100** | 0 | 0 | **0** | 0 | 100 | **0** | 100 | 0 | **100** | 0 | 0 | 0 | 0 | 100 | **100** | 0 | 0 | **50** | 33 | 17 |
| Enrollee Rights (13 of 14 scored) | **92** | 0 | 8 | **85** | 0 | 15 | **85** | 15 | 0 | **100** | 0 | 0 | **92** | 8 | 0 | **69** | 31 | 0 | **87** | 9 | 4 |
| 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) | **68** | 11 | 21 | **79** | 5 | 16 | **68** | 32 | 0 | **89** | 11 | 0 | **89** | 11 | 0 | **63** | 11 | 26 | **76** | 13 | 11 |
| Practice Guidelines (3) | **100** | 0 | 0 | **67** | 33 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **95** | 5 | 0 |
| Provider Selection (3) | **100** | 0 | 0 | **100** | 0 | 0 | **67** | 33 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **95** | 5 | 0 |
| QAPI Program (5) | **80** | 20 | 0 | **20** | 20 | 60 | **60** | 40 | 0 | **80** | 20 | 0 | **40** | 20 | 40 | **60** | 40 | 0 | **57** | 27 | 17 |
| Subcontractual Relationships and Delegation (4) | **75** | 25 | 0 | **100** | 0 | 0 | **75** | 25 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **100** | 0 | 0 | **92** | 8 | 0 |

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.

These standards were scored during the first half of 2009. 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 2009.

## Access Standards

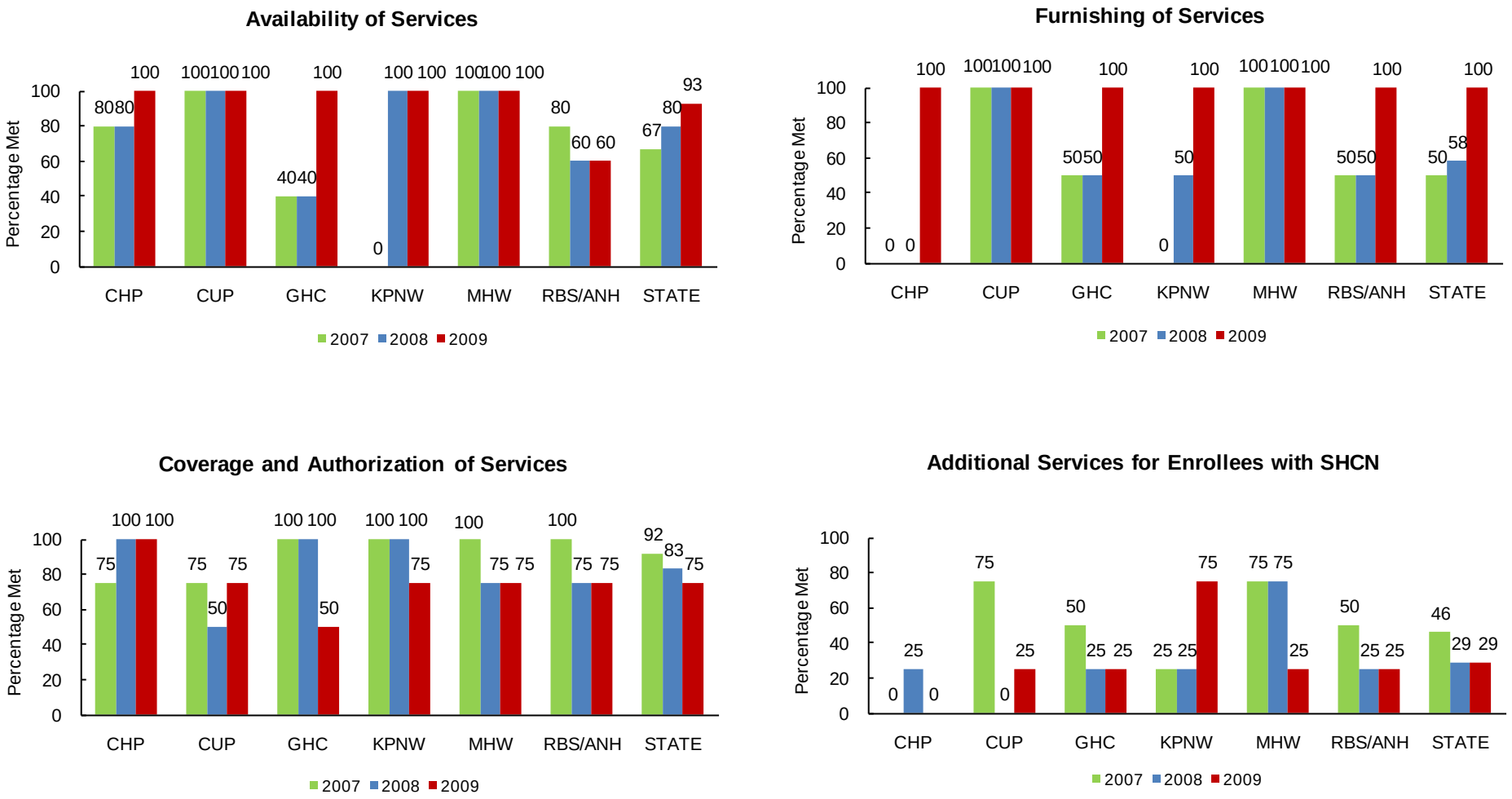



**Figure 24. Changes in compliance scores for selected physical health regulatory standards by MCO, 2007–2009.**

## Timeliness and Quality Standards

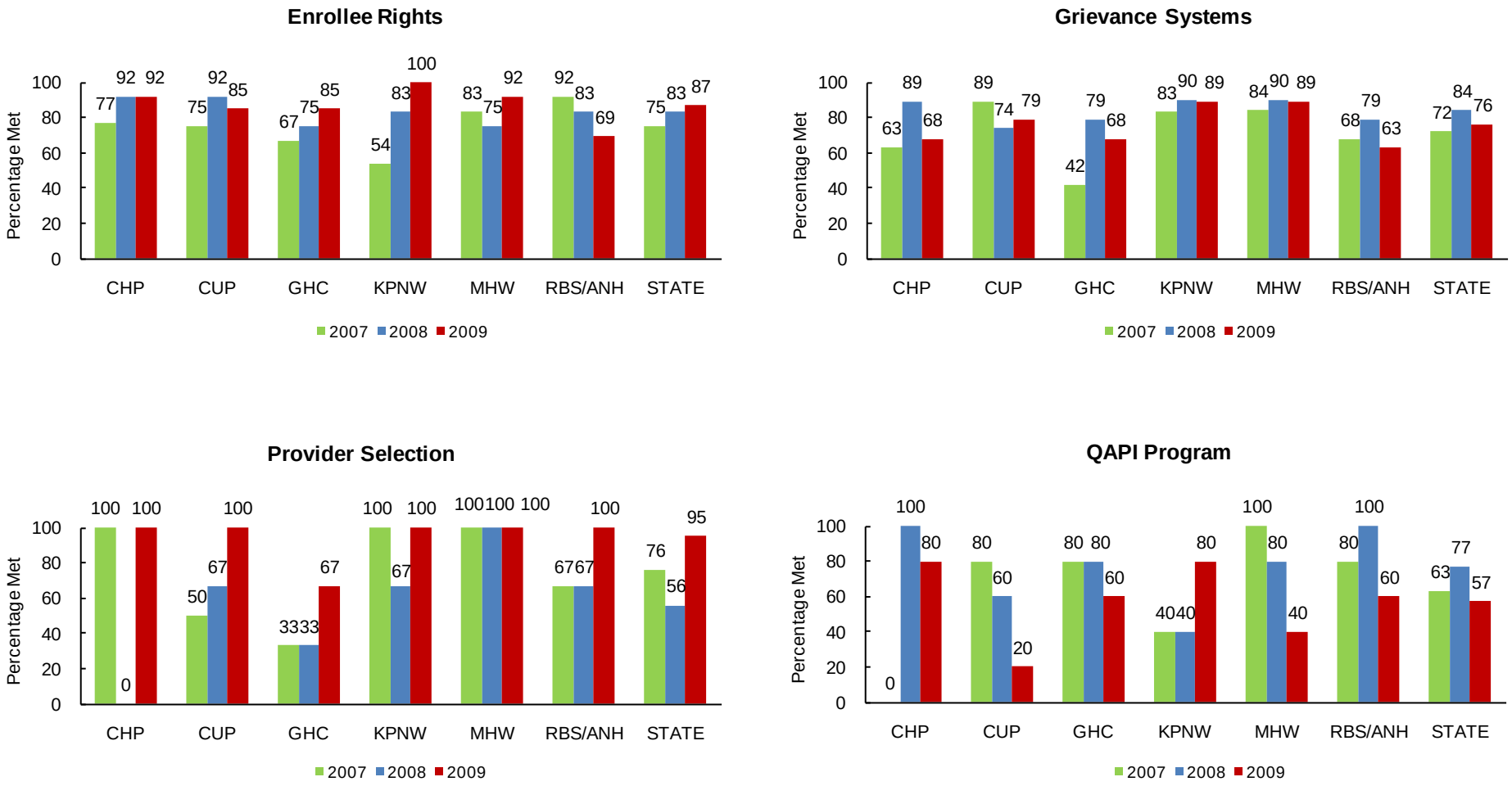



**Figure 24. Changes in compliance scores for selected physical health regulatory standards by MCO, 2007–2009 (cont.).**

## Corrective action plans

In 2009, TEAMonitor reviewed the MCOs' 2008 corrective action plans (CAPs), documenting resolution of corrective action as part of the review process. If, as part of the 2009 review, old or new findings were observed, TEAMonitor documented those findings and required corrective action. The state required a 2009 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 2008 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 19 shows the disposition of CAPs required in 2009.

**Table 19. Disposition of MCOs' corrective action plans.**

| Health plan | 2009 CAPs required | 2009 CAPs accepted | 2009 percentage accepted | 2008 CAP status not resolved |
|---|---|---|---|---|
| CHP | 18 | 18 | 100 | 1 |
| CUP | 22 | 21 | 95 | 4 |
| GHC | 21 | 21 | 100 | 0 |
| KPNW | 7 | 7 | 100 | 0 |
| MHW | 15 | 14 | 93 | 0 |
| RBS/ANH | 25 | 24 | 96 | 1 |
| WMIP | 41 | 35 | 85 | 10 |

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

- Coordination and Continuity of Care: continued refinement of the case identification mechanism
- Patient Review and Restriction (Healthy Options and S-CHIP): appeal process and written notification to member regarding placement
- Grievance Systems: internal review process out of compliance with contract requirements
- Coverage and Authorization of Services: incomplete data
- Additional Services for Enrollees with SHCN: mechanism for identifying enrollees is in need of review

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 address unresolved CAPs.

## Physical health PIP validation

The current managed care contract requires each MCO to conduct at least one clinical and one nonclinical PIP. 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 2009 review evaluated the PIPs each MCO conducted during 2008. Four 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 20 shows the topics of the PIPs conducted by each MCO in 2009 and the scores assigned by TEAMonitor. All MCOs addressed WCC visits through their clinical PIPs, and CUP and RBS each conducted an immunization PIP, as required by contract. The nonclinical PIP topics varied as shown. CHP and MHW earned a "Met" score for both of their PIPs, while other MCOs achieved varying degrees of success.

A discussion of each MCO's PIPs follows Table 20. 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 20. PIP topics and scores by MCO, 2009.**

| Plan | PIP topic | Score |
|---|---|---|
| **CHP** | Clinical: Well-Child Exams: Improving HEDIS Measurement Rates | Met |
| | Nonclinical: Improving Access to Primary Care | Met |
| | | |
| **CUP** | Clinical: Improving Well-Child Visit Rates | Partially Met |
| | Clinical: Improving Early Childhood Immunization Rates | Partially Met |
| | Nonclinical: Not submitted | Not Met |
| | | |
| **GHC** | Clinical: Improving Well-Child and Well-Adolescent Visit Rates | Met |
| | Nonclinical: Improving Member Utilization of Online Services to Enhance Health Information and Patient Self-Care | Not Met |
| | | |
| **KPNW** | Clinical: Improving Well-Child Visit Rates | Partially Met |
| | Nonclinical: Regional Appointment Center Call Answer Timeliness | Met |
| | | |
| **MHW** | Clinical: Improving Well-Child Visit Rates | Met |
| | Nonclinical: Medicaid Pharmacy Authorization Turnaround Times | Met |
| | | |
| **RBS/ANH** | Clinical: Well-Child Visits With a Disparity Aspect Involving the Hispanic Population | Not Met |
| | Clinical: Improving the Rate of Child Immunizations in the Medicaid Population | Partially Met |
| | Nonclinical: Improve Response Time of Pharmacy Prior-Authorization Denials | Partially Met |

## Community Health Plan

Table 21 displays the topics and scores of CHP's PIPs in the past three years. CHP carried over one clinical project from 2007 through 2009, aimed at improving WCC visit rates. This was the only contractually required PIP conducted by CHP this year.

**Table 21. Community Health Plan PIP topics and scores, 2007–2009.**

| Topic | 2007 | 2008 | 2009 |
|---|---|---|---|
| Clinical: Improve Clinical Outcomes for Members With a Diagnosis of Asthma | Met | Partially Met | Not reported |
| Clinical: Well-Child Exams: Improving HEDIS Measurement Rates | Partially Met | Partially Met | Met |
| Clinical: Childhood Immunizations: Improving HEDIS Measurement Rates | Partially Met | Partially Met | Not reported |
| Nonclinical: Access to Care—A Lean Perspective | Not conducted | Partially Met | Not reported |
| Nonclinical: Simple Rules and Access to Care | Not conducted | Partially Met | Not reported |
| Nonclinical: Improving Access to Primary Care | Not conducted | Not conducted | Met |

### Strengths

- CHP's interventions with providers to increase WCC visit rates are a best practice and include quarterly reports, incentives and technical assistance.
- Improvement in access to primary care due to the nonclinical PIP has encouraged the start of a similar improvement project for access to specialized care in 2009.
- The nonclinical PIP report includes six graphs illustrating six individual measures that show improved client access to primary care during 2008.

### Opportunities for improvement

- CHP's description of interventions for the clinical PIP needs more detail in terms of when each intervention was implemented, and what the plans are for new interventions.
- For the clinical PIP, CHP performed statistical significance tests only from 2007 to 2008 rather than from baseline to current period or over three data points. CHP would benefit from analyzing data over a longer time period.

## Columbia United Providers

Table 22 displays the topics and scores of CUP's PIPs in the past three years. As shown, CUP carried over two clinical PIPs from 2007 through 2009. These were the contractually-required PIPs related to immunizations and WCC. The plan did not submit a nonclinical PIP, resulting in a "Not Met" score for this standard.

**Table 22. Columbia United Providers PIP topics and scores, 2007–2009.**

| Topic | 2007 | 2008 | 2009 |
|---|---|---|---|
| Clinical: Improving Early Childhood Immunization Rates | Met | Partially Met | Partially Met |
| Clinical: Improving Management of Asthma as a Chronic Disease | Partially Met | Partially Met | Not reported |
| Clinical: Improving Well-Child Visit Rates | Partially Met | Partially Met | Partially Met |
| Nonclinical: Decreasing Inappropriate Emergency Department Utilization | Partially Met | Partially Met | Not reported |
| Nonclinical: Improving Member Understanding of Plan Benefits and Services | Partially Met | Partially Met | Not reported |
| Nonclinical: Not submitted | --- | --- | Not Met |

### Strengths

- CUP implemented novel trial interventions to improve performance (e.g., Televox trial, incentive programs for provider and clients).
- CUP's PIPs are well documented.

### Opportunities for improvement

- Active interventions were limited; many were not continued even when they showed a positive impact. CUP is encouraged to examine sustaining tests of change and to broaden successful interventions to other clinics (e.g., pilot recall/reminder system at Family Medicine Southwest).
- Most interventions were passive (e.g., providing educational materials to enrollees and providers, birthday and reminder postcards, new parent packets). CUP should aim its interventions at engaging providers in the goal of improving WCC.

## Group Health Cooperative

Table 23 displays the topics and scores of GHC's PIPs in the past three years. GHC carried over one clinical and one nonclinical PIP from 2007 to 2009. The WCC-related PIP was required by contract.

**Table 23. Group Health Cooperative PIP topics and scores, 2007–2009.**

| Topic | 2007 | 2008 | 2009 |
|---|---|---|---|
| Clinical: Improving Well-Child and Well-Adolescent Visit Rates | Partially Met | Met | Met |
| Clinical: Improving Childhood and Adolescent Immunization Rates | Partially Met | Met | Not reported |
| Clinical: Ensuring Members Receive Recommended Prenatal Care | Not conducted | Met | Not reported |
| Nonclinical: Improving Member Utilization of Online Services | Met | Partially Met | Not Met |
| Nonclinical: Improving Physician Communication with Members | Not conducted | Met | Not reported |
| Clinical: Improving Antidepressant Medication Management During the Acute Phase of Treatment | Partially Met | Not conducted | Not reported |
| Nonclinical Project: Improving Primary Care Access | Partially Met | Not conducted | Not reported |

### Strengths

- GHC's web-based system for enrollees, MyGroupHealth, was cited by TEAMonitor as a best practice.
- TEAMonitor once again cited GHC's best practice of identifying barriers and developing interventions to improve childhood immunization rates.
- GHC continues to extensively use electronic data sets for data collection and measurement.
- GHC's clinical PIPs were well documented and executed. Two of the three measures showed a statistically significant improvement.

### Opportunities for improvement

- Although GHC has implemented a number of interventions in the past to encourage enrollee use of the website, no recent interventions have occurred.
- To encourage greater use of the enrollee website, GHC should conduct a barrier analysis (through focus groups) to identify interventions aimed at the specific circumstances of Medicaid enrollees.

## Kaiser Permanente Northwest

Table 24 displays the topics and scores of KPNW's PIPs in 2007 and 2009. The WCC-related PIP was required by contract.

**Table 24. Kaiser Permanente Northwest PIP topics and scores, 2007–2009.**

| Topic | 2007 | 2008 | 2009 |
|---|---|---|---|
| Clinical: Adolescent Immunizations | Partially Met | * | Not reported |
| Clinical: Pediatric Obesity | Partially Met | * | Not reported |
| Clinical: Improving Well-Child Visit Rates | Partially Met | * | Partially Met |
| Nonclinical: Postpartum Follow-up | Met | * | Not reported |
| Nonclinical: Telephone Access to Membership Services | Met | * | Not reported |
| Nonclinical: Regional Appointment Center Call Answer Timeliness | Not conducted | * | Met |

*TEAMonitor did not review PIPs for KPNW in 2008; they were not submitted in a timely manner.

### Strengths

- KPNW used multiple robust interventions (e.g., hired more staff, increased staff training) to reduce telephone answering times to 30 seconds or less. This resulted in a dramatic and sustained improvement.
- KPNW has the support and involvement of its senior management and clinical leaders in instituting improvement projects.
- KPNW used strong, multiple interventions to improve care, including member outreach, provider incentives, and care gap information for providers.
- PIPs were well documented with excellent data display.

### Opportunities for improvement

- KPNW achieved no demonstrated improvement in the clinical PIP. To receive a Fully Met rating, KPNW is encouraged to continue its current interventions and consider adding telephonic outreach to further improve rates.

## Molina Healthcare of Washington

Table 25 displays the topics and scores of MHW's PIPs in the past three years. As shown, MHW carried over one clinical PIP from 2007 to 2009. The WCC-related PIP required by contract.

**Table 25. Molina Healthcare of Washington PIP topics and scores, 2007–2009.**

| Topic | 2007 | 2008 | 2009 |
|---|---|---|---|
| Clinical: Improving Childhood Immunization Rates | Met | Met | Not reported |
| Clinical: Improving HEDIS Well-Child Rates | Partially Met | Met | Met |
| Clinical: Adolescent Immunization Status | Not conducted | Met | Not reported |
| Clinical: Asthma Medication Prescribing Practices | Partially Met | Not conducted | Not reported |
| Nonclinical: Improving Member Knowledge of Benefits | Not conducted | Partially Met | Not reported |
| Nonclinical: Pre-Service Authorization Dates | Not conducted | Partially Met | Not reported |
| Nonclinical: Improving Quality of the Specialty Network | Partially Met | Not conducted | Not reported |
| Nonclinical: Improving Satisfaction With Customer Service | Partially Met | Not conducted | Not reported |
| Nonclinical: Medicaid Pharmacy Authorization Turnaround Times | Not conducted | Not conducted | Met |

### Strengths

- MHW's clinical PIP report was well written and demonstrated statistically significant increases, over time, in two of three WCC measures.
- Project goals and results for improved Pharmacy Authorization Turnaround-Times are well beyond contractual and other requirements.
- PIP reports contained excellent display of data in charts, graphs, and tables.

### Opportunities for improvement

- Continued success of the clinical PIP may require a creative refocus and the design of new interventions to move this effort to the next level.
- TEAMonitor again recommends that new or novel interventions include performance feedback to clinics.

## Regence BlueShield/Asuris Northwest Health

Table 26 displays the topics and scores of RBS/ANH's PIPs in the past three years. RBS/ANH carried over three projects from 2007 through 2009. One PIP score remained the same, while scores fell for the other two. RBS/ANH conducted contractually required PIPs for immunizations and WCC.

**Table 26. Regence BlueShield/Asuris Northwest Health PIP topics and scores, 2007–2009.**

| Topic | 2007 | 2008 | 2009 |
|---|---|---|---|
| Clinical: Improve Appropriate Medication Use for Members With Asthma | Met | Met | Not reported |
| Clinical: Well-Child Visits With a Disparity Aspect Involving the Hispanic Population | Met | Met | Not Met |
| Clinical: Improving the Rate of Child Immunizations | Met | Met | Partially 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 | Met | Not reported |

### Strengths

- TEAMonitor cited as a best practice the health disparities aspect of the WCC-related PIP.
- Another best practice cited by TEAMonitor included a narrative description in table format linking interventions to barriers.
- Excellent documentation of potential causes for poor performance in pharmacy timeliness, enabling the causes to be addressed. Generally robust interventions to address root causes for performance.

### Opportunities for improvement

- Interventions were not substantively added or enhanced in the WCC-related PIP, though statistically significant rate decreases occurred for 3- to 6-year olds and adolescents. The focus of this year's PIP, the adolescent WCC visit rate, was not clearly documented. In addition, the PIP did not contain sufficient analysis for identifying the causes of rate decreases and planning follow-up activities.
- The PIP addressing timeliness of prior authorization for pharmacy prescriptions showed no evidence of sustained improvement and reflected some difficulties with evaluating the variables.

# 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 Molina Healthcare of Washington (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 2009, 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 year-to-year changes in the WMIP measurements for some indicators of diabetes care and service utilization.

For 2009, 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. The data were validated through CMS's Information Systems Capabilities Assessment tool and the NCQA HEDIS compliance audit. This report analyzes the results of those measurements. MHW also conducted the CAHPS survey to measure WMIP enrollee satisfaction.

Table 27 presents the WMIP results for comprehensive diabetes care from 2007 through 2009. The 2009 rates for HbA1c tests, eye exams, lipid profile and control, monitoring of nephropathy, and blood pressure control (<140/90 mm Hg) were higher than the rates reported in 2008, though none were significantly higher. These measures are moving in the right direction, indicating that more patients are being monitored, potentially leading to better control.

**Table 27. WMIP comprehensive diabetes care measures, 2007–2009.**

| | 2007 | 2008 | 2009 |
|---|---|---|---|
| HbA1c tests (percentage tested) | 82.90 | 82.16 | 86.67 |
| Enrollees with poor control of HbA1c levels (percentage with HbA1c>9.0%) | 42.49 | 43.87 | 37.00 |
| Enrollees with good control of HbA1c levels (percentage with HbA1c<7.0%) | 36.79 | 36.06 | Not conducted |
| Enrollees with good control of HbA1c levels (percentage with HbA1c<8.0%); first-year measure | | | 55.00 |
| Dilated retinal exams (percentage examined) | 54.40 | 59.11 | 63.00 |
| Lipid profile (LDL-C) performed (percentage profiled) | 76.17 | 76.58 | 82.00 |
| Lipids controlled (percentage with <100mg/dL) | 31.09 | 35.32 | 39.00 |
| Nephropathy monitored annually (percentage monitored) | 77.72 | 82.16 | 84.67 |
| Blood pressure control (percentage with <130/80 mm Hg) | 31.61 | 38.66 | 37.00 |
| Blood pressure control (percentage with <140/90 mm Hg) | 56.48 | 65.80 | 67.67 |

No statistically significant differences in percentages from 2008 to 2009 ($p \leq 0.05$).

Tables 28 and 29 present WMIP results for inpatient utilization, general hospital/acute care, in reporting years 2007–2009, and for inpatient nonacute care in 2008 and 2009. Table 30 presents the results for ambulatory care utilization in 2007–2009.

Overall, utilization rates for general hospital/acute care have increased in the past year. Acute care and surgical days rose significantly, as did the surgical average length of stay (ALOS). Rates for outpatient and ER visits and for ambulatory surgery or procedures performed showed a significant increase as well. At the same time, the nonacute total inpatient discharges and days decreased significantly.

**Table 28. WMIP inpatient utilization, general hospital/acute care measures, 2007–2009.**

| | Discharges/1000MM[a] | | | Days/1000MM[a] | | | ALOS[b] | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2007 | 2008 | 2009 | 2007 | 2008 | 2009 |
| Total inpatient | 14.76 | 14.87 | 15.86 | 72.65 | 70.92 | 80.71↑ | 4.92 | 4.77 | 5.09 |
| Medical | 7.16 | 8.37 | 9.18 | 26.15 | 32.56 | 32.27 | 3.65 | 3.89 | 3.51 |
| Surgical | 7.43 | 5.83 | 5.67 | 34.19 | 36.02 | 45.09↑ | 6.53 | 6.17 | 7.96↑ |

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

↓↑ indicates statistically significant differences in percentages from 2008 to 2009 ($p \leq 0.05$).

**Table 29. WMIP inpatient utilization, nonacute care measures, 2007–2009.**

| | Discharges/1000MM[a] | | | Days/1000MM[a] | | | ALOS[b] | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2007 | 2008 | 2009 | 2007 | 2008 | 2009 |
| Total inpatient | 1.21 | 1.43 | 0.84↓ | 6.65 | 28.50 | 25.38↓ | 5.52 | 19.98 | 30.30 |

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

↓↑ Indicates statistically significant differences in percentages from 2008 to 2009 ($p \leq 0.05$).

**Table 30. WMIP ambulatory care measures, 2007–2009.**

| | Visits/1000MM[a] | | |
|---|---|---|---|
| | **2007** | **2008** | **2009** |
| Outpatient visits | 470.32 | 456.31 | 543.83↑ |
| Emergency room visits | 104.28 | 112.10 | 120.46↑ |
| Surgery or procedures performed | 10.70 | 13.47 | 22.53↑ |

| | Stays/1000MM[a] | | |
|---|---|---|---|
| | **2007** | **2008** | **2009** |
| Observation room stays resulting in discharge | 0.95 | 1.20 | 0.87 |

[a]1000MM = 1000 member months.
↓↑ Indicates statistically significant differences in percentages from 2008 to 2009 ($p \leq 0.05$).

Tables 31 and 32 present WMIP results for two behavioral health measures introduced in 2008. The antidepressant medication management measure (Table 31) examines the percentage of patients initiated on an antidepressant drug who received an effective acute-phase trial of medications (three months) and the percentage of patients who completed a period of continuous treatment for major depression (six months). The percentage of patients receiving effective acute phase treatment increased in 2009, while the percentage receiving effective continuation-phase treatment decreased, although neither change percentage was significant.

**Table 31. WMIP antidepressant medication management measures, 2008–2009.**

| | Effective acute-phase treatment | | Effective continuation-phase treatment | |
|---|---|---|---|---|
| | **2008** | **2009** | **2008** | **2009** |
| Percentage of patients receiving medication management | 41.46 | 52.08 | 39.02 | 33.33 |

No statistically significant differences in percentages from 2008 to 2009 ($p \leq 0.05$).

The follow-up measure (Table 32) looks at continuity of care—the percentage of enrollees 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. In 2009, the percentage of patients seen by an outpatient mental health provider within 30 days increased significantly.

**Table 32. WMIP follow-up after hospitalization for mental illness measures, 2008–2009.**

| | 30-day follow-up | | 7-day follow-up | |
|---|---|---|---|---|
| | **2008** | **2009** | **2008** | **2009** |
| Percentage of patients receiving follow-up | 47.37 | 69.81↑ | 28.95 | 47.17 |

↓↑ Indicates statistically significant differences in percentages from 2008 to 2009 ($p \leq 0.05$).

Table 33 reports an additional behavioral health measure from 2007 to 2009, 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. The percentage for both measures decreased in 2009 (representing better performance), but the change was not significant.

**Table 33. WMIP use of high-risk medications for the elderly measures, 2007–2009.**

| | One prescription | | | At least two prescriptions | | |
|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2007 | 2008 | 2009 |
| Percentage of patients receiving medication | 19.08 | 18.43 | 16.16 | 4.62 | 4.10 | 3.01 |

No statistically significant differences in percentages from 2008 to 2009 ($p \leq 0.05$).

## WMIP compliance review

HRSA and the Aging and Disability Services Administration reviewed MHW's compliance with BBA managed care regulations and WMIP contract provisions. This review addressed many of the same standards as those addressed by TEAMonitor's MCO compliance reviews, but examined a greater number of elements related to specific WMIP contract provisions. Table 34 reports the WMIP compliance scores for each of 10 standards (excluding PIPs).

As shown, MHW fully met elements for 4 of the 10 standards. The Coverage and Authorization of Services and the QAPI Program results heavily weighted the Partially Met elements, while results for Additional Services for Enrollees with Special Healthcare Needs heavily weighted the Not Met elements.

**Table 34. WMIP compliance scores, 2009.**

| Standard (# of elements) | Percentage of elements Met (M), Partially Met (PM), Not Met (NM) | | |
|---|---|---|---|
| | M | PM | NM |
| Availability of Services (9) | **67** | 11 | 22 |
| Program Integrity (3) | **100** | 0 | 0 |
| Claims Payment (3) | **34** | 33 | 33 |
| Primary Care and Coordination (1) | **100** | 0 | 0 |
| Additional Services for Enrollees with Special Healthcare Needs (18) | **22** | 28 | 50 |
| Coverage and Authorization of Services (5) | **40** | 60 | 0 |
| Enrollee Rights (3) | **100** | 0 | 0 |
| Practice Guidelines (6) | **34** | 33 | 33 |
| QAPI Program (7) | **14** | 86 | 0 |
| Health Information Systems (3) | **100** | 0 | 0 |

## WMIP PIP validation

For 2009, 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 35 shows the PIP topics and the scores assigned by TEAMonitor.

**Table 35. WMIP PIP topics and scores, 2009.**

| Topic | Score |
|---|---|
| Clinical: Improving Identification of Members at High Risk for Chemical Dependency Issues | Partially Met |
| Clinical: Improving Compliance with Chemical Dependency Assessment and Follow-Up Referrals for Chemical Dependency | Not Met |
| Clinical: Improving the Rate of Completion of Documented Care Plans | Not Met |
| Nonclinical: Increasing Successful Initial Contacts Between WMIP Members and the Care Coordination Team | Not Met |
| Nonclinical: Improving Satisfaction with Customer Service | Met |

### Strengths

- **Project 1:** HRSA commended MHW on its efforts to effectively screen and identify members with a high risk of chemical dependency issues, leading to appropriate treatment.
- **Project 3:** HRSA commended MHW on improvements in completing and documenting initial care plans, demonstrated by statistically improved rates.

### Opportunities for improvement

- **Project 2:** This PIP is not in compliance with the contract language that specifies the criteria for admission to chemical dependency treatment programs. For the past three years, HRSA has recommended additional measurement tools to track participation in chemical dependency programs, and MHW has yet to correct this deficiency.
- **Project 3:** HRSA recommends that MHW retire this PIP because of deficiencies in study questions and indicators.
- **Project 4:** MHW needs to verify the accuracy and consistency of the data before the next audit.
- **Project 5:** MHW indicated that it would include another measure for this PIP, but identified no new sources of data. MHW has the option of retiring one of its nonclinical PIPs; HRSA suggests retiring this one.

## CAHPS survey

The annual CAHPS surveys, developed and managed by the Agency for Healthcare Research and Quality, are designed to measure patients' experiences with the healthcare system. HRSA has required a satisfaction survey for the WMIP population since the inception of the pilot program in 2005, and initiated satisfaction surveys for the FFS population in 2007. For the 2008 survey year, the CAHPS survey was administered to WMIP enrollees and to a comparison group of FFS enrollees

The Medicaid FFS population responded to the survey at a higher rate (49.02 percent) than did the WMIP enrollee population (32.32 percent). For the most part, the differences between the two groups' responses were not statistically significant. However, significant differences emerged between the groups with regard to customer service and doctor office communication:

- WMIP enrollees were **more satisfied** than FFS clients with customer service, stating that office staff usually or always treated them with courtesy and respect.
- WMIP enrollees were **less satisfied** than FFS clients with how doctors communicated and explained things in an understandable way.

In addition, WMIP enrollees reported a significantly higher level of satisfaction with getting needed care in 2008, compared with their responses in 2007:

- In 2008, 77 percent of WMIP enrollees reported that they usually or always got necessary care, tests, or treatment, compared with 67 percent of WMIP enrollees in 2007.

Top-priority correlation analysis identified the specific aspects of care that deserve further scrutiny and would most benefit from focused QI activities. Specific elements of Getting Needed Care and of Customer Service were identified as top priorities for both survey populations. Additional elements of Getting Care Quickly and of Customer Service were identified as top priorities for FFS enrollees.

## Discussion

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.

Current research regarding the dual-eligible population focuses on reducing hospitalizations and improving outcomes for beneficiaries with multiple chronic illnesses who are not cognitively impaired. Three types of interventions have been demonstrated to be effective:

- **Transitional care interventions** engage patients while they are hospitalized and follow them intensively for four to six weeks after discharge to ensure that patients understand and can adhere to post-discharge instructions for medication and self-care, recognize symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their PCPs. These interventions use advanced practice nurses and "transition coaches." In successful interventions, these professionals had substantial amounts of in-person contact with their patients.

- **Self-management education interventions** engage patients from four to seven weeks in community-based programs designed to "activate" them in managing their chronic conditions. Patients learn to self-manage symptoms, take part in activities that maintain function and reduce health declines (e.g., taking their medications properly), participate in diagnostic and treatment choices, and collaborate with their providers.
- **Coordinated care interventions** identify patients with chronic conditions who are at high risk of hospitalization in the next year; conduct initial assessments and care planning; and monitor patients' symptoms and self-care on an ongoing basis. Registered nurses often coordinate this care. For some patients, social workers assist with assessing eligibility and arranging services such as transportation, home-delivered meals, emergency response systems, advanced care planning, and coordination with home health agencies. Information is coordinated among the patient, PCP, and caregivers.[10,11]

The authors suggest that the "optimal" model involves augmenting ongoing care coordination with transitional care, and offering group education on self-management, tailoring educational materials to people with lower educational levels and assessing their comprehension.

In May 2009, the Center for Health Care Strategies launched an initiative called Transforming Care for Dual Eligibles. Seven states will implement strategies to improve care and control costs for dual-eligible enrollees over 18 months. Colorado, Maryland, Massachusetts, Michigan, Pennsylvania, Texas, and Vermont will receive in-depth technical assistance addressing program design, care models, contracting strategies, and financing mechanisms.[12] The findings, when they become available, are likely to prove useful for WMIP program managers.

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.

Because the WMIP program administers the mental health benefit for enrollees, opportunities exist for shared learning between WMIP and the mental health RSN system. The following recommendations from the 2008 EQR report still apply.

- ***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 HRSA-DHS should meet with mental health program managers to discuss 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.***

Acumentra Health offers this additional recommendation:

- ***HRSA should explore opportunities to promote the WMIP program as a model that supports the medical or health home model.***

# 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 from EQR activities is intended to provide a systems perspective that will help HRSA define QI expectations for the MCOs and RSNs and design effective incentives for improvement.

Previous annual reports since 2005 have established continuous data on many aspects of medical care delivered by the MCOs. In addition, this year's annual report presents the second year of data on mental health PIPs, along with baseline data on the RSNs' information systems and compliance with certain regulatory and contractual standards.

DSHS is moving ahead with plans to integrate the delivery of medical and mental health care for Medicaid enrollees. As HRSA revises its Medicaid quality strategy to address that goal, the scope and focus of EQR activities is likely to evolve on a parallel track. Ultimately, the EQR is expected to evaluate medical and mental health services on a standardized basis, using similar measures and methodologies.

Budget challenges facing the Washington Medicaid program may qualify the following discussion and recommendations. Although federal "stimulus" funds have helped to protect many Medicaid-funded programs from severe budget cuts, HRSA has borne its share of the reduction in state funding. Between late 2008 and June 2009, HRSA laid off approximately 150 full-time employees and made major structural changes aimed at containing costs while advancing the mission of health care integration.

## Medicaid managed care highlights

**Focus on children.** State policy initiatives continue to focus on improving children's 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, set in motion 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. DSHS recommendations for the Children's Healthcare Improvement System (CHIS) program are aimed at ensuring the delivery of care within a medical home.[13] The program goals include linking provider rate increases to medical-home-related performance measures, and establishing contract incentives for providers and health plans that promote sustained improvement in those measures through use of evidence-based practices.

A 2007 law, **SSHB 1088**, declared the state's intent to develop a system of children's mental health emphasizing early identification, intervention, and prevention, with greater reliance on evidence-based and promising practices. The law directed DSHS to increase from 12 to 20 the number of outpatient therapy visits allowed annually for Medicaid-enrolled children, and to allow those services to be provided by all DOH-licensed mental health professionals. **2SHB 1373**, enacted in 2009, extended those provisions beyond July 2010.

**Medical home initiatives.** A 2008 law, **E2SHB 2549**, directed DSHS and the Health Care Authority (HCA) to study changes in payment practices that might support the development and maintenance of primary care medical homes. The agencies' report to the legislature presented four

payment options that may hold promise for a broad coalition of payers, providers, and patients.[14] Each option is derived from one of two broad classes of payment:

- Fee-For-Service "Plus"—one option based on the current coding system and another involving an add-on payment separate from coding-based reimbursement
- Payment Re-engineering—bundled fixed payment or full-risk capitation

E2SHB 2549 also directed DOH to develop a medical home learning collaborative to promote adoption of medical homes in a variety of primary care practice settings. DOH implemented the Patient-Centered Medical Home Collaborative in mid-2009. Based on the Chronic Care Model, the collaborative defines the specific changes that clinical practices need to make to demonstrate that they are medical homes, as well as the data needed to measure those changes. The first of four group learning sessions took place in September 2009, with 33 clinics participating. Project work is scheduled to continue through September 2011.

**SSB 5891**, enacted in 2009, directs DSHS and HCA to design, oversee implementation of, and evaluate one or more medical home reimbursement pilot projects. The requirements include identifying performance measures for clinical quality, chronic care management, cost, and patient experience. Eight health plans (including RBS, CHP, GHC, and MHW) have committed to take part in the Patient-Centered Medical Home Multipayer Reimbursement Model pilot project, coordinated by the Puget Sound Health Alliance, beginning in 2010.

**Access to care.** The medical MCOs are fully complying with most federal and state standards for coverage, authorization, and availability of services. In particular, all MCOs are complying with requirements to provide timely access to care and services. The mental health RSNs typically provide timely access to outpatient care and deploy well-developed crisis and stabilization resources, including telephone access to crisis services 24 hours a day, 7 days a week. The RSNs generally can provide timely access to geriatric, child, and developmental disability specialty services, although access to minority mental health specialists and child psychiatry is spotty, especially in rural areas.

To mitigate the limited availability of child psychiatrists, the state-funded Partnership Access Line (PAL) provides "just in time" telephone-based psychiatric consultation to PCPs regarding children with psychiatric problems. Child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital deliver PAL consultation services. The project is being piloted in two regions of the state and will expand to other regions in the future.

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

- **Mental health wraparound:** SSHB 1088 required DSHS to contract with RSNs to implement wraparound mental health services for children in as many as six pilot sites. The three pilot sites that were granted funding are operated by NSMHA, GHRSN, and SWRSN. As of December 2009, these three sites had served a total of 67 young people and their families.
- **PACT teams:** Since July 2007, 10 PACT teams across the state have been serving RSN enrollees, with priority given to state hospital patients. The teams have achieved full enrollment capacity and serve as many as 800 enrollees statewide. More than 90 percent of consumers have reported being highly satisfied with PACT services.

Since the previous annual report, budget cuts have caused the elimination of four **Patient Navigator** pilot sites across the state. The pilots, initiated in September 2008, were focused on creating cultural bridges to help Medicaid enrollees from minority communities navigate the healthcare system and obtain the treatment and information they need.

**Quality of care.** TEAMonitor's 2009 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 continue to implement the Recovery Model of care, with emphasis on increasing enrollees' dignity, respect, and involvement in the design and delivery of mental health services. The 2009 EQR site visits found that the RSNs use diverse strategies to monitor the quality and appropriateness of care delivered by mental health providers. Almost all RSNs reviewed clinical records of their provider agencies, and most have required their providers to take corrective action when quality-of-care concerns are identified. All RSNs have implemented at least one evidence-based practice guideline, and many monitor their providers' fidelity in applying the guidelines.

**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. These incentives, coupled with the requirement for MCOs to conduct PIPs in areas where their performance measures fall below the state benchmark, constitute a "best practice" in Medicaid managed care. 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.

Previous recommendations for the CHIS program called for reimbursing Medicaid providers at higher rates for historically underused procedures, reimbursing for targeted services not previously paid by Medicaid, and providing financial incentives for clinic-based performance. Budget constraints have prevented HRSA from taking action on those recommendations. However, HRSA is considering a contractual requirement for MCOs to direct a portion of their incentive payments to PCPs. Also, the medical home reimbursement model pilot project, mentioned above, may incorporate performance incentives.

**Improving clinical care.** The Healthy Options MCOs continue to perform above the national average Medicaid performance in several clinical measures. For example, the Washington MCOs compare favorably to the national norm in providing *diabetes care*, in terms of administering blood glucose testing, retinal examinations, and blood-pressure readings. The MCOs continue to rank high in providing timely *postpartum care* for female enrollees. 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. Future analysis will examine performance across the Medicaid system as a whole, encompassing FFS as well as managed care.

## The path to future improvements: Mental health care

The RSNs generally are dedicated to serving Medicaid enrollees and have made commendable efforts to maintain their effectiveness in the face of resource limitations. HRSA needs to focus resources on the following opportunities to improve the mental health system.

**Network development.** Many RSNs have little information about the Medicaid-eligible population in their service areas. This makes it difficult for the RSNs to identify barriers or gaps in service delivery, and to develop outreach efforts to the underserved populations who do not present for service.

- ***HRSA needs to ensure that RSNs have accurate information about the Medicaid-eligible population in their service area, including demographic information, language needs, and geographic distribution.***

**Second opinions.** Most RSNs do not track second opinions for reasons other than denial of medical necessity. Because the RSNs do not require providers to track and report requests for second opinions, information about treatment planning, diagnoses, and medication is not readily available to RSNs for monitoring network capacity, enrollee satisfaction, and quality.

- ***HRSA needs to ensure that the RSNs track all requests for second opinions at the provider level, and require RSNs to track the timeliness of second opinions at all levels within the network.***

**Out-of-network services.** Most RSNs do not require provider agencies to report out-of-network services secured by providers on behalf of enrollees. This information is essential to determine whether the RSN needs to develop capacity within the network.

- ***HRSA needs to require the RSNs to track all out-of-network services.***
- ***HRSA's information distributed to all enrollees needs to describe how to obtain out-of-network services.***

**Routine access.** Many RSNs report a lack of consistency among their providers regarding what constitutes a request for service. A clear definition of a service request is the first step in accurately tracking timeliness of access.

- ***HRSA needs to clarify in writing the definition of a "request for service" to enable RSNs to standardize their processes for tracking enrollee access to outpatient assessments and first clinical appointments.***

The RSNs have not consistently required or implemented corrective action to address problems related to enrollee access.

- ***HRSA needs to require RSNs to follow up on issues identified through monitoring and initiate corrective action when lack of compliance to routine access is identified.***

Most RSNs authorize services for six months to a year at a time and rarely deny reauthorization for outpatient services. The RSNs have made few efforts to manage care at higher levels of care. RSNs are not always involved in authorizing hospital stays before admission, and thus cannot intervene to offer alternatives to hospitalization if appropriate.

- ***HRSA needs to establish continued-stay and discharge criteria to guide treatment and discharge planning as the RSNs continue to implement the Recovery Model.***

- ***HRSA needs to work with the RSNs to implement a more robust level-of-care system with a wider array of services to meet the unique needs of enrollees.***
- ***HRSA needs to work with the RSNs to develop a system whereby the RSNs are involved in decision making before hospital admissions and in developing and providing alternatives to hospital care.***

**Timeliness issues.** Most RSNs find it hard to meet the 30-day requirement for minority mental health specialist consultations. Scheduling difficulties often delay access to outside consultations. Modifying the qualifications for becoming a mental health specialist could help resolve timeliness issues.

- ***HRSA needs to continue its process to redefine how RSNs are to ensure that enrollees with specialized needs have access to specialists in a timely manner.***

HRSA data show only one RSN meeting the contract requirement limiting the time between a request for service and authorization of service to 14 days.

- ***HRSA needs to provide direction on defining authorization timelines and take steps to ensure that the RSNs meet those timelines, including requiring corrective action when noncompliance is identified.***

HRSA reports that in 2008, only one RSN met the requirement to provide the first routine service within 28 days of an enrollee's request. The RSNs lack a clear understanding of this standard, resulting in confusion and inaccurate reporting.

- ***HRSA needs to clarify the requirements for reporting on timelines for first available appointments, to ensure consistent reporting on availability of services.***

**QM programs.** The EQR site visits revealed inconsistent implementation of QM processes across the state. Only a few RSNs had QM plans that included indicators, performance goals, and benchmarks. The majority of RSNs lacked comprehensive programs for monitoring for over- and underutilization. Four RSNs lacked a current QM plan in 2008. Most RSNs did not conduct an annual evaluation of their QM program.

- ***HRSA needs to require all RSNs to submit QM plans and annual evaluations. HRSA needs to review those plans and evaluations as part of its RSN certification process.***
- ***HRSA needs to provide direction for the RSNs on expectations for monitoring for over- and underutilization of outpatient services.***

**Provider selection.** Most RSNs lacked formal policies and procedures for credentialing of provider agencies, and for verifying the credentials of provider agency or RSN staff. Credentialing files at the RSN and provider agencies did not consistently contain the required documentation, especially of monitoring to ensure that the provider was not excluded from participating in federal healthcare programs.

- ***HRSA needs to provide clear direction to the RSNs regarding credentialing of RSN staff and monitoring of provider agency credentialing.***
- ***HRSA needs to clarify the expectations regarding routine screening to ensure that RSN or provider agency staff are not excluded from participating in federal healthcare programs.***

**Oversight of delegated activities.** The RSNs are uncertain about the requirements for monitoring delegated activities—in particular, provider credentialing and screening for exclusion from federal healthcare programs. Many RSNs do not monitor their providers' subcontractors. Some do not monitor after-hours service providers, crisis clinics, and other contracted entities.

- ***HRSA needs to provide direction to the RSNs regarding the definition of delegated activities, the need to assess subcontractors' ability to perform activities before contracting, and requirements for monitoring of delegated activities.***

**Care for enrollees with specialized needs.** The RSNs lack confidence in the quality of mental health specialist consultations. Acumentra Health's review of a sample of clinical records of enrollees with specialized needs at each RSN revealed a lack of consistency in the quality of the consultations, and in incorporating the recommendations of mental health specialist consultations into enrollee treatment plans. Certain populations of enrollees do not qualify for mental health specialty consultations despite having special cultural needs.

- ***HRSA needs to continue its process to redefine how RSNs are to ensure that enrollees with specialized needs are appropriately assessed, and that treatment plans incorporate the recommendations of mental health specialists.***

**Quality monitoring.** The clinical record review protocols used by the RSNs do not always address items from the federal protocol in a complete manner. The RSNs need direction regarding monitoring the overall quality of care in their service areas. The focus of clinical review currently addresses individual needs on a case-by-case basis. The RSNs need to establish a method to incorporate the results of clinical review into system-wide QI efforts.

- ***HRSA needs to provide direction to the RSNs regarding how to incorporate clinical quality monitoring into their QM plans and annual evaluations.***

**Enrollment data.** RSNs currently have to ask enrollees to correct their enrollment information at the Community Services Office where the enrollee is active. This is an inefficient method for updating essential enrollment data.

- ***HRSA needs to provide RSNs with a process or method for removing duplicate enrollees from the eligibility files.***

## Response to 2008 recommendations

The 2008 EQR report noted that the RSNs were still in transition to the BBA regulatory environment, and many were still overhauling their operations in response to EQR requirements. The report offered many recommendations as to how HRSA and the RSNs could work together to improve access to mental health care and the quality and timeliness of care. Table 36 outlines HRSA's response to those recommendations to date.

**Table 36. HRSA response to 2008 EQR recommendations for mental health.**

| 2008 recommendation | HRSA response | EQRO comments |
|---|---|---|
| ***Care coordination*** | | |
| • *Work with RSNs to establish standards and priorities for coordinating mental health and primary care services.*<br>• *Take steps to ensure exchange of information between the mental health clinician and PCP, and between the mental health clinician and ancillary agencies.* | DSHS's new vision for HRSA describes a set of health priorities. A key priority is behavioral and primary health care integration through person-centered healthcare homes, complemented by other priorities: chronic care self-management, improved quality, cost and effectiveness, and improved nutrition. Secretary Dreyfus has met with community representatives and stakeholders to obtain input and feedback on key questions related to integration of healthcare services.<br>RSN contract provisions effective October 1, 2009, require the contractor to<br>• respond to EPSDT referrals from primary medical care providers<br>• ensure that enrollees receive appropriate referrals for physical health care<br>• ensure coordination with other service delivery systems responsible for meeting enrollee needs identified in the Individual Service Plan, including primary medical care and social services<br>In 2009, the Legislature enacted HB 2025, allowing greater sharing of personal mental healthcare information among providers for the purposes of care coordination and treatment. The Washington Community Mental Health Council provided training on this change in the law in 2009 to approximately 200 people from across the state, primarily individuals who work with clinical records. | DSHS's focus on integrating physical and mental health care, coupled with the RSN contract amendments, represent a good first step toward fulfilling this recommendation. |
| ***Managing care*** | | |
| • *Increase efforts to clarify the criteria for initial and continuing care, to help RSNs effectively manage outpatient mental health services in line with the Recovery Model.*<br>• *Require RSNs to ensure that providers*<br>○ *document psychiatric symptoms that establish medical necessity and meet access-to-care standards for authorization of ongoing services* | MHD is exploring the feasibility of using federal block monies to fund RSN training on level-of-care guidelines. The intent is to educate RSNs on the application of objective and evidence-based level-of-care criteria when determining the appropriateness of behavioral healthcare services.<br>Once the RSNs are trained, HRSA will revisit RSN contract language and require the use of objective level-of-care criteria and guidelines, as well as documentation of systems that establish medical necessity for authorization of services. HRSA will establish documentation standards including (1) confirmation of diagnoses within 180 days of admission and at routine reevaluation periods going forward, (2) assessment of psychiatric symptoms, (3) recommended services, and (4) written justification for same. | HRSA's response addresses the recommendations. HRSA will need to monitor the RSNs' performance following the completion of these steps. |

| 2008 recommendation | HRSA response | EQRO comments |
|---|---|---|
| ○ *clarify deferred, rule-out, or provisional diagnoses within 180 days*<br>○ *assess and address sensitive cultural issues when developing treatment plans* | MHD has contracted with an outside entity to research best practices across the nation with regard to providing culturally competent and other specialty services. | |
| ***Mental health assessments*** | | |
| • *Establish a policy regarding frequency of comprehensive reassessment of enrollee's treatment needs.* | No work has occurred to address the frequency of reassessment.<br>RSN contract provisions effective October 1, 2009, require the contractor to review requests for additional services to determine a reauthorization following the exhaustion of previously authorized services by the enrollee. This must include:<br>• an evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods or intensity of services provided<br>• a method for determining if the enrollee has met discharge criteria | The contract revision provides needed direction for the RSNs. |
| ***Provider oversight*** | | |
| • *Clarify requirements for RSNs to monitor their provider networks versus the state's licensing of community mental health agencies. RSNs need to ensure that they monitor all delegated functions as required by federal regulations, and take corrective action as needed.* | HRSA plans to provide delegation training for the RSNs during 2010.<br>RSN contract provisions effective October 1, 2009, stipulate that<br>• a subcontract does not end the RSN's legal responsibility to perform the terms of the contract<br>• the contractor must monitor functions and responsibilities performed by or delegated to subcontractors on an ongoing basis<br>• RSN responsibilities for care management, authorization standards, and quality management may not be delegated to a contracted community mental health agency<br>• the contractor must develop a delegation plan before any new delegation of responsibility or authority related to information management, care management, authorization standards, or quality management through a subcontract or other legal agreement<br>• the contractor must maintain and make available to HRSA and the EQRO all delegation plans for subcontractors currently in place | HRSA's training plan and contract revisions address the recommendation. |

| 2008 recommendation | HRSA response | EQRO comments |
|---|---|---|
| ***Data improvements*** | | |
| • *Upgrade the data system used to calculate performance measures in order to identify Medicaid patients receiving state hospital or E&T services.*<br>• *Calculate all four statewide performance measures for the RSNs serving Medicaid enrollees.*<br>• *Devote sufficient staff resources to produce timely and accurate calculations of the statewide PIP indicators.* | HRSA has responded separately to the EQRO regarding issues related to data improvement. | See Performance Measure Validation and ISCA sections of this report, pages 56–76. |
| ***Compliance issues*** | | |
| • *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.*<br>• *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.* | Each Medicaid enrollee receives a benefits booklet published by DSHS. The benefits booklet explains due process. | The EQRO remains concerned that a decrease in the level of service can occur unless the enrollee understands that he or she has a right to appeal decisions. |
| • *Clarify that the requirements to provide interpretation and translation apply to all types of communication with enrollees.* | RSN contract provisions under Section 5.1.1.5–5.1.1.8 address this recommendation. The benefits booklet also explains the enrollee's right to translation and interpreter services. | HRSA will need to ensure that RSNs comply with the new contract requirements. |

| 2008 recommendation | HRSA response | EQRO comments |
|---|---|---|
| • *Revisit the complaint and grievance system to ensure that adequate data are available to identify system issues that affect the quality of care.* | | Not yet addressed. |
| • *Provide the RSNs with demographic data about all Medicaid-eligible people within their service areas.* | | Not yet addressed. |
| • *Develop a method to inform enrollees of changes in the benefit package, notification system, and provider listings on a timely basis.* | | Not yet addressed. |

## The path to future improvements: Physical health care

HRSA has taken limited action on the recommendations presented in the 2008 annual report for improving the medical managed care system (see Table 37). Those recommendations still apply. In addition, Acumentra Health offers the following "priority" recommendations.

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

- ***HRSA needs to require the MCOs to provide performance measure feedback to clinics and providers on a frequent and regular schedule.***

**Provider incentives.** Previously, Acumentra Health has recommended that MCOs serve as a resource to support clinical QI efforts. As an example, CHP has a grant program in place to support clinics that conduct focused QI initiatives. CHP's 2009 grants focused on establishing medical homes and reducing unnecessary ER utilization. The MCO awarded 19 grants to its network clinic systems this year.

- ***The MCOs should support and reward high-performing provider groups—e.g., those that develop medical homes for enrollees and improve their quality indicators.***

**Data completeness.** This issue is relevant when MCOs deliver services that are capitated or when providers may not submit claims if they perceive the reimbursement to be low. The Healthy Options MCOs should

- ***evaluate expected claims or encounter volumes by provider type to help identify missing data***
- ***monitor data submitted by vendors (e.g. pharmacy and lab data) to help ensure that the data are complete and accurate, and ensure that formal reconciliation processes are in place to ensure the integrity of data transfer between MCOs and their vendors***

HRSA requires the Healthy Options MCOs to report race and ethnicity data for all enrollees each year (a HEDIS measure). However, reporting is not consistent among the MCOs, and large gaps remain in the repored ethnicity data.

- ***HRSA either should institute corrective action for an MCO that fails to report complete race/ethnicity data, or require the MCO to conduct a PIP to improve reporting of complete race/ethnicity data.***

### Response to 2008 recommendations

The 2008 EQR report offered recommendations as to how HRSA and the MCOs could work together to improve access to physical health care and the quality and timeliness of care. Table 37 outlines HRSA's response to those recommendations to date.

**Table 37. HRSA response to 2008 EQR recommendations for physical health.**

| 2008 recommendation | HRSA response | EQRO comments |
|---|---|---|
| ***Value-based purchasing*** | | |
| • *Redirect a significant portion of MCO incentive funds to the provider level.* | HRSA has taken no action on this recommendation.<br><br>HRSA is expanding value-based purchasing in a planned Healthy Options Request for Proposals (RFP) to be released in late 2010. HRSA is considering a contractual requirement for MCOs to pass a portion of incentive payments to PCPs.<br><br>HRSA has redirected efforts toward testing and evaluating "medical home" as part of a statewide (and insurance-wide) effort to implement a medical home model. The group tasked with this effort may include performance incentives as part of the model. The Puget Sound Health Alliance is leading this effort on behalf of the HCA and HRSA. | EQRO supports the plan to include this requirement in the next RFP for MCOs. |
| ***Improving preventive care*** | | |
| • *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, addressing provider performance feedback as well as financial incentives to clinics.* | See above. Also, reductions in staff and budget have impaired HRSA's ability to move forward on the performance feedback recommendation. HRSA has partnered with the Puget Sound Health Alliance in producing a report card on Medicaid performance compared to commercially insured populations. In some instances, Medicaid performs comparably or better than commercial health plans in the Puget Sound area. To view the report card, visit *www.pugetsoundhealthalliance.org/documents/PSHealthAlliance_MedicaidvCommercialInsurRpt_May09.pdf* | Consider adding this reporting requirement in the next MCO contract. |
| • *Continue support for shared learning to help providers collaborate in their efforts to improve care for children.* | The Washington Medicaid program no longer directly supports the Washington State Collaborative to Improve Health. For 2011–2013, HRSA will require the Healthy Options MCOs to provide financial support for the collaborative, based on enrollment in the MCO. | This plan is responsive. |
| • *Consider organizing a statewide PIP targeting WCC visit rates that would pool resources and capitalize on partnerships.* | HRSA will consider this recommendation in crafting the Healthy Options RFP. | |

| 2008 recommendation | HRSA response | EQRO comments |
|---|---|---|
| ***Compliance review*** | | |
| • *Consider incorporating visits to provider clinic sites into the annual compliance review.* | Reductions in staff and budget have impaired HRSA's ability to move forward on this recommendation. In addition, HRSA sees this activity as primarily the responsibility of the Healthy Options contractors. | EQRO agrees with this response. |
| • *Consider requiring NCQA accreditation for all Medicaid MCOs.* | Because of reductions in Healthy Options contractor funding, HRSA believes the timing is not right for this recommendation, as it would place additional burden and costs onto the Healthy Options contractors. | EQRO considers this action responsive. |
| • *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.* | As part of continuous quality improvement, HRSA strives to ensure that its monitoring activities reflect a valid and reliable process. HRSA seeks feedback on its process from the MCOs annually and uses that feedback to inform and strengthen the monitoring process. HRSA also seeks feedback from monitoring staff and uses that feedback to improve the monitoring process. | EQRO considers this action responsive. |
| • *Move beyond a focus on regulatory compliance to offer health plans more technical assistance and support.* | HRSA offers technical assistance to Healthy Options plans on numerous topic areas as appropriate to the need. For example, in 2009, agency staff provided technical assistance to MCOs on the Patients Requiring Consultation program as a result of the TeaMonitor review. | EQRO considers this action responsive. |
| ***Data improvements*** | | |
| • *Continue to help the MCOs study and overcome barriers to collecting adequate administrative data for HEDIS measures. Consider conducting an optional study aimed at improving or validating encounter data, as per the EQR protocol.* | While HRSA acknowledges such a need, reductions in HRSA and Healthy Options contractor funding prevent HRSA from considering this recommendation at this time. The requirement would place additional burden and costs onto the agency and Healthy Options contractors. | EQRO recommends that HRSA explore data validation activities to ensure data completeness. |
| • *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.* | HRSA plans to implement this recommendation. | EQRO encourages HRSA to incorporate formal expectations for the MCOs into the next contract. |

## The path to future improvements: WMIP

The following recommendations from the 2008 EQR report continue to apply.

- ***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 HRSA-DHS should meet with mental health program managers to discuss 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.***

Acumentra Health offers this additional recommendation:

- ***HRSA should explore opportunities to promote the WMIP program as a model that supports the medical or health home model.***

## The path to future improvements: EQR follow-up

The 2008 EQR report recommended that HRSA

- ***implement contractual requirements for all MCOs and RSNs to address the specific recommendations in this report.*** HRSA is considering this recommendation in connection with a future Healthy Options Request for Proposals, including contract revisions. HRSA has modified RSN contract provisions to address certain recommendations.
- ***merge and integrate the DHS and MHD Medicaid quality strategies to reflect a coordinated approach to managed care for physical and mental health.*** HRSA is in the process of rewriting the Medicaid Quality Strategy so that it will reflect an integrated and coordinated approach.

Following HRSA's physical/mental health merger and extensive personnel cuts, staff support for EQR program administration is underfunded and fragmented throughout three divisions. This affects all of HRSA's QI activities, and especially those that depend on a robust IT infrastructure. The current crisis, however, offers an opportunity for HRSA to take several steps needed to ensure the continuity and long-term viability of the EQR program:

- ***convene personnel from all divisions, in conjunction with its quality oversight committee, to review the 2009 EQR recommendations and prioritize the actions that HRSA will take in response***
- ***realign HRSA's organizational structure to support the efficient administration of EQR program activities***

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 for improvement were based on Acumentra Health's compliance review of each RSN.

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# Chelan-Douglas Regional Support Network (CDRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Fully met (4.8 out of 5)** | |
| • RSN contracts with providers that offer a broad spectrum of mental health treatment, rehabilitation, and support services to help meet enrollee needs.<br>• Incorporates the need for cultural awareness into many of its programs, policies, and procedures. Enrollee rights include the right to consideration of cultural variables. | • Needs to develop a method to inform enrollees that out-of-network services are available and how to obtain them. |
| **Coordination and Continuity of Care — Fully met (5 out of 5)** | |
| • Chart audits include monitoring to ensure coordination of mental health treatment with other service providers.<br>• Clinical records demonstrate that enrollees' treatment plans incorporate the recommendations of other agencies and providers of specialized services, and are developed with the participation of enrollees and/or their families. | |
| **Coverage and Authorization of Services — Fully met (5 out of 5)** | |
| • Medical Criteria/Utilization Management Guidelines serve as the framework for authorizing medically necessary services for eligible children, youth, and adults. | |
| **Provider Selection — Fully met (4.6 out of 5)** | |
| • Contracts outline the provider agencies' responsibility to ensure that practitioners are credentialed and participate in the RSN's annual credentialing review. | • Needs to continue screening of RSN and provider agency staff to ensure that no employees have been excluded from participating in federal healthcare programs, and retain documentation of the screening results. |
| **Subcontractual Relationships and Delegation — Substantially met (4 out of 5)** | |
| • Policy and contracts specify delegated activities and the subcontractor's responsibilities. | • Needs to monitor all delegated functions and perform an annual review of the performance of all subcontractors. |
| **Practice Guidelines — Fully met (4.7 out of 5)** | |
| • Convened a work group of local providers to develop guidelines appropriate for the community healthcare system. | • Needs to develop a written policy on the dissemination of practice guidelines. |
| **QA/PI General Rules and Basic Elements — Fully met (4.7 out of 5)** | |
| • Key QI components include monitoring the performance of delegated functions; monitoring satisfaction through enrollee surveys and review of complaints and grievances; clinical performance measurement; and resource management. | • Needs to submit updated documentation for its nonclinical PIP.<br>• Needs to develop a policy/procedure on over- and underutilization of services, including the process for identifying, monitoring, tracking, and taking action. |
| **Certification and Program Integrity — Fully met (5 out of 5)** | |
| • Administrative infrastructure and management arrangements and procedures are aligned to guard against fraud and abuse.<br>• Compliance plan states the RSN's commitment to prevent, detect, and address fraud and abuse. | |
| 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 CY 2008, CDRSN provided outpatient services to 1,849 out of 23,647 (7.8%) Medicaid enrollees. | |
| Data source: Chelan-Douglas RSN 2009 External Quality Review Report (Acumentra Health). | |

# Chelan-Douglas Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Metabolic Syndrome Screening and Intervention — Fully met (72 out of 80)** | |
| Completed data collection and metabolic syndrome screening on 34 enrollees with schizophrenia at baseline and remeasurement, and concluded that the intervention did not improve the study indicators. Clearly identified barriers to improvement, such as the difficulty in obtaining completed lab results and the sensitivity of the study indicator to detect change. | Needs to use local qualitative and quantitative data to justify the selection of the study topic; describe the rate and reasons for enrollee attrition from baseline to remeasurement; validate that all screening data are complete and accurate; and explain the rationale for choosing a particular statistical test to analyze the data. |
| **Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Not met (0 out of 80)** | |
| | Did not provide timely written or verbal documentation to support its nonclinical PIP. The RSN was sent a corrective action plan by the state and submitted documentation in mid-November 2009. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Partially met (2.5 out of 3)** | |
| • Effectively monitors and oversees the Washington State Consortium and activities contracted to NetSmart, the RSN's application service provider. | • **Finding:** Lacks proper oversight and monitoring of the RSN's utilization management subcontractor regarding the collection and storage of Medicaid enrollment and service utilization information. |
| **Staffing — Fully met (3 out of 3)** | |
| • NetSmart provides new software programmers with formal training that includes mentoring by senior programmers. | |
| **Hardware Systems — Fully met (3 out of 3)** | |
| • NetSmart maintains current premium-level hardware, software, and network vendor service contracts.<br>• CDRSN's and NetSmart's data center facilities and hardware systems are well designed and maintained. | |
| **Security — Partially met (2.3 out of 3)** | |
| • NetSmart's secure architecture makes it hard for unauthorized users to gain access to data and other network resources.<br>• NetSmart employs an outside vendor to perform annual penetration testing of its network to ensure that proper security measures and safeguards are in place. | • **Finding**: Utilization management subcontractor denied the EQRO's request to perform a security walkthrough of the subcontractor's data facilities. |
| **Administrative Data (Encounter data) — Fully met (3 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process to verify data accuracy and validity. | |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Performs frequent audits of MHD's eligibility enrollment files to ensure that they are free of anomalies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Partially met (2.5 out of 3)** | |
| • Conducts onsite review of all provider agencies twice a year, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository to help enrollees make decisions about access to providers that can meet their special care needs. |

# Clark County Regional Support Network (CCRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Fully met (4.6 out of 5)** | |
| • Monitors provider performance by conducting office visits, reviewing provider schedules, performing "secret shopper" calls, and reviewing enrollees' grievances and appeals.<br>• Partnered with local hospitals to develop protocols for bed management of patients boarded in ED. RSN staff performs daily "check-in" to determine bed capacity and staffing levels. | • Needs to continue to closely monitor all contracted agencies to ensure that enrollees are receiving services in a timely manner, to identify access issues, and to initiate corrective action as indicated. |
| **Coordination and Continuity of Care — Fully met (4.7 out of 5)** | |
| • Electronic health records permit quick access to information needed to develop treatment plan and care coordination.<br>• Care managers facilitate coordination among organizations that provide services for enrollees. Care managers can coordinate services when an enrollee is admitted to an acute care or long-term care facility. | • Needs to work with providers to ensure that mental health specialist consultants' recommendations are incorporated into enrollees' treatment plans. |
| **Coverage and Authorization of Services — Substantially met (4.1 out of 5)** | |
| • Contracts with a crisis outreach team to deliver crisis response and intervention, referral, and linkage services for all adult Medicaid enrollees in Clark County.<br>• Compiles and analyzes a large number of reports to monitor program effectiveness and utilization trends. | • Needs to ensure that service authorization records contain sufficient documentation to justify the determination of medical necessity and level of care.<br>• Records need to document that decisions are made by mental health professionals with appropriate clinical expertise. |
| **Provider Selection — Substantially met (4.2 out of 5)** | |
| • Performs annual site review at each contracted agency. The audit tool covers administrative activities, authorization decisions, PIPs, data integrity, clinical chart review, credentialing, and practice guideline monitoring. | • Needs to develop and maintain a policy defining credentialing and recredentialing of RSN staff, and apply the existing policy on monitoring for excluded providers to RSN staff.<br>• Needs to continue to monitor subcontractors' credentialing processes to ensure that documented processes are followed. |
| **Subcontractual Relationships and Delegation — Fully met (5 out of 5)** | |
| • Basic interagency agreement contains all necessary standards and policies to comply with state and federal laws.<br>• Initiated appropriate corrective action plans as a result of its oversight of delegated entities. | |
| **Practice Guidelines — Substantially met (4.7 out of 5)** | |
| • Endorses nationally recognized and locally accepted guidelines and reviews them annually.<br>• Monitors application of guidelines through annual clinical chart review at provider agencies. | • To ensure consistent application of practice guidelines, needs to define the criteria for making medical necessity decisions when considering service authorization requests. |
| **QA/PI General Rules and Basic Elements — Fully met (5 out of 5)** | |
| • Comprehensive QM program includes quality assurance and improvement activities.<br>• Staff conducts focused audits of clinical records, requires corrective action, and provides technical assistance. | |
| **Certification and Program Integrity — Fully met (5 out of 5)** | |
| • Compliance plan is comprehensive.<br>• Routinely reviews management reports to identify irregularities in service delivery. | |
| 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 CY 2008, CCRSN provided outpatient services to 5,684 out of 72,619 (7.8%) Medicaid enrollees. | |
| Data source: Clark County RSN 2009 External Quality Review Report (Acumentra Health). | |

# Clark County Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Employment Outcomes for Adult Consumers — Substantially met (59 out of 80)** | |
| Has done well in designing and documenting all completed standards for its clinical PIP, and particularly in developing a comprehensive intervention strategy based on the identified barriers to enrollee employment. | At time of review, had not reported its baseline enrollee employment rate nor completed its first remeasurement, since intervention activities began in mid-December 2008. |
| **Nonclinical: Timeliness of Access to Outpatient Services — Substantially met (59 out of 80)** | |
| Has done a good job of refining its study documentation, designing sound data collection and validation procedures, and continually monitoring its system to modify intervention strategies and obtain further improvement. | Needs to be able to capture through its data collection procedures all enrollees who request routine outpatient services, since this is the target study population. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Fully met (3 out of 3)** | |
| • Effectively monitors and oversees the Washington State Consortium and activities contracted to NetSmart, the RSN's application service provider.<br>• Uses well-documented process to verify that all reports produce the desired data, formats, and distribution. | |
| **Staffing — Fully met (3 out of 3)** | |
| • Provides training for care management and IS staff, including refresher and external training as needed. | |
| **Hardware Systems — Fully met (3 out of 3)** | |
| • CCRSN and NetSmart maintain current premium-level hardware, software, and network vendor service contracts.<br>• CCRSN's and NetSmart's data center facilities and hardware systems are well designed and maintained. | |
| **Security — Fully met (2.9 out of 3)** | |
| • NetSmart's secure architecture makes it hard for unauthorized users to gain access to data and other network resources.<br>• NetSmart employs an outside vendor to perform penetration testing of its network to ensure that proper security measures and safeguards are in place. | • Clark County's and NetSmart's security policies and procedures are not managed within an organized control framework (a set of generally accepted measures, indicators, processes, and best practices that help an organization improve its security posture). |
| **Administrative Data (Encounter data) — Fully met (2.9 out of 3)** | |
| • Contracted providers submit encounter data electronically; stringent screening process verifies data accuracy and validity.<br>• Automated edits and verification checks ensure completeness and correctness of data. | • Performs regular backups of data but does not "freeze" the data extracted for reporting. |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Performs frequent audits of MHD's eligibility enrollment files to ensure they are free of anomalies.<br>• Provides timely determination of enrollee eligibility for provider agencies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (3 out of 3)** | |
| • Conducts onsite review of all provider agencies annually.<br>• Maintains up-to-date provider profile information to help Medicaid enrollees make informed decisions about access to providers that can meet their special care needs. | |

# Grays Harbor Regional Support Network (GHRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Substantially met (4.3 out of 5)** | |
| • Policy requires coordination with the RSN to ensure that the enrollee's cost of out-of-network services is no greater than it would be if services were furnished within the network.<br>• Some staff skilled in American Sign Language and Spanish.<br>• Actively seeks programs and contracts that provide services for diverse cultural and ethnic backgrounds. | • Needs to monitor to ensure that providers meet standards for timely access to care. |
| **Coordination and Continuity of Care — Substantially met (3.6 out of 5)** | |
| • Monitors compliance to ensure that "special populations" as defined by the state receive consultation in a timely manner.<br>• Monthly chart audits address enrollee assessment, treatment and crisis plans, advance directives, and whether goals and objectives reflect "client voice." RSN requires agencies to follow up with staff training as needed. | • Needs to demonstrate that mechanisms exist to ensure care coordination with physical healthcare providers and plans.<br>• Needs to ensure that recommendations from mental health specialists are incorporated into enrollees' treatment plans.<br>• Needs to develop a mechanism to monitor the frequency of requests for direct access to specialists. |
| **Coverage and Authorization of Services — Substantially met (4 out of 5)** | |
| • Level-of-care clinical guidelines serve as framework for authorizing medically necessary services for enrollees eligible to receive treatment for psychiatric disorders. | • Needs to continue to improve data reporting capabilities and monitor frequency, type, and outcomes of enrollees seeking crisis, stabilization, and post-hospitalization services. |
| **Provider Selection — Partially met (2.6 out of 5)** | |
| • Mental Health Advisory Board reviews all Requests for Proposals when the RSN adds providers or services, evaluates the strength of proposals, and makes recommendations to the local Public Health and Social Service Administration. | • Needs to develop a policy defining the credentialing and recredentialing process for RSN and provider agency staff.<br>• Needs to develop a method to monitor staff credentials.<br>• Needs documentation to verify that it does not employ or contract with providers who are excluded from participating in federal healthcare programs. |
| **Subcontractual Relationships and Delegation — Partially met (3 out of 5)** | |
| • Joined other RSNs in a consortium that used a common managed care/practice management system. | • Needs to monitor the credentialing/recredentialing process.<br>• Needs to ensure that subcontractors' performance is monitored and mechanisms are in place to respond to deficiencies. |
| **Practice Guidelines — Substantially met (3.7 out of 5)** | |
| • Developed practice guidelines in cooperation with network mental health service providers. | • Needs to develop mechanisms to ensure that utilization management, enrollee education, and coverage are consistent with guidelines. |
| **QA/PI General Rules and Basic Elements — Partially met (3.3 out of 5)** | |
| • Requires contractors to perform annual QA/PI self-evaluation.<br>• Monitoring discovered that a certified mental health agency was not delivering full scope of a service. Follow-up indicated that service delivery changed; no further issues noted.<br>• Identifies enrollees with co-occurring disorders who need better coordination of services. | • Needs to evaluate performance of its QA/PI activities annually.<br>• Needs to continue to develop a system to ensure accurate monitoring of access to care and services.<br>• Needs to develop a mechanism for taking action on findings of over- and underutilization of services. |
| **Certification and Program Integrity — Substantially met (4 out of 5)** | |
| • One contracted agency has developed a fraud and abuse hotline and tested its system. No fraud or abuse was identified. | • Needs to fully implement the internal auditing processes defined in its compliance plan.<br>• Needs to ensure that internal processes are in place to prevent inadvertent release of personal health information. |
| 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 CY 2008, GHRSN provided outpatient services to 1,702 out of 17,849 (9.5%) of Medicaid enrollees. | |
| Data source: Grays Harbor RSN 2009 External Quality Review Report (Acumentra Health). | |

# Grays Harbor Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder (MDD) — Partially met (52 out of 80)** | |
| Presented local data showing the prevalence of MDD in the enrollee population, supporting the selection of the study topic. Cited a clear rationale for developing the study indicator based on a standardized instrument for measuring depression. | Needs to track the implementation of the intervention (clinician adherence to MDD practice guideline), and explain how the intervention represents a new aspect of care that is expected to improve clinical outcomes. |
| **Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Fully met (71 out of 80)** | |
| After assigning a discharge oversight clinician to arrange follow-up care, the percentage of enrollees with an outpatient service within seven days of discharge rose from 37% to 51%, a statistically significant improvement. | Needs to conduct an analysis to determine if the intervention worked as planned; identify additional factors that may have contributed to improvement; and relate the success of the intervention to improvement in the study indicators. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Partially met (2.5 out of 3)** | |
| • Effectively monitors and oversees the Washington State Consortium and activities contracted to NetSmart, the RSN's application service provider.<br>• NetSmart's Avatar product suite gives programmers flexibility to develop sophisticated data processing methods. | • **Finding:** Lacks proper oversight and monitoring of the RSN's utilization management subcontractor regarding the collection and storage of Medicaid enrollment and service utilization information. |
| **Staffing — Partially met (2.4 out of 3)** | |
| • NetSmart provides new software programmers with formal training that includes mentoring by senior programmers. | • Lacks a training manual and/or collection of written standard operating procedures to help new employees learn to maintain and administer RSN information systems. |
| **Hardware Systems — Partially met (2.3 out of 3)** | |
| • NetSmart's data center facilities and hardware systems are well designed and maintained. | • Grays Harbor County does not maintain a current hardware vendor service contract for the RSN's Medicaid server. The server is located on the floor in the computer room of the RSN facility, which is located in a designated A2 flood zone. |
| **Security — Partially met (2.2 out of 3)** | |
| • NetSmart's secure architecture makes it hard for unauthorized users to gain access to data and resources. | • **Finding**: Utilization management subcontractor denied the EQRO's request to perform a security walkthrough of the subcontractor's data facilities. |
| **Administrative Data (Encounter data) — Fully met (3 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process to verify data accuracy and validity.<br>• Automated adjudication edits and verification checks ensure correctness of submitted encounter data. | |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Performs frequent audits of MHD's eligibility enrollment files to ensure that they are free of anomalies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (2.7 out of 3)** | |
| • Conducts onsite review of all provider agencies every year, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository to help enrollees make decisions about access to providers that can meet their special needs. |

# Greater Columbia Behavioral Health (GCBH)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Substantially met (3.8 out of 5)** | |
| • Annual clinical record reviews include monitoring for timely access to care and services. Other monitoring methods include reviewing complaints and grievances, and performing enrollee surveys. Sends individual reports to agencies and a roll-up report to the Quality Management Oversight Committee.<br>• Has a multicultural competency committee. | • Needs to determine how the RSN intends to measure network capacity and sufficiency.<br>• Needs to ensure that clinically necessary services are delivered in a timely manner when the network cannot provide them.<br>• Needs to develop a mechanism to track out-of-network services secured for enrollees by network providers. |
| **Coordination and Continuity of Care — Fully met (4.8 out of 5)** | |
| • Contract requires coordination with primary care physicians or clinics; clinical record review demonstrates coordination of care.<br>• Enrollees with specialized needs are identified at intake, through self-reporting, or at the time of a referral for services.<br>• Care coordinators perform chart audits annually, which include requirements for specialized healthcare needs. | • Needs to formalize reporting mechanisms to more adequately reflect how timely the agencies are providing direct access. |
| **Coverage and Authorization of Services — Fully met (4.7 out of 5)** | |
| • Level-of-care guidelines serve as a framework for authorizing medically necessary services for children, youth, and adults.<br>• Monitors service authorization through annual chart audits; reviews enrollee survey feedback, grievances and appeals, and inter-rater reliability audits. | • Needs to resume tracking and monitoring of inappropriate use of crisis services, and report results to appropriate committees. |
| **Provider Selection — Fully met (4.6 out of 5)** | |
| • Credentialing files reviewed for care coordinators contained all required items. | • Needs to ensure that all RSN, provider, and subcontractor staff are screened for exclusion from participating in federal healthcare programs. |
| **Subcontractual Relationships and Delegation — Substantially met (4 out of 5)** | |
| • Contract specifies activities and responsibilities providers are required to perform, including steps the RSN will take if the contractor fails to perform. | • Pre-delegation credentialing is informal; needs to develop and implement a more formal system for capturing, recording, and storing results from credentialing. |
| **Practice Guidelines — Fully met (4.7 out of 5)** | |
| • Practice guidelines are posted on the RSN's website.<br>• Monitors providers' use of approved guidelines when making medical and utilization management decisions, including consistency of decision making. | • Needs to review practice guidelines to ensure that the needs of enrollees are adequately addressed. |
| **QA/PI General Rules and Basic Elements — Partially met (3 out of 5)** | |
| • QM plan specifies data elements needed to facilitate meaningful analysis for a given indicator/measure, the means by which the data are collected, and who is responsible. | • Needs to conduct annual evaluation of QM program.<br>• Quality Management Oversight Committee needs to meet regularly. |
| **Certification and Program Integrity — Fully met (5 out of 5)** | |
| • Has administrative and management arrangements and procedures in place to guard against fraud and abuse.<br>• Has tested its systems and taken action when indicated. | |
| 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 CY 2008, GCBH provided outpatient services to 13,105 out of 172,859 (7.6%) Medicaid enrollees. | |
| Data source: Greater Columbia Behavioral Health 2009 External Quality Review Report (Acumentra Health). | |

# Greater Columbia Behavioral Health (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Impact of Implementing the PACT Model on the Use of Inpatient Treatment— Substantially met (67 out of 80)** | |
| Clearly documented study question, indicators, data collection and validation methodology. Preliminary data show an improvement (reduction) in the number of inpatient days for PACT enrollees. | Needs to describe how this PIP topic was prioritized and whether the RSN considered input from consumers and other stakeholders in the selection process. Needs to report results using final study data. |
| **Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Fully met (79 out of 80)** | |
| Used barrier analysis to develop its intervention strategy. Used local data to formulate study population and indicator, and used sound data validation techniques. Reported that it did not achieve statistical or clinical improvement. | None. Used sound methodology to draw conclusions about the effectiveness of the intervention. Does not plan to continue this PIP in 2010. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Partially met (2.5 out of 3)** | |
| • Hired chief information officer in October 2008 to oversee RSN information systems.<br>• IT governance provides effective strategic direction and decision making. | • **Finding:** Lacks proper oversight and monitoring of RSN's utilization management subcontractor regarding the collection and storage of Medicaid enrollment and service utilization information.<br>• Lacks proper oversight and monitoring of RSN's data management consultant.<br>• Does not have a quality assurance process or maintain technical documentation of its information systems. |
| **Staffing — Partially met (2.5 out of 3)** | |
| • Data processing and IT staff adhere to established productivity standards for meeting the state's service encounter reporting requirements. | • Lacks a training manual and/or collection of written standard operating procedures to help new employees learn to maintain and administer RSN information systems, develop and analyze reports, and process encounter/claims data.<br>• Written job descriptions are not up-to-date. |
| **Hardware Systems — Fully met (3 out of 3)** | |
| • Servers are housed in a secure location, away from personnel who are not authorized to have physical access to them. | |
| **Security — Partially met (2.5 out of 3)** | |
| • Maintains a Disaster Recovery Plan that is audited and tested annually to ensure that information systems can be maintained, resumed, and/or recovered as intended. | • **Finding:** Utilization management subcontractor denied the EQRO's request to perform a security walkthrough of the subcontractor's data facilities.<br>• Needs to adopt an IT control framework to help build control structure and ensure a sustainable information security program. |
| **Administrative Data (Encounter data) — Partially met (2.5 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process to verify data accuracy and validity. | • Does not provide exception and "aging" reports to enable provider agencies to examine possible encounter errors and correct them. |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Performs frequent audits of MHD's eligibility enrollment files to ensure that they are free of anomalies. | |
| **Vendor Data Integrity — Fully met (2.7 out of 3)** | |
| • Transmits all encounter data to the state in HIPAA-compliant format. | |
| **Provider Data (Compensation and profiles) — Fully met (3 out of 3)** | |
| • Maintains up-to-date provider profile information to help Medicaid enrollees make informed decisions about access to providers that can meet their special care needs. | |

# King County Regional Support Network (KCRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Substantially met (4.3 out of 5)** | |
| • Has a robust method for monitoring network capacity.<br>• Routinely analyzes frequency of requests for out-of-network services and uses information to identify service gaps.<br>• Actively seeks programs and contracts that provide services for enrollees from diverse cultural and ethnic backgrounds. | • Should consider requiring providers to track and report requests for second opinions.<br>• Needs to continue to monitor all contracted provider agencies closely to ensure that enrollees receive timely services. |
| **Coordination and Continuity of Care — Fully met (4.8 out of 5)** | |
| • Medical director co-chaired a committee that sought to identify ways to improve integration of services within the county.<br>• Requires mental health agencies to identify and communicate with each enrollee's physical healthcare provider.<br>• Annual chart audit covers intake assessments, referrals, treatment planning, progress notes, medication supervision, and discharge planning. | • Needs to continue working with provider agencies to ensure that enrollees with specialized needs have timely access to care. |
| **Coverage and Authorization of Services — Substantially met (4.4 out of 5)** | |
| • Offers performance incentive payments to providers to encourage better performance on specific quality measures.<br>• Implemented a Recovery Model of care in 2008.<br>• Identifies crisis admissions as critical incidents and performs retrospective review. | • Needs to develop a formal process for ensuring inter-rater reliability among review staff, including physician review.<br>• Needs to ensure that all authorization decisions follow the same process and timelines, including for services that are less than the amount, frequency, and/or duration requested. |
| **Provider Selection — Fully met (4.6 out of 5)** | |
| • Credentialing process is comprehensive.<br>• Compliance plan requires providers to implement procedures to screen their employees and subcontractors to determine whether they are excluded from participating in federal healthcare programs. | • Needs to review expectations with all agencies to ensure that they routinely monitor for excluded providers. |
| **Subcontractual Relationships and Delegation — Substantially met (4 out of 5)** | |
| • Conducts quarterly performance review of delegated activities and annual recredentialing of all providers. | • Needs to verify that providers are implementing the processes they attest to being in place during recredentialing. |
| **Practice Guidelines — Fully met (4.7 out of 5)** | |
| • Developed guidelines for schizophrenia and for specific diagnoses through a process that involved convening an internal work group, analyzing prevalent diagnoses within the network, obtaining feedback from providers, and performing a web search for evidence-based practices. | • Needs to revise its written policy to specify the mechanism for disseminating practice guidelines. |
| **QA/PI General Rules and Basic Elements — Fully met (4.5 out of 5)** | |
| • Maintains comprehensive QM program.<br>• Developed process and outcome measures for Life Activities, Housing, Community Tenure, and Quality of Life. | • Needs to evaluate its QM program annually, as required by the RSN contract and state regulations.<br>• Needs to specify its criteria for determining over- and underutilization of services. |
| **Certification and Program Integrity — Fully met (5 out of 5)** | |
| • Compliance plan is comprehensive and clear. | |
| 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 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 CY 2008, KCRSN provided outpatient services to 26,804 out of234,212 (11.4%) Medicaid enrollees. | |
| Data source: King County RSN 2009 External Quality Review Report (Acumentra Health). | |

# King County Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Metabolic Syndrome Screening and Intervention — Fully met (78 out of 80)** | |
| Clearly documented all aspects of this PIP. Progressed to the point of determining that the interventions were not strong enough to improve enrollee clinical outcomes. Barrier analysis and expert consultation helped refocus the PIP toward making screening for metabolic syndrome part of routine clinical practice. | Plans to refocus the study to incorporate metabolic syndrome screening into routine practice at the provider level, and measure success via the percentage of at-risk enrollees screened for symptoms. |
| **Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Substantially met (60 out of 80)** | |
| After careful barrier analysis, formed a Centralized Diversion Team to review discharge planning, identify needed resources, and ensure continuity of care between inpatient and outpatient services. Intervention pilot began in September 2009 at largest provider agency. Agencies are developing their own intervention strategies since the RSN implemented pay for performance. | Needs to complete baseline and remeasurement data collection and determine whether the intervention resulted in statistically significant improvement. Plans to create a timeline to track performance with the implementation of the pilot and provider-level interventions, to demonstrate that any improvement is related to the interventions. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Fully met (3 out of 3)** | |
| • In-house encounter data processing database is secure, robust, and scalable.<br>• Software programming, quality assurance, and IT staff are highly trained and experienced. | |
| **Staffing — Fully met (3 out of 3)** | |
| • Maintains low staff turnover, a good indicator of effective management and employee satisfaction. | |
| **Hardware Systems — Fully met (3 out of 3)** | |
| • Takes full advantage of redundant software and hardware designs. | |
| **Security — Fully met (2.8 out of 3)** | |
| • Performs quarterly penetration testing of its network to ensure that proper security measures and safeguards are in place. | • IT security policies and procedures, although well documented, are not managed within an organized control framework. |
| **Administrative Data (Encounter data) — Fully met (2.8 out of 3)** | |
| • Automated pre- and post-adjudication edits and verification checks ensure completeness and correctness of submitted encounter data.<br>• Performs regular audits of encounter claims to ensure data integrity and validity. | • Does not maintain an “aging” report to enable the RSN to monitor provider agencies with outstanding encounter data claims. |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Provides timely determination of enrollee eligibility for provider agencies.<br>• Performs a monthly reconciliation process to verify the state’s eligibility data against information submitted by providers. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (2.7 out of 3)** | |
| • Conducts onsite review of all provider agencies every year, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository to help enrollees make decisions about access to providers that can meet their special care needs. |

# North Central Washington Regional Support Network (NCWRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Substantially met (4.1 out of 5)** | |
| • Implemented telehealth services in most counties during January 2008.<br>• Monitors cultural awareness at the practitioner level when performing audits. | • Needs to establish clear criteria for determining whether its providers are meeting capacity expectations.<br>• Needs to establish formal process to ensure that network capacity is sufficient to meet needs of population.<br>• Needs to closely monitor contracted agencies to ensure that enrollees are receiving services in a timely manner. |
| **Coordination and Continuity of Care — Substantially met (4 out of 5)** | |
| • Requires providers to refer all enrollees over age 60 who are seeking services for mental health *and* substance abuse to a primary care provider.<br>• Audits 10% of clinical records monthly to ensure sound management of individual care plans, that treatment goals reflect enrollee "voice," that goals are identified and care is coordinated, and that treatment is congruent.<br>• Reports that each agency has sufficient staff to address enrollees with specialized needs. | • Needs to continue to coach and provide technical assistance to agency staff for coordination of care.<br>• Needs to continue to guide subcontractors in incorporating the recommendations of mental health specialists and others into the enrollee's treatment plan.<br>• Needs to continue to monitor all subcontractors' compliance with direct access standards and require corrective action when necessary. |
| **Coverage and Authorization of Services — Substantially met (4.4 out of 5)** | |
| • Reviews all service authorizations to ensure that the requested services meet level-of-care requirements.<br>• Reports that most authorization decisions are made within 3 days of receiving a request.<br>• Maintains a spreadsheet of each hospitalization by provider and tracks post-hospital appointments. | • Needs to establish formal process to ensure uniform application of utilization management criteria.<br>• Needs to establish a mechanism to ensure that payment for crisis services is not denied.<br>• Needs to analyze data to identify potential inappropriate or avoidable use of crisis services. |
| **Provider Selection — Substantially met (3.8 out of 5)** | |
| • Reviews annually all records of mental health practitioners hired at each agency within the past year and a sample of those previously hired. | • Needs to develop a policy/procedure clearly defining the credentialing and recredentialing expectations for delegated agencies and RSN staff. |
| **Subcontractual Relationships and Delegation — Substantially met (4 out of 5)** | |
| • Performs yearly monitoring of the duties delegated to each subcontractor. Audit tool provides for corrective action and follow-up. | • Needs to establish a policy/procedure specifying how the RSN oversees/evaluates the activities delegated to subcontractors. Policy needs to specify the oversight body. |
| **Practice Guidelines — Fully met (4.7 out of 5)** | |
| • Expects all contracted providers to implement RSN's clinical guidelines endorsed by the American Psychiatric Association. | • Needs to ensure that adopted guidelines are reviewed and updated. |
| **QA/PI General Rules and Basic Elements — Partially met (2.7 out of 5)** | |
| • Requires provider agencies to have processes in place to ensure the submission of accurate data.<br>• Monthly utilization review collects data on service utilization, congruence between diagnosis and treatment, enrollee voice, specialist referrals, and coordination of care. | • Needs to evaluate QM activities annually.<br>• Needs to reconvene an oversight body and adopt/implement a comprehensive QM program.<br>• Needs to implement processes to ensure the reporting of accurate and complete data in a timely manner.<br>• Needs to implement a formal mechanism to detect over- and underutilization of services. |
| **Certification and Program Integrity — Fully met (4.5 out of 5)** | |
| • Infrastructure guards against fraud and abuse. | • Needs to provide ongoing training to staff members. |
| NCWRSN administers mental health systems in Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties. The RSN'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. During CY 2008, NCWRSN provided outpatient services to 4,000 out of 63,866 (6.3%) Medicaid enrollees. | |
| Data source: North Central Washington RSN 2009 External Quality Review Report (Acumentra Health). | |

# North Central Washington Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Minimally met (30 out of 80)** | |
| Documented a clear study question, creating a framework for data collection and analysis. Used local data sources to calculate and report on baseline performance. | Baseline data show that performance is well above the statewide average and above the MHD benchmark, raising doubts that this is an appropriate QI topic. Needs to develop an intervention, based on analysis of system needs and barriers, that represents a new practice likely to improve the study indicator. |
| **Nonclinical: Improved Access to Services—Intakes Provided Within 14 Days of a Service Request — Not met (19 out of 80)** | |
| Based on the data presented, is already performing well on this indicator, with 86% of enrollees receiving services within 14 days of a request. | Timely access to intake does not appear to be a significant quality issue. Should conduct systems analysis to identify a pertinent quality issue and develop an effective intervention strategy to address barriers to improved performance. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Not met (1.8 out of 3)** | |
| | • **Finding:** Lacks proper oversight and monitoring of utilization management subcontractor regarding collection and storage of Medicaid enrollment and service utilization data. |
| **Staffing — Not met (1.9 out of 3)** | |
| | • Lacks a training manual and/or collection of written standard operating procedures to help new employees learn how to maintain/administer RSN information systems.<br>• Lacks effective monitoring and oversight of staff activities. Has not established standards for processing encounter claims data in a timely manner. |
| **Hardware Systems — Partially met (2 out of 3)** | |
| | • Lacks adequate software and hardware redundancy, including a documented failover strategy.<br>• Medicaid servers are not housed in a secure location away from personnel who are not authorized to have physical access. |
| **Security — Not met (1.8 out of 3)** | |
| • Maintains a Disaster Recovery Plan that is audited and tested annually to ensure that information systems can be maintained, resumed, and/or recovered as intended. | • **Finding:** Utilization management subcontractor denied the EQRO's request to perform a security walkthrough of the subcontractor's data facilities. |
| **Administrative Data (Encounter data) — Partially met (2.1 out of 3)** | |
| • Contracted providers submit data electronically; stringent screening process verifies data accuracy/validity. | • Does not perform regular audits of encounter claims to ensure data integrity and validity.<br>• Does not notify provider agencies when data submitted to state need to be corrected and resubmitted; affected agencies face a significant backlog. |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Performs frequent audits of MHD's eligibility enrollment files. | |
| **Vendor Data Integrity — Partially met (2.7 out of 3)** | |
| • Transmits all encounter data to the state in HIPAA-compliant format. | |
| **Provider Data (Compensation and profiles) — Not met (1.6 out of 3)** | |
| | • **Finding:** Failed to submit encounter data to MHD within the required time frames.<br>• Does not maintain up-to-date provider-level profile information in an accessible repository to help enrollees make decisions about access to providers that can meet their special care needs. |

# North Sound Mental Health Administration (NSMHA)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Fully met (4.6 out of 5)** | |
| • Provides second opinions and requires provider agencies to track frequency of requests.<br>• Monthly meetings include local tribal members. Minutes reflect an active committee with information sharing and education.<br>• Routinely analyzes the frequency of requests and uses the information when performing gap analysis. | • Needs to continue to closely monitor service availability and accessibility at each agency, the frequency and type of *ad hoc* subcontracted arrangements, and use the information when performing network planning.<br>• Needs to closely monitor all contracted agencies to ensure that enrollees are receiving services in a timely manner. |
| **Coordination and Continuity of Care — Fully met (4.7 out of 5)** | |
| • Conducts monthly reviews of clinical records to ensure that enrollees with special healthcare needs are identified and assessed by appropriate mental health professionals.<br>• When existing provider panel cannot meet an enrollee's mental healthcare need, RSN helps identify an appropriate provider outside the network. | • Needs to identify sufficient number of certified mental health specialists to meet required service timelines.<br>• Needs to continue to recruit qualified mental health specialists to provide timely consultations for enrollees who are members of special populations. |
| **Coverage and Authorization of Services — Substantially met (4.3 out of 5)** | |
| • Staff, including medical director, consults with practitioners to seek additional information and educate practitioners about authorization requirements and review decisions.<br>• Monitors the use of crisis and stabilization services by performing site visits and chart reviews. | • Audit process needs to include RSN staff members who perform utilization management functions.<br>• Needs to ensure that standard authorization decisions are made within the 14-day timeline. |
| **Provider Selection — Partially met (3.4 out of 5)** | |
| • Provider contracts require the provider to comply with the RSN's policies. | • Needs to consistently follow documented process for credentialing and recredentialing providers that have signed contracts or participation agreements.<br>• RSN and providers need to consistently screen employees for exclusion from participation in federal healthcare programs. |
| **Subcontractual Relationships and Delegation — Substantially met 4 out of 5)** | |
| • Has policies/procedure describing the delegation process. | • Needs to ensure that duties delegated to providers are performed as defined in policies/procedures. |
| **Practice Guidelines — Fully met (5 out of 5)** | |
| • Guidelines are consensus-based and have received consumer and stakeholder input.<br>• Audit process addresses fidelity to evidence-based practice. RSN develops a performance improvement plan as necessary. | |
| **QA/PI General Rules and Basic Elements — Substantially met (4.4 out of 5)** | |
| • QM program includes quality assurance and improvement activities and utilization management.<br>• Has comprehensive QM work plan. | • Needs to perform an annual evaluation of ongoing QI activities, data trends, and barriers to meeting goals.<br>• Needs to continue to identify barriers to access, and develop a mechanism to improve timeliness of access to care. |
| **Certification and Program Integrity — Fully met (5 out of 5)** | |
| • Tested the compliance plan by conducting five to six investigations. To date, no fraud or abuse has been detected. | |
| 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 CY 2008, NSMHA provided outpatient services to 12,164 out of 160,116 (7.6%) Medicaid enrollees. | |
| Data source: North Sound Mental Health Administration 2009 External Quality Review Report (Acumentra Health). | |

# North Sound Mental Health Administration (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Decrease in the Days to First Prescriber Appointment after Request for Service — Substantially met (55 out of 80)** | |
| Systematically selected and prioritized its study topic. Developed its intervention strategy based on thorough systems and barrier analysis. Clearly documented its study question and indicator. | Needs to document how the RSN verifies all study inclusion and exclusion criteria through its data; describe all planned analyses and methodology for ensuring that the intervention is implemented as planned; complete baseline and remeasurement data collection. |
| **Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Fully met (79 out of 80)** | |
| Conducted good barrier analysis regarding its intervention strategy. Tracked implementation of the intervention and made minor modifications to try to improve performance. Because the intervention was not effectively implemented, the RSN found statistical but not clinical improvement. | Needs to clearly document all data collection and validation procedures regarding how the RSN captured the study population and verified Medicaid eligibility. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Fully met (2.7 out of 3)** | |
| • Demonstrated effective monitoring and oversight of subcontracted activities. | • Needs to perform formal onsite reviews to verify performance of the RSN's application service provider and data security. |
| **Staffing — Fully met (3 out of 3)** | |
| • Maintains low staff turnover, a good indicator of effective management and employee satisfaction.<br>• Provides adequate training for staff in processing and tracking errors in encounter data submission. | |
| **Hardware Systems — Fully met (2.7 out of 3)** | |
| • Data management subcontractor takes full advantage of redundant software and hardware designs. | • Needs to require the RSN's application service provider to adopt a formal policy on hardware retention. |
| **Security — Partially met (2.5 out of 3)** | |
| | • Security policies and procedures, although well documented, are not managed within an organized control framework. |
| **Administrative Data (Encounter data) — Fully met (2.7 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process to verify data accuracy and validity.<br>• Automated pre- and post-adjudication edits and verification checks ensure completeness and correctness of submitted encounter data. | • Does not use "aging" reports for pended encounter data claims to reduce submission lag time and liability. |
| **Enrollment Systems (Medicaid eligibility) — Partially met (2.5 out of 3)** | |
| • Provides timely determination of enrollee eligibility for provider agencies. | • Needs to verify client eligibility on the date of service before submitting encounter data to MHD. |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (2.7 out of 3)** | |
| • Conducts onsite review of all provider agencies, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository, and thus cannot produce reports for enrollees upon request. |

# Peninsula Regional Support Network (PRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Fully met (4.8 out of 5)** | |
| • Comprehensive onsite audit process includes monthly visits to provider sites. When the RSN identifies problems, the core team offers timely technical assistance for providers.<br>• Actively promotes cultural competency throughout the RSN. | • Needs to continue to monitor all contracted providers closely to ensure that enrollees receive services in a timely manner, to identify access issues, and to initiate corrective action as indicated. |
| **Coordination and Continuity of Care — Fully met (4.6 out of 5)** | |
| • Identifies enrollees with specialized needs at initial intake, through self-reporting, or at the time of a referral for services.<br>• Monthly and annual chart audits include a comprehensive clinical review. At least 18 questions pertain to development of and progress with treatment plans. | • Needs to continue monitoring to ensure that providers coordinate mental health services with the services furnished for RSN enrollees by other healthcare providers.<br>• Needs to continue working with provider agencies to ensure that enrollees with specialized needs have timely access to special-population consultations. |
| **Coverage and Authorization of Services — Substantially met (4.4 out of 5)** | |
| • Crisis review tool includes diagnosis, special-population status, timelines for access to urgent/emergent care, confirmation that safety and risk factors were appropriately addressed, and inpatient service justification and follow-up. | • Needs to continue to monitor the authorization function delegated to its subcontractor to ensure that enrollees receive timely and medically appropriate services.<br>• Needs to continue monitoring to ensure that the mechanism for tracking routine/expedited authorizations is reliable and timely. |
| **Provider Selection — Substantially met (3.8 out of 5)** | |
| • Monitors licensing and certification of contracted providers during annual administrative review, auditing 10% of all staff personnel files.<br>• Policies/procedures are in place regarding hiring and contracting with individuals and agencies excluded from participating in federal healthcare programs. | • Needs to adopt and implement its draft policy/procedure defining the credentialing and recredentialing of RSN staff and the expectations of the provider.<br>• Providers need to verify active status of practitioner licenses directly from the licensing body. |
| **Subcontractual Relationships and Delegation — Fully met (5 out of 5)** | |
| • Provided excellent examples of corrective action plans and follow-up, including ongoing monitoring. | |
| **Practice Guidelines — Fully met (4.7 out of 5)** | |
| • Has endorsed nationally recognized and locally accepted guidelines for schizophrenia and bipolar disorder. Guidelines adopted in 2005 are reviewed annually.<br>• During annual chart review, monitors each provider's use of the approved guidelines when making medical and QM decisions, including the consistency of decision making. | • Needs to seek input from providers and to ensure that practice guidelines reflect the diverse needs of enrollees in the RSN's service area. |
| **QA/PI General Rules and Basic Elements — Fully met (4.8 out of 5)** | |
| • Assesses quality and appropriateness of care for enrollees with special healthcare needs by analyzing data gathered through random chart audits, enrollee complaints and appeals, and enrollee and stakeholder surveys. | • Needs to evaluate its QM program annually, as required by the RSN contract and state regulations. |
| **Certification and Program Integrity — Fully met (4.5 out of 5)** | |
| • Contracts stipulate that the contractor must have administrative and management procedures in place to guard against fraud and abuse. | • Compliance officer may need refresher training related to certification and program integrity. |
| 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 CY 2008, PRSN provided outpatient services to 6,152 out of 51,015 (12.1%) Medicaid enrollees. | |
| Data source: Peninsula RSN 2009 External Quality Review Report (Acumentra Health). | |

# Peninsula Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Metabolic Syndrome Screening and Intervention — Substantially met (64 out of 80)** | |
| Clearly documented all technical aspects of the PIP with excellent data validation procedures. Developed multiple study indicators with varying levels of sensitivity to maximize ability to detect change in clinical outcomes. Reported on baseline data and identified barriers to address in next phase of the PIP. | After completing remeasurement data collection (December 2009), needs to compare baseline and remeasurement data to determine whether the interventions improved the study indicators. |
| **Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Substantially met (61 out of 80)** | |
| Clearly documented all aspects of the PIP. Barrier analysis identified poor agency-to-enrollee communication as a key factor in community hospital's poor performance level. Audits verified that all providers had implemented intervention strategies. | Needs to clarify whether intervention strategies were focused solely on community hospitals or involved E&T centers as well. After completing remeasurement data collection (January 2010), needs to report on whether the interventions improved the study indicator. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Fully met (2.8 out of 3)** | |
| | • Data administration subcontractor needs to provide RSN with additional management reporting tools to ensure ongoing security of information systems. |
| **Staffing — Fully met (3 out of 3)** | |
| • Provides adequate training to RSN staff for processing and tracking errors in encounter data submission.<br>• Maintains low staff turnover, a good indicator of effective management and employee satisfaction. | |
| **Hardware Systems — Not met (1.9 out of 3)** | |
| | • **Finding:** Operating system for the practice management system application server is obsolete and no longer supported by the vendor, posing a security risk. |
| **Security — Fully met (2.8 out of 3)** | |
| | • Kitsap County and the RSN's data administration subcontractor need to adopt an IT control framework to help build control structure and ensure a sustainable information security program. |
| **Administrative Data (Encounter data) — Fully met (3 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process. | |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Provides timely determination of enrollee eligibility for provider agencies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (2.7 out of 3)** | |
| • Conducts onsite review of all provider agencies every year, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository, and thus cannot produce reports for enrollees upon request. |

# Southwest Regional Support Network (SWRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Fully met (4.6 out of 5)** | |
| • All authorizations for out-of-network services come to the RSN for approval.<br>• Provider contract specifies access standards for which providers will be held responsible. Compliance is carefully monitored, with development of an action plan, if needed. | • Should consider issuing Requests for Proposals to deliver services for children, and/or alternative plans of action to guarantee adequate service delivery.<br>• Needs to continue to develop access to minority mental health consultants for enrollees with cultural and ethnic needs. |
| **Coordination and Continuity of Care — Fully met (4.7 out of 5)** | |
| • Conducts monthly random reviews of clinical records to ensure that enrollees with special healthcare needs are identified and assessed correctly.<br>• In the event that the existing provider panel cannot meet an enrollee's mental healthcare need, the RSN helps identify an appropriate provider outside the network. | • Needs to work with providers to ensure that mental health specialist consultants' recommendations are incorporated into enrollees' treatment plans. |
| **Coverage and Authorization of Services— Fully met (5 out of 5)** | |
| • Clinical staff discusses outpatient and hospital cases at utilization management meetings to ensure consistent decisions. Medical director provides training and oversight of all review decisions.<br>• Crisis services are available to anyone in the county through Cowlitz County Guidance Association contracts. | |
| **Provider Selection — Substantially met (4.2 out of 5)** | |
| • Has policies/procedures in place to ensure a nondiscriminatory process for selecting and compensating providers. | • Needs to develop policies/procedures defining credentialing and recredentialing of RSN staff, and for determining whether contracted individuals or agencies are excluded from participating in federal healthcare programs. |
| **Subcontractual Relationships and Delegation — Substantially met (4.0 out of 5)** | |
| • Has policies/procedures in place to oversee and evaluate the delegated activities performed by subcontractors. | • Written delegation agreements with providers need to specify the providers' responsibilities in adopting and disseminating practice guidelines. |
| **Practice Guidelines — Fully met (5 out of 5)** | |
| • Expects all contracted providers to apply evidence-based practices in providing clinical treatment for enrollees.<br>• Reviews clinical records to ensure that decision making is consistent with evidence-based practices. | |
| **QA/PI General Rules and Basic Elements — Fully met (4.8 out of 5)** | |
| • Has a comprehensive QM program. QM Committee meets monthly and evaluates the QM program annually.<br>• Assesses the quality and appropriateness of care furnished to enrollees with special healthcare needs. | • Needs to re-establish routine reporting to the QM Committee regarding utilization, grievances, and changing providers. |
| **Certification and Program Integrity — Fully met (4.5 out of 5)** | |
| • Administrative infrastructure and management arrangements and procedures are aligned to guard against fraud and abuse. | • Needs to ensure that RSN's compliance officer has necessary training and education to address issues related to program integrity. |
| 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 CY 2008, SWRSN provided outpatient services to 3,042 out of 23,586, (12.9%) of Medicaid enrollees. | |
| Data source: Southwest RSN 2009 External Quality Review Report (Acumentra Health). | |

# Southwest Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Using Assertive Community Treatment to Decrease Consumer Hospital Utilization — Partially met (49 out of 80)** | |
| Clearly described the inclusion and exclusion criteria for the study and for enrollment in Program for Assertive Community Treatment (PACT). In addition to providing hospitalization data on PACT enrollees, SWRSN provided some cost data and concluded that using PACT has saved the RSN some costs. | Needs to define performance indicators clearly to demonstrate the link between PACT and a reduction in hospitalizations. Needs to calculate and analyze baseline and remeasurement data, and discuss how the intervention directly affected hospitalizations. |
| **Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization — Minimally met (39 out of 80)** | |
| Identified a barrier stemming from communication between the hospital discharge planner and the provider agencies responsible for outpatient care. Has identified possible intervention strategies to improve performance. | Needs to demonstrate that this is a significant local QI issue. Must progress by collecting, calculating, and reporting baseline data and developing intervention strategies that are likely to improve the study indicator. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Fully met (2.6 out of 3)** | |
| • Effectively monitors and oversees the Washington State Consortium and activities contracted to NetSmart, the RSN's application service provider.<br>• NetSmart's software programming, quality assurance, and IT staff are highly trained. | • RSN does not maintain technical documentation of its in-house billing system and of other support databases. |
| **Staffing — Partially met (2.5 out of 3)** | |
| • NetSmart provides new software programmers with formal training that includes mentoring by senior programmers. | • RSN lacks adequate written policies/procedures describing its accepted standards for processing and tracking errors in encounter data submissions, and describing its accepted productivity standards for data processing staff. |
| **Hardware Systems — Partially met (2.4 out of 3)** | |
| • IT governance provides adequate strategic direction and decision making. | • RSN has no failover strategy to respond to possible failures, including hardware-related faults. |
| **Security — Partially met (2.4 out of 3)** | |
| • NetSmart's secure architecture makes it hard for unauthorized users to gain access to data and other network resources.<br>• NetSmart employs an outside vendor to perform network penetration testing to ensure that proper security measures are in place. | • IT security policies and procedures, although well documented, are not managed within an organized control framework.<br>• RSN does not lock its server equipment room, which contains individually identifiable health information subject to HIPAA regulations. |
| **Administrative Data (Encounter data) — Fully met (2.7 out of 3)** | |
| • Contracted providers submit encounter data electronically; stringent screening verifies data accuracy/validity.<br>• Performs regular audits to ensure data integrity and validity. | • Does not maintain an "aging" report to monitor provider agencies with outstanding pended authorizations. |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Performs frequent audits of MHD's eligibility enrollment files to ensure that they are free of anomalies.<br>• Provides timely determination of eligibility for provider agencies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (2.7 out of 3)** | |
| • Conducts onsite review of all provider agencies every year, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository to help enrollees make decisions about access to providers that can meet their special care needs. |

# Spokane County Regional Support Network (SCRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Fully met (4.6 out of 5)** | |
| • Conducted system-wide analysis of its crisis and post-stabilization system, using utilization reports to compare the census at different facilities. As a result, reduced census at state hospital and opened an E&T facility.<br>• Has made efforts to coordinate with tribes in the service area. | • Needs to develop/implement a policy to track all out-of-network services and use data for analysis and utilization review.<br>• Should consider including in its provider contracts a requirement for each provider to track and report second opinions on a monthly basis. |
| **Coordination and Continuity of Care — Fully met (4.8 out of 5)** | |
| • Has memoranda of understanding and contracts with several physical health plans.<br>• Chart reviews help to ensure that enrollees are assessed by appropriate mental health professionals. | • Needs to continue working with smaller agencies to ensure that enrollees with specialized needs have timely access to specialist consultations. |
| **Coverage and Authorization of Services — Fully met (5 out of 5)** | |
| • Reports that average turnaround time for processing standard authorizations is well within the required 14-day time frame, and most requests are approved within 3 days.<br>• Crisis response and stabilization services include home visits to provide crisis intervention, a stabilization unit, a detoxification unit, chemical dependency treatment providing 24-hour housing, crisis respite beds, and a children's hospital diversion program. | |
| **Provider Selection — Fully met (5 out of 5)** | |
| • Policies/procedures describe the credentialing/recredentialing process and outline expectations of individual practitioners.<br>• Monitors monthly to identify practitioners who may be excluded from participating in federal healthcare programs. | |
| **Subcontractual Relationships and Delegation — Substantially met (4 out of 5)** | |
| • Has policies/procedures in place to oversee and evaluate activities delegated to subcontractors.<br>• Delegation agreements include a delegation matrix monitored annually through the annual administration audit processes. | • Needs to monitor activities delegated to all subcontractors. |
| **Practice Guidelines — Partially met (3.3 out of 5)** | |
| • Has practice guidelines in place for Psychiatric Evaluation of Adults and for Treating Major Depression. | • Needs to implement mechanism to ensure that providers' practices are based on and consistent with the approved guidelines. |
| **QA/PI General Rules and Basic Elements — Fully met (4.5 out of 5)** | |
| • Has mechanisms in place to monitor quality and appropriateness of care for enrollees with specialized needs.<br>• Performed extensive analysis of utilization during the planning process for its recently opened E&T center. | • Needs to continue its work to implement an effective QM program. |
| **Certification and Program Integrity — Substantially met (4 out of 5)** | |
| • Administrative infrastructure and management arrangements and procedures are aligned to guard against fraud and abuse. | • Should consider providing training in fraud and abuse prevention for its compliance officer.<br>• Needs to negotiate written procedures with RSN's utilization management subcontractor regarding collection and storage of Medicaid enrollment and service utilization data. |
| SCRSN is housed within Spokane County's Community Services Division, which administers public mental health services 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 CY 2008, SCRSN provided outpatient services to 8,115 out of 97,504 (8.3%) Medicaid enrollees. | |
| Data source: Spokane County RSN 2009 External Quality Review Report (Acumentra Health). | |

# Spokane County Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Implementing an Evidence-Based Practice — Minimally met (37 out of 80)** | |
| Consulted with consumers and families in selecting and prioritizing the topic. Selected as its intervention strategy an evidence-based practice (motivational interviewing, or MI) and plans to monitor fidelity to the practice model. | Needs to explain how the intervention (MI) is expected to increase enrollees' feelings of respect and their involvement in treatment, and how monitoring clinician competency in MI is a proxy indicator for increased consumer voice and inclusion. Needs to describe how training 50 clinicians (approximately 8% of clinical network) will achieve system-wide improvement. |
| **Nonclinical: Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines - Partially met (43 out of 80)** | |
| Developed system-wide intervention strategy to refine instructions for service encounter reporting, train providers, and offer ongoing technical assistance. Reported significant improvement in terms of reducing coding errors for rehab case management services. | Needs to clearly link improved service encounter reporting with better enrollee outcomes; focus the PIP exclusively on Medicaid enrollees and/or Medicaid services; and develop clear, consistent methodology for calculating and statistically comparing study indicators at baseline and remeasurement. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Partially met (2.5 out of 3)** | |
| | • **Finding:** Lacks proper oversight and monitoring of utilization management subcontractor regarding collection and storage of Medicaid enrollment and service utilization data. |
| **Staffing — Fully met (3 out of 3)** | |
| • Provides adequate training to staff for processing and tracking errors in encounter data submission. | |
| **Hardware Systems — Partially met (2.5 out of 3)** | |
| • Data management subcontractor takes full advantage of redundant software and hardware designs. | |
| **Security — Partially met (2.2 out of 3)** | |
| | • **Finding:** Utilization management subcontractor denied the EQRO's request to perform a security walkthrough of the subcontractor's data facilities.<br>• Security policies and procedures, although well documented, are not managed within an organized control framework. |
| **Administrative Data (Encounter data) — Fully met (3 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process to verify data accuracy and validity.<br>• Automated pre- and post-adjudication edits and verification checks ensure completeness and correctness of submitted encounter data. | |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Provides timely determination of eligibility for provider agencies.<br>• Audits MHD's eligibility enrollment files often to ensure that they are free of anomalies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (3 out of 3)** | |
| • Conducts onsite review of all provider agencies every year, including an encounter data validation. | |

# Thurston-Mason Regional Support Network (TMRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Substantially met (4.4 out of 5)** | |
| • Informs enrollees of their right to a second opinion and requires all providers to offer and track second opinions.<br>• Trains providers in cultural competency; conducts tribal outreach; has tribal participation on children's advisory board. | • Needs to improve monitoring of enrollee access to services.<br>• Needs to clarify wording in its member handbook regarding out-of-area services for emergency care.<br>• Needs to work closely with largest provider to improve the timeliness of access. |
| **Coordination and Continuity of Care — Substantially met (4.1 out of 5)** | |
| • Has mechanisms in place to identify enrollees with specialized needs and ensure that they are assessed by appropriate healthcare professionals.<br>• Has policies/procedures for ensuring enrollee participation in treatment decisions. | • Needs to address coordination of care with primary care physicians and other managed medical care providers for adults and for enrollees with identified healthcare needs.<br>• Needs to ensure that the recommendations of mental health specialists are consistently incorporated into enrollees' treatment plans. |
| **Coverage and Authorization of Services — Fully met (4.7 out of 5)** | |
| • Has well-written policies/procedures pertaining to emergency and post-stabilization services. | • Needs to establish a method to ensure consistent application of service authorization criteria. |
| **Provider Selection — Substantially met (3.8 out of 5)** | |
| • Policy on subcontractual relationships and delegation prohibits discrimination against providers who treat high-risk populations or populations that require costly treatments. | • Lacked a recredentialing policy during 2008. Many files omitted documentation of primary source verification.<br>• Needs to develop a policy/procedure for determining whether contracted individuals or organizations have been excluded from participating in federal healthcare programs. |
| **Subcontractual Relationships and Delegation — Substantially met (4 out of 5)** | |
| • Has policies/procedures in place to oversee and evaluate its subcontractors' performance of delegated activities.<br>• Monitoring program specifies the types of monitoring to be performed, staffing, scheduling, and process for initiating corrective action plans. | • Staffing reductions have caused some monitoring functions to fall behind schedule. RSN needs to prioritize monitoring, adjust the schedule, and require providers to submit reports on compliance with contract requirements. |
| **Practice Guidelines — Substantially met (4.3 out of 5)** | |
| • Established a committee for developing guidelines.<br>• Reviews utilization data for inpatient/outpatient services to assess enrollee needs and guide selection of guidelines. | • Needs to finish implementing its Major Depressive Disorder guideline.<br>• Needs to continue to work with all providers to ensure that practice guidelines are based on all enrollee needs. |
| **QA/PI General Rules and Basic Elements — Fully met (5 out of 5)** | |
| • Uses diverse methods to monitor service over-/underutilization.<br>• Uses random chart audits to assess quality and appropriateness of care furnished to enrollees with special needs. | |
| **Certification and Program Integrity — Fully met (5 out of 5)** | |
| • Administrative infrastructure and management arrangements and procedures are aligned to guard against fraud and abuse.<br>• Creates environment in which staff and consumers are encouraged to report potential incidents of noncompliance and suspected fraud and abuse without fear of retaliation. | |
| 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 opened in 2005 provides voluntary and involuntary inpatient treatment and crisis outreach and stabilization. During CY 2008, TMRSN provided outpatient services to 4,717 out of 47,248 (10%) Medicaid enrollees. | |
| Data source: Thurston-Mason RSN 2009 External Quality Review Report (Acumentra Health). | |

# Thurston-Mason Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Multisystemic Therapy — Fully met (77 out of 80)** | |
| Selected PIP topic after systematic investigation of enrollee needs and service deficiencies; implemented an evidence-based intervention with high fidelity ratings, and achieved improvement in all study indicators, though not statistically significant. | Needs to discuss attrition from baseline to remeasurement and how and when Medicaid eligibility is verified for inclusion in the study. |
| **Nonclinical: Improved Rate of Medicaid Adults Seen for a Non-Crisis Outpatient Appointment Within 7 Days of Discharge from a Psychiatric Inpatient Level of Care — Fully met (70 out of 80)** | |
| Clearly documented that hospital follow-up is a significant performance and cost issue locally, and documented clear study question and indicators. Calculated baseline and remeasurement data and concluded that the intervention did not achieve statistical or clinical improvement. | Needs to perform data validation procedures to ensure that data used to capture the study population and indicators are accurate, and track the implementation of the intervention to ascertain whether the intervention is responsible for improvement. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Partially met (2.5 out of 3)** | |
| • Practice management system is secure, robust, and scalable, giving programmers the flexibility to develop sophisticated data processing methods. | • Lacks effective monitoring and oversight of activities performed by its data administration subcontractor.<br>• Does not maintain technical documentation of its information systems and encounter data processing system. |
| **Staffing — Partially met (2.5 out of 3)** | |
| • Provides adequate training for its staff in processing and tracking errors in encounter data submission. | • Lacks a training manual and/or collection of written standard operating procedures to help new employees and contractors learn to maintain and administer RSN information systems. |
| **Hardware Systems —Fully met (3 out of 3)** | |
| • Servers are housed in a secure location away from personnel who are not authorized to have physical access to them. | |
| **Security — Partially met (2.4 out of 3)** | |
| • Thurston County and TMRSN perform daily backups to a tape-based storage system, and transport encrypted backup tapes in a locked container to an offsite location once a week. | • Security policies and procedures, although well documented, are not managed within an organized control framework. |
| **Administrative Data (Encounter data) — Fully met (2.9 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process. | |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Provides timely determination of enrollee eligibility for provider agencies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (2.7 out of 3)** | |
| • Conducts onsite review of all provider agencies every year, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository to help enrollees make decisions about access to providers that can meet their special care needs. |

# Timberlands Regional Support Network (TRSN)

| Strengths | Opportunities for improvement |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Delivery Network — Partially met (3.2 out of 5)** | |
| • Clinical record review includes monitoring for timely access.<br>• Quality Review Team conducts "secret shopper" calls that have demonstrated good service.<br>• Utilization review tool includes tracking timeliness of access. | • Needs to use existing reports or develop new management reports to monitor network sufficiency, review reports routinely, and establish a measurement tool.<br>• Needs to ensure that all medically necessary out-of-network services are available to enrollees in a timely manner. |
| **Coordination and Continuity of Care — Partially met (3.4 out of 5)** | |
| • Utilization review addresses whether provider identified medical needs, whether provider complied with policies regarding EPSDT services for young enrollees, and whether specialist consultation was timely. | • Needs to ensure coordination of care for adults, and monitor whether mental health providers coordinate with primary care physicians for all enrollees.<br>• Needs to ensure that enrollees with specialized needs are assessed by appropriate healthcare professionals, and that treatment plans incorporate their recommendations. |
| **Coverage and Authorization of Services — Substantially met (3.9 out of 5)** | |
| • Policy describes a process in which the agency care manager reviews the authorization request before submitting it to RSN's administrative services organization (ASO).<br>• ASO publishes a service authorization timeliness report.<br>• Clinical director reviews a sample of clinical records monthly. | • Needs to continue to monitor service authorization function delegated to ASO, and initiate corrective action as needed.<br>• Needs to track and monitor the use of crisis, stabilization, and post-hospital follow-up services. |
| **Provider Selection — Substantially met (3.8 out of 5)** | |
| • Policy and contract prohibit the RSN from employing or contracting with providers excluded from participating in federal healthcare programs. | • Needs to document and follow procedure for ensuring provider qualifications, and include all subcontractors in its credentialing/recredentialing process.<br>• Needs to routinely screen all RSN, provider, and subcontractor staff to ensure that they have not been excluded from participating in federal healthcare programs. |
| **Subcontractual Relationships and Delegation — Partially met (3 out of 5)** | |
| • Contract specifies activities and responsibilities required of providers and the steps the RSN will take if the provider fails to perform. | • Needs to monitor activities delegated to all subcontractors. |
| **Practice Guidelines — Substantially met (4 out of 5)** | |
| • Has adopted practice guidelines that reflect enrollees' needs.<br>• During clinical record reviews, RSN's clinical director monitors providers' adherence to practice guidelines. | • Needs to ensure that practice guidelines are disseminated to enrollees upon request, and implement a method to disseminate practice guidelines to providers. |
| **QA/PI General Rules and Basic Elements — Partially met (2.9 out of 5)** | |
| • Clinical director monitors enrollee access during monthly clinical record reviews. | • Needs to establish a mechanism to develop, implement, and evaluate its QM program annually.<br>• Needs formal criteria for identifying and monitoring over- and underutilization of services. |
| **Certification and Program Integrity — Fully met (5 out of 5)** | |
| • Has administrative and management procedures in place to prevent fraud and abuse | |
| TRSN, headquartered in Cathlamet, administers mental health services for Medicaid enrollees in Lewis, Pacific, and Wahkiakum counties. The RSN also contracts with the state to provide crisis services to any resident not covered by Medicaid. During CY 2008, TRSN provided outpatient services to 2,405 out of 22,945 (10.5%) Medicaid enrollees. | |
| Data source: Timberlands RSN 2009 External Quality Review Report (Acumentra Health). | |

# Timberlands Regional Support Network (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Clinical: Not submitted — Not met (0 out of 80)** | |
| | RSN has not selected a clinical PIP topic, and submitted no documentation for this PIP in 2009. |
| **Nonclinical: Improving Coordination of Care with Primary Care Providers — Not met (3 out of 80)** | |
| Used multiple sources to determine that coordination of care between mental health and primary care providers needs attention. | Needs to define its study question, indicators, and population, and the intervention it will use to improve coordination of care. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| **Information Systems — Partially met (2.3 out of 3)** | |
| • Effectively monitors and oversees the Washington State Consortium and activities contracted to NetSmart, the RSN's application service provider.<br>• NetSmart's software programming, quality assurance, and IT staff are highly trained and experienced. | • **Finding:** Lacks proper oversight and monitoring of RSN's utilization management subcontractor regarding collection and storage of Medicaid enrollment and service utilization data.<br>• Lacks effective monitoring and oversight of activities delegated to its hardware maintenance subcontractor. |
| **Staffing — Partially met (2.4 out of 3)** | |
| • NetSmart provides new software programmers with formal training that includes mentoring by senior programmers. | • Lacks a training manual and/or collection of written standard operating procedures to help new employees learn to maintain and administer RSN information systems. |
| **Hardware Systems — Fully met (3 out of 3)** | |
| • NetSmart's IT governance provides adequate strategic direction and decision making. | |
| **Security — Partially met (2 out of 3)** | |
| • NetSmart's secure architecture makes it difficult for unauthorized users to gain access to data and other network resources. | • **Finding:** Utilization management subcontractor denied the EQRO's request to perform a security walkthrough of the subcontractor's data facilities.<br>• **Finding:** RSN lacks a Disaster Recovery Plan.<br>• NetSmart's security policies and procedures are not managed within an organized control framework.<br>• RSN lacks written security policies and procedures, and uses no formal IT control framework. |
| **Administrative Data (Encounter data) — Fully met (3 out of 3)** | |
| • Contracted providers submit encounter data electronically, passing through a stringent screening process.<br>• Automated pre- and post-adjudication edits and verification checks ensure completeness and correctness of submitted encounter data. | |
| **Enrollment Systems (Medicaid eligibility) — Fully met (3 out of 3)** | |
| • Performs frequent audits of MHD's eligibility enrollment files to ensure that they are free of anomalies.<br>• Provides timely determination of eligibility for provider agencies. | |
| **Vendor Data Integrity — Fully met (3 out of 3)** | |
| • Member data include encounter data from all services provided to Medicaid enrollees, creating a complete picture of care. | |
| **Provider Data (Compensation and profiles) — Fully met (2.7 out of 3)** | |
| • Conducts onsite review of all provider agencies every year, including an encounter data validation. | • Does not maintain up-to-date provider-level profile information in an accessible repository to help enrollees make decisions about access to providers that can meet their special care needs. |

# Appendix B. MCO Profiles

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

MCO scores for compliance with regulatory and contractual standards were calculated from ratings in the TEAMonitor reports, and strengths and opportunities for improvement were derived from the written TEAMonitor reviews. Scores and comments for the Access, Timeliness, and Quality measures were derived from the Performance Measure Comparative Analysis Report produced by Acumentra Health.

NOTE: 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.

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# Asuris Northwest Health (ANH)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | — | | |
| Child WCC Visits | 50% ▼ | | |
| Adolescent WCC Visits | 32% | | |
| **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% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 69% |
| Program Integrity | 50% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 63% |
| Primary Care and Coordination | 0% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 25% | Provider Selection (Credentialing) | 100% |
| Patient Review and Restriction | 50% | QAPI Program | 60% |
| Coverage and Authorization of Services | 75% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving the Rate of Childhood Immunizations | Partially Met | Improve Response Time of Pharmacy Prior-Authorization Denials | Partially Met |
| Well-Child Visits with a Disparity Aspect Involving the Hispanic Population | Not Met | | |

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

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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, totaling fewer than 1 percent of Healthy Options enrollees. ANH insures approximately 60,000 lives, 3.15 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. ⇨

# Asuris Northwest Health (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| | Child WCC rate is significantly lower than the state average. |
| **Timeliness of Care*** | |
| | |
| **Quality of Care*** | |
| | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Furnishing of Services<br>• Claims Payment<br>• Emergency and Post-stabilization Services<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• Subcontractual Relationships/Delegation<br>Met 75% of Coverage and Authorization of Services, 69% of Enrollee Rights, 63% of Grievance Systems, 60% of Availability of Services, and 60% of QAPI elements. | Met 50% of elements for:<br>• Program Integrity<br>• Patient Review and Restriction<br><br>Met less than 50% of elements for:<br>• Additional Services for Enrollees with Special Healthcare Needs<br>• Primary Care and Coordination |
| **Performance Improvement Projects (PIPs)**** | |
| • Narrative description in table format linking interventions to barriers is a best practice.<br>• Excellent documentation of potential causes for poor performance in timelines so causes could be addressed. | • Additional measurement periods are needed to confirm that a consistent process has been used to achieve a steady state.<br>• The childhood immunization and adolescent well-child rates did not contain enough written analysis linking interventions to rates and planning for follow-up activities. |

*Data source: 2009 Performance Measure Comparative Analysis Report.

**Data source: 2009 TEAMonitor report.

# Columbia United Providers (CUP)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 74% ▲ 🡅 | | |
| Child WCC Visits | 51% ▼ | | |
| Adolescent WCC Visits | 33% | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 56% ▼ | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 56% ▼ | | |
| Childhood Immunizations (Combo 3) | 53% ▼ | | |
| Diabetes Care (HbA1c test) | 86% | | |
| **Regulatory and Contractual Standards—Percent Met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 0% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 85% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 50% | Grievance Systems | 79% |
| Primary Care and Coordination | 100% | Practice Guidelines | 67% |
| Enrollees with Special Healthcare Needs | 25% | Provider Selection (Credentialing) | 100% |
| Patient Review and Restriction | 50% | QAPI Program | 20% |
| Coverage and Authorization of Services | 75% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Clinical: Improving Early Childhood Immunization Rates | Partially Met | Nonclinical: Not submitted | Not Met |
| Clinical: Improving Well-Child Visits | Partially met | | |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
🡅 🡇 MCO percentage for 2009 is significantly higher or lower than the 2008 percentage ($p<0.05$).
*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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 38,163 lives, 89 percent of whom are insured by Medicaid. About 82 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. ⇨

# Columbia United Providers (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| Infant WCC visits (6 visits) are significantly above this year's state average and last year's plan average. | Child WCC visits are significantly lower than the state average. |
| **Timeliness of Care*** | |
| | Postpartum care after 21–56 days is significantly lower than the state average. |
| **Quality of Care*** | |
| | Childhood immunizations (Combo 2 and Combo 3 are significantly lower than the state average.) |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Program Integrity<br>• Primary Care and Coordination<br>• Enrollment and Disenrollment<br>• Provider Selection (Credentialing)<br>• Subcontractual Relationships/Delegation<br>Met 85% of Enrollee Rights, 79% of Grievance Systems, and 67% of Practice Guidelines elements. | Met 50% of elements for:<br>• Claims Payment<br>• Patient Review and Restriction<br><br>Met less than 50% of elements for:<br>• Additional Services for Enrollees with Special Healthcare Needs<br>• QAPI Program |
| **Performance Improvement Projects (PIPs)**** | |
| • CUP has demonstrated novel trial interventions over time to improve performance.<br>• PIPs are well documented. | • There were limited active interventions; many were not continued even when they showed a positive impact. CUP is encouraged to examine sustaining tests of change and to broaden successful interventions to other clinics.<br>• Most interventions were passive. CUP should aim its interventions at engaging providers in the goal of improving well-child care.<br>• PIP documentation needs to be streamlined. |

*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 TEAMonitor report.

# Community Health Plan (CHP)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 47% ▼ | | |
| Child WCC Visits | 63% | | |
| Adolescent WCC Visits | 36% | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 57% ▼ | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 77% ▲ | | |
| Childhood Immunizations (Combo 3) | 75% ▲ | | |
| Diabetes Care (HbA1c test) | 82% | | |
| **Regulatory and Contractual Standards—Percent Met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 92% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 50% | Grievance Systems | 68% |
| Primary Care and Coordination | 0% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 0% | Provider Selection (Credentialing) | 100% |
| Patient Review and Restriction | 63% | QAPI Program | 80% |
| Coverage and Authorization of Services | 100% | Subcontractual Relationships/Delegation | 75% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Well-Child Exams: Improving HEDIS Measurement Rates | Met | Improving Access to Primary Care | Met |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
🡅 🡇 MCO percentage for 2009 is significantly higher or lower than the 2008 percentage ($p<0.05$).
*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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 about 31 percent of Healthy Options enrollees, including those with S-CHIP and BH+ coverage. CHP insures more than 235,000 lives, 70 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. ⇨

# Community Health Plan (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| | Infant WCC visits (6 visits) are significantly lower than the state average. |
| **Timeliness of Care*** | |
| | Postpartum care after 21–56 days is significantly lower than the state average. |
| **Quality of Care*** | |
| Childhood immunizations (Combo 2 and Combo 3) are significantly above the state average. | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services<br>• Program Integrity<br>• Coverage and Authorization of Services<br>• Emergency and Post-stabilization Services<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>• Provider Selection<br><br>Met 92% of Enrollee Rights, 80% of QAPI Program, 75% of Subcontractual Relationships/Delegation, 68% of Grievance Systems, and 63% of Patient Review and Restriction elements. | Met 50% of elements for:<br>• Claims Payment<br><br>Met less than 50% of elements for:<br>• Primary Care and Coordination<br>• Additional Services for Enrollees with Special Healthcare Needs |
| **Performance Improvement Projects (PIPs)**** | |
| TEAMonitor cited the following best practices:<br>• CHP's interventions with providers to increase WCC visit rates are a best practice and include quarterly reports, incentives and technical assistance.<br>• Improvement in access to primary care due to the nonclinical PIP has encouraged the start of a similar improvement project for access to specialized care in 2009. | CHP's description of interventions for the clinical PIP needs more detail in terms of when each intervention was implemented, and what the plans are for new interventions.<br><br>For the clinical PIP, CHP performed statistical significance tests only from 2007 to 2008, rather than from baseline to current period or over three data points. CHP would benefit from analyzing data over a longer time period. |

*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 TEAMonitor report.

# Group Health Cooperative (GHC)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 49% ▼ | | |
| Child WCC Visits | 60% | | |
| Adolescent WCC Visits | 40% | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 72% ▲ 🡅 | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 76% ▲ | | |
| Childhood Immunizations (Combo 3) | 72% | | |
| Diabetes Care (HbA1c test) | 84% | | |
| **Regulatory and Contractual Standards—Percent Met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 0% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 85% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 68% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 25% | Provider Selection (Credentialing) | 67% |
| Patient Review and Restriction | 63% | QAPI Program | 60% |
| Coverage and Authorization of Services | 50% | Subcontractual Relationships/Delegation | 75% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving Well-Child and Well-Adolescent Visit Rates | Met | Improving Member Utilization of Online Services | Not met |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
🡅 🡇 MCO percentage for 2009 is significantly higher or lower than the 2008 percentage ($p<0.05$).
*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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 xx 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. ⇨

# Group Health Cooperative (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| | Infant WCC visits (6 visits) are significantly below the state average. |
| **Timeliness of Care*** | |
| Postpartum care after 21–56 days is significantly above this year's state average and last year's plan average. | |
| **Quality of Care*** | |
| Childhood immunizations (Combo 2) are significantly above this year's state average. | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Program Integrity<br>• Claims Payment<br>• Primary Care and Coordination<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>Met 85% of Enrollee Rights elements, 75% of Subcontractual Relationships/Delegation elements, 68% of Grievance Systems elements, 67% of Provider Selection (Credentialing) elements, 63% of Patient Review and Restriction elements, and 60% of QAPI Program elements. | Met less than 50% of elements for:<br>• Additional Services for Enrollees with Special Healthcare Needs<br>• Emergency and Post-stabilization Services<br>Met 50% of Coverage and Authorization of Services. |
| **Performance Improvement Projects (PIPs)**** | |
| • MyGroupHealth, a web-based system for enrollees, was identified by TEAMonitor as a best practice."<br>• Continued use of the QI process to identify barriers and interventions to improve childhood immunization rates again earned a best practice citation.<br>• The clinical PIPs were well documented and executed. Two of the three measures showed a statistically significant improvement. | • Although a number of interventions to encourage enrollee use of the website were implemented in the past, there has not been any recent action.<br>• GHC does not appear to have validated the use of the Internet as appropriate and effective for Healthy Options enrollees. GHC would benefit from conducting a barrier analysis (through focus groups) specifically for this population. |

*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 TEAMonitor report.

# Kaiser Permanente Northwest (KPNW)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | — | | |
| Child WCC Visits | 63% | | |
| Adolescent WCC Visits | 36% | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 79% | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | — | | |
| Childhood Immunizations (Combo 3) | — | | |
| Diabetes Care (HbA1c test) | — | | |
| **Regulatory and Contractual Standards—Percent Met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 100% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 89% |
| Primary Care and Coordination | 0% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 75% | Provider Selection (Credentialing) | 100% |
| Patient Review and Restriction | 100% | QAPI Program | 80% |
| Coverage and Authorization of Services | 75% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Well-Child Visits | Partially Met | Regional Appointment Center Call Answer Timeliness | Met |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
🡅 🡇 MCO percentage for 2009 is significantly higher or lower than the 2008 percentage ($p<0.05$).
— Sample size was less than the minimum required during the reporting year.
*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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 479,500 lives; fewer than 1 percent 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. ⇨

# Kaiser Permanente Northwest (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| | |
| **Timeliness of Care*** | |
| | |
| **Quality of Care*** | |
| | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Program Integrity<br>• Claims Payment<br>• Patient Review and Restriction<br>• Emergency and Post-stabilization Services<br>• Enrollee Rights<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• Subcontractual Relationships/Delegation<br>Met 89% of Grievance Systems, 80% of QAPI Program, 75% of Additional Services for Enrollees with Special Healthcare Needs, and 75% of Coverage and Authorization of Services elements. | Met less than 50% of elements for:<br>• Primary Care and Coordination |
| **Performance Improvement Projects (PIPs)**** | |
| • KPNW used multiple robust interventions (e.g., hiring more staff, increased staff training) to reduce telephone answering times to 30 seconds or less. This resulted in a dramatic and sustained improvement.<br>• KPNW has the support and involvement of its senior management and clinical leaders in instituting improvement projects.<br>• KPNW used strong, multiple interventions to improve care, including member outreach, provider incentives, and care gap information for providers. | • KPNW demonstrated no improvement in the clinical PIP. To receive a Fully Met rating, KPNW is encouraged to continue its current interventions and consider adding telephonic outreach to further improve rates. |

*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 TEAMonitor report.

# Molina Healthcare of Washington (MHW)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 56% | | |
| Child WCC Visits | 68% ▲ | | |
| Adolescent WCC Visits | 45% ▲ | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 60% | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 74% | | |
| Childhood Immunizations (Combo 3) | 70% | | |
| Diabetes Care (HbA1c test) | 81% | | |
| **Regulatory and Contractual Standards—Percent Met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 0% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 92% |
| Program Integrity | 50% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 89% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 25% | Provider Selection (Credentialing) | 100% |
| Patient Review and Restriction | 63% | QAPI Program | 40% |
| Coverage and Authorization of Services | 75% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improvement of HEDIS Well-Child Rates | Met | Medicaid Pharmacy Authorization Turnaround Times | Met |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
🡅 🡇 MCO percentage for 2009 is significantly higher or lower than the 2008 percentage ($p<0.05$).
*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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 about 51 percent of Healthy Options enrollees, including those covered by S-CHIP and BH+. MHW insures about 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. ⇨

# Molina Healthcare of Washington (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| Child and adolescent WCC visits are significantly above the state average. | |
| **Timeliness of Care*** | |
| | |
| **Quality of Care*** | |
| | |
| | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services<br>• Claims Payment<br>• Primary Care and Coordination<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• Subcontractual Relationships/Delegation<br>Met 92% of Enrollee Rights, 89% of Grievance Systems, 75% of Coverage and Authorization of Services, and 63% of Patient Review and Restriction elements. | Met 50% of elements for:<br>• Program Integrity<br><br>Met less than 50% of elements for:<br>• QAPI Program<br>• Additional Services for Enrollees with Special Healthcare Needs<br>• Emergency and Post-stabilization Services |
| **Performance Improvement Projects (PIPs)**** | |
| • MHW continues to lead all Healthy Options managed care plans in well-child HEDIS rates for each of the three childhood measures.<br>• Well-written and documented data analysis.<br>• Project goals and results for pharmacy turnaround times are well beyond contractual and other requirements. | • Continued success of the clinical PIP may require a creative refocus and the design of new interventions to move this effort to the next level.<br>• New/novel interventions should include performance feedback to clinics. |

*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 TEAMonitor report.

# Regence BlueShield (RBS)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 58% | | |
| Child WCC Visits | 62% | | |
| Adolescent WCC Visits | 37% | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 68% | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 73% | | |
| Childhood Immunizations (Combo 3) | 68% | | |
| Diabetes Care (HbA1c test) | 78% | | |
| **Regulatory and Contractual Standards—Percent Met**** | | | |
| Availability of Services | 60% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 69% |
| Program Integrity | 50% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 63% |
| Primary Care and Coordination | 0% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 25% | Provider Selection (Credentialing) | 100% |
| Patient Review and Restriction | 50% | QAPI Program | 60% |
| Coverage and Authorization of Services | 75% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving the Rate of Childhood Immunizations | Partially Met | Improve Response Time of Pharmacy Prior-Authorization Denials | Partially Met |
| Well-Child Visits with a Disparity Aspect Involving the Hispanic Population | Not Met | | |

*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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 6 percent of Healthy Options enrollees, including those covered by S-CHIP. RBS insures approximately 1,015,000 lives, 3.66percent of whom are insured by Medicaid. Approximately 80percent of Medicaid clients are 18 years of age or younger.

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

# Regence BlueShield (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| | |
| **Timeliness of Care*** | |
| | |
| **Quality of Care*** | |
| | |
| | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Furnishing of Services<br>• Claims Payment<br>• Emergency and Post-stabilization Services<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• Subcontractual Relationships/Delegation<br>Met 75% of Coverage and Authorization of Services, 69% of Enrollee Rights, 63% of Grievance Systems, 60% of Availability of Services, and 60% of QAPI Program elements. | Met 50% of elements for:<br>• Program Integrity<br>• Patient Review and Restriction<br><br>Met less than 50% of elements for:<br>• Additional Services for Enrollees with Special Healthcare Needs<br>• Primary Care and Coordination |
| **Performance Improvement Projects (PIPs)**** | |
| • Narrative description in table format linking interventions to barriers is a best practice.<br>• Excellent documentation of potential causes for poor performance in timelines so causes could be addressed. | • The PIP addressing timeliness of prior authorization for pharmacy prescriptions showed no evidence of sustained improvement and reflected some difficulties with evaluating the variables.<br>• The childhood immunization and adolescent well-child rates did not contain enough written analysis linking interventions to rates and planning for follow-up activities. |

*Data source: 2009 Performance Measure Comparative Analysis Report.
**Data source: 2009 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 to mental health care. Table C-2 lists the elements of each regulatory standard, with citations from the Code of Federal Regulations (CFR) and a summary description of each element.

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

| Contract provisions | 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; *7.12* |
| The MCO/RSN's provider network must meet ***distance standards*** in each service area. For physical health care, two PCPs must be available within 10 miles for 90 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; *7.13* |
| Each MCO must provide all medically necessary ***specialty care*** for enrollees in its service area, whether within or outside the provider network. The MCO must help providers obtain timely referrals to specialty care. | 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; *7.6* |

| 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 18 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; *13.5* |
| 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; *7.11* |
| The MCO/RSN must guarantee ***enrollee rights***, including the right to be treated with respect and with consideration for dignity and privacy; to be informed of available treatment options and alternatives; to participate in decisions regarding their health care; to be free from unnecessary restraint or seclusion; and to request and receive copies of their medical records and ask that they be amended. RSN enrollees must have individual service plans, developed with the participation of enrollees and their families. Each RSN must provide an independent mental health ombuds to inform enrollees of their rights and help them resolve complaints and grievances. | 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; *7.14* |
| 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; *7.10* |
| 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; *7.7–7.8* |
| MCO/RSN ***grievance systems*** must meet standards regarding procedures and time frames for grievances, appeals, and access to the hearing process. | 13; *12.1–12.7* |
| 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 must ensure coordination with other service delivery systems responsible for meeting needs identified in the enrollee's individual service plan, including primary medical care and services such as education, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections, and juvenile justice. | 14.6; *10.3.3* |
| 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; *13.8–13.11* |
| Each MCO must maintain a ***quality assessment and performance improvement*** program that meets federal regulatory requirements. The program must include a Quality Improvement Committee that oversees quality functions. an annual work plan, and an annual program evaluation. Each RSN's quality management program must include an annual review of community mental health agencies within the network. | 8.1; *8.1–8.4* |
| 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; *8.2.5* |
| 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; *8.3* |
| The MCO must meet state standards regarding placement of enrollees in the ***Patient Review and Restriction/Patient Review and Coordination program***. This program is designed to determine and coordinate care for enrollees who have used medical services at a frequency or amount that is not medically necessary. Elements of the standards include guidelines, placement, appeals, and notification. | 14.16 |

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

| CFR section | Description |
|---|---|
| **438.206 Availability of Services**<br>438.206(b)(1)(i-v) Delivery network<br>438.206(b)(2) Direct access to a women's health specialist<br>438.206(b)(3) Provides for a second opinion<br>438.206(b)(4) Services out of network<br>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**<br>438.206(c)(1)(i) through (vi) Timely access<br>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**<br>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**<br>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**<br>438.208(c)(1) Identification<br>438.208(c)(2) Assessment<br>438.208(c)(3) Treatment plans<br>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**<br>438.210(b) Authorization of services<br>438.210(c) Notice of adverse action<br>438.210(d) Timeframe for decisions<br>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**<br>***(a) General rule***<br>438.100(a) General rule<br>438.10(b) Basic rule<br>438.10(c)(3) Language – non-English<br>438.10(c)(4) and (5) Language – oral interpretation<br>438.10(d)(1)(i) Format, easily understood<br>438.10(d)(1)(ii) and (2) Format, alternative formats<br>438.10(f) General information<br>438.10(g) Specific information<br>438.10(h) Basic rule<br>438.100(b)(2)(iii) Specific rights<br>438.100(b)(2)(iv) and (v) Specific rights<br>438.100(b)(3) Specific rights<br>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**<br>438.226 and 438.56(b)(1) - (3) Disenrollment requested by the MCO, PIHP<br>438.56(c) Disenrollment requested by the enrollee<br>438.56(d) Procedures for disenrollment<br>438.56(d)(5) MCO grievance procedures<br>438.56(e) Timeframe for disenrollment determinations | Establish policies, procedures, and mechanisms to ensure appropriate process for disenrollment. |
| | |
| **438.228 Grievance Systems**<br>438.228 Grievance systems<br>438.402(a) The grievance system<br>438.402(b)(1) Filing requirements - Authority to file<br>438.402(b)(2) Filing requirements - Timing<br>438.402(b)(3) Filing requirements - Procedures<br>438.404(a) Notice of action - Language and format<br>438.404(b) Notice of action - Content of notice<br>438.404(c) Notice of action - Timing of notice<br>438.406(a) Handling of grievances and appeals - General requirements<br>438.406(b) Handling of grievances and appeals - Special requirements for appeals<br>438.408(a) Resolution and notification: Grievances and appeals - Basic rule<br>438.408(b) and (c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes<br>438.408 (d) and (e) Resolution and notification: Grievances and appeals- Format of notice and Content of notice of appeal resolution<br>438.408(f) Resolution and notification: Grievances and appeals-Requirements for State fair hearings<br>438.410 Expedited resolution of appeals<br>438.414 Information about the grievance system to providers and subcontractors<br>438.416 Recordkeeping and reporting requirements<br>438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending<br>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**<br>438.240(b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs<br>438.240(d) Performance improvement projects<br>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**<br>438.236(b)(1-4) Adoption of practice guidelines<br>438.236(c) Dissemination of [practice] guidelines<br>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)**<br>438.214(a) General Rules and 438.214(b) Credentialing and recredentialing requirements<br>438.214(c) and 438.12 Nondiscrimination and provider discrimination prohibited<br>438.214(d) Excluded providers<br>438.214(e) State requirements | Adhere to state policies and procedures based on NCQA credentialing standards. |
| | |
| **438.240 Quality Assessment and Performance Improvement Program**<br>438.240(a)(1) Quality assessment and performance improvement program - General rules<br>438.240(b)(2) and (c), and 438.204(c) Performance measurement<br>438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and under utilization of services<br>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<br>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**<br>The MCO oversees functions delegated to subcontractor:<br>438.230 (a) and (b) Subcontractual relationships and delegation | Meet requirements for MCO oversight of delegated entities responsible for providing care and services; subcontract language regarding solvency, provider nondiscrimination, assigned responsibilities, and other provisions consistent with federal regulations in this area, such as reimbursement rates and procedures. |

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# Appendix D. PIP Review Procedures

TEAMonitor reviews the performance improvement projects (PIPs) conducted by the 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 <u>all of the following twelve (12) elements</u>:**

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

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

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

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

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

# Acumentra Health PIP Review Steps

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.