2010 External Quality Review Annual Report

Washington State Healthy Options

Children's Health Insurance Program

Division of Behavioral Health and Recovery

Washington Medicaid Integration Partnership

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Acronyms Used in This Report

ALOS	average length of stay
BBA	Balanced Budget Act of 1997
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CIT	Crisis Intervention Training
CMS	Centers for Medicare & Medicaid Services
DBHR	Division of Behavioral Health and Recovery
DMHP	designated mental health professional
DSHS	Department of Social & Health Services
E&T	evaluation and treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	emergency room
FFS	fee for service
HCA	Health Care Authority
HEDIS®	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act of 1996
ISCA	Information Systems Capabilities Assessment
MCO	managed care organization
MPA	Medicaid Purchasing Administration
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
SHCN	special health care needs
WCC	well-child care
WMIP	Washington Medicaid Integration Partnership

Acronyms for individual RSNs and MCOs are listed on pages 18 and 54, 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 & Health Services (DSHS).

This report builds on the findings of previous annual reports since 2005. Reports from 2005 to 2007 focused on physical health services delivered through the Healthy Options managed care organizations (MCOs). Reports since 2008 have incorporated a review of mental health services provided through the state's regional support networks (RSNs).

Currently, the MCO contracts and monitoring functions are overseen by DSHS's Medicaid Purchasing Administration (MPA), and RSNs are overseen by the Division of Behavioral Health and Recovery (DBHR) within the Aging and Disability Services Administration.

This report also presents quality measurements for the Washington Medicaid Integration Partnership (WMIP), a pilot program aimed at improving health care for enrollees in Snohomish County who are eligible for both Medicaid and Medicare.

To evaluate the services delivered to Medicaid enrollees by the MCOs and RSNs, Acumentra Health analyzed data related to a variety of performance indicators and compliance criteria. The analysis reflects MCO and RSN performance in contract year 2009.

State-level strengths

Acumentra Health's 2010 review activities identified high-level strengths of the Medicaid managed care program.

- The Healthy Options MCOs generally are complying with federal and state standards for coverage, authorization, and availability of services, and have strengthened their compliance with access standards for enrollees with special health care needs.
- The MCOs significantly outperform the national Medicaid average in providing the Combo 2 package of child immunizations, and in several measures of diabetes care: administering blood glucose testing and retinal examinations, and maintaining good blood-pressure levels among enrollees with diabetes. Two-thirds of Medicaid children in Washington are receiving Combo 2 immunizations, and this percentage has climbed steadily since 2002.
- All MCOs use evidence-based practice guidelines in decision making for utilization management and service coverage.
- The RSNs typically provide timely access to outpatient mental health care, and most deploy well-developed crisis and stabilization resources. All RSNs have access to child mental health specialists, and RSNs generally can provide child mental health consultations in a timely manner. RSNs in some areas of the state have ethnic-specific service providers.
- The RSNs use diverse strategies to monitor the quality and appropriateness of care delivered by mental health providers.
- Interviews with local law enforcement officials indicate that Crisis Intervention Training (CIT) at the RSN level is a successful strategy to ensure that mental health consumers are treated in the least restrictive environment. Designated mental health professionals report a positive working relationship with law enforcement as a consequence of CIT programs.

Recommendations for improvement

Mental health care delivered by RSNs

The following recommendations arose from Acumentra Health's focused Quality Management Study of the RSN system, conducted as part of the 2010 EQR site reviews.

Mental health specialists: The RSN system struggles with lack of access to minority mental health specialists. RSNs express a need for specialists in cultures that are not ethnic or age-related (e.g., sexual minorities). Most RSNs lack adequate access to geriatric mental health specialists. Some RSNs need specialists to work with Russian-speaking consumers and recent immigrants from Eastern Europe, and/or with consumers who are deaf or hearing-impaired.

- ***DBHR needs to work with the RSNs to ensure an adequate number of certified mental health specialists to provide consultations for enrollees in special populations, or revise the mental health specialist certification requirements.***

Culturally and linguistically appropriate services. Most RSNs report a shortage of bilingual and bicultural staff among their regional community mental health agencies.

- ***DBHR needs to work with the RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural.***

Services for children. Most RSNs report a lack of respite services and limited access to acute care services for children.

- ***DBHR needs to work with the RSNs and community mental health agencies to provide adequate community based services as an alternative to acute care for children in the RSN system.***

Services for transition-age youth. Most RSNs lack programs designed to meet the needs of transition-age youth (age 18–21), especially young people aging out of the foster care system.

- ***DBHR needs to encourage RSNs to develop resources for transition-age youth.***

Services for geriatric consumers. Across the state, there is a scarcity of step-down resources for geriatric enrollees with dementia and co-occurring medical conditions. This leads to long stays in acute care settings.

- ***DBHR needs to coordinate with other state agencies and geriatric facilities to ensure that enrollees discharged from the State Hospital and community hospitals receive long term care.***

Consumer voice in system planning. Some RSNs struggle with recruiting and keeping Quality Review Team (QRT) members. Several described the need to restructure, redirect, and revitalize their QRTs. A few RSNs are finding it hard to maintain the balance between QRT members' independence and ensuring constructive input.

The majority of QRTs seek more involvement and influence in meetings and system decisions. QRT members interviewed for this study requested that the RSN contract incorporate stronger language related to QRTs.

- ***DBHR needs to facilitate discussion between the RSNs and QRTs to determine how to incorporate QRT input into the RSN delivery system.***

RSN board and committee representation. Several RSNs' boards and committees provide little representation for consumers and family advocates. Most RSNs' advisory boards do not represent all age groups, and most do not represent the ethnic and minority enrollee populations in their service area. One RSN's advisory board includes no representation from allied agencies, making it difficult to ensure coordination and continuity of care.

- ***DBHR needs to work with the RSNs to ensure that RSN advisory boards represent all enrollees and, as needed, represent allied agencies.***

Least restrictive environment. The RSNs are financially responsible for psychiatric inpatient care for enrollees of Healthy Options and of General Assistance for the Unemployed. The RSNs are not always involved in a consumer's services before inpatient admission, and thus cannot intervene to offer alternatives to hospitalization, if appropriate.

- ***DBHR needs to work with the RSNs and the Healthy Options MCOs to improve collaboration and ensure that Medicaid enrollees receive mental health care in the least restrictive environment.***

Some RSNs struggle to keep the census at the State Hospital below their designated caps. Penalties for census over the cap reduce revenue that RSNs could use to develop less restrictive local resources.

- ***DBHR needs to work with the RSNs to maintain a continuum of community-based services and alternatives to acute care to ensure that enrollees are served in the least restrictive environment.***

Only about half of the consumers in the focus groups had crisis plans, and most of those consumers did not feel that their plans were helpful during crises. The vast majority of crisis plans reviewed in 2010 primarily listed mental health resources and services and did not include family and friends or techniques that consumers can use to calm themselves.

- ***DBHR needs to work with the RSNs, providers, and consumers to build consensus regarding effective crisis plans.***

A few RSNs have not implemented Crisis Intervention Training (CIT) for law enforcement.

- ***DBHR needs to encourage all RSNs to implement CIT to help ensure that law enforcement officers can intervene effectively with consumers in crisis.***

Recovery and resilience. Budget constraints have forced several RSNs to cut back on supported employment programs and peer-run services, which are highly valued by consumers.

- ***DBHR is encouraged to identify creative solutions, such as cross-system funding, to ensure the availability of supported employment programs and peer-run services.***

Timeliness of assessments. Acumentra Health's review of 1,274 clinical records found that only 60 percent of enrollees had had comprehensive assessments completed within the past two years. For 13 percent of enrollees, the most recent assessment was more than five years old. Comprehensive assessments need to be updated in a timely manner, since an enrollee's life skills, strengths, and needs change over time.

- ***DBHR needs to work with RSNs to ensure timely assessment of enrollees' skills, strengths, and needs.***

Physical health care delivered by MCOs

Some recommendations presented in previous annual reports continue to apply. Acumentra Health offers these "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.

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

Technical assistance for providers. Training providers in quality improvement (QI) principles will help them improve outcomes for enrollees.

- ***MPA should encourage MCOs to identify providers that need technical assistance with QI and to implement training at the clinic level.***

Care coordination. MCO compliance scores declined for Primary Care and Coordination and for Emergency and Post-stabilization Services in 2010. Only one health plan fully met the Primary Care and Coordination standard. Other MCOs needed to refine their care coordination/case management programs, or failed to document program outcomes sufficiently.

- ***MPA should consider requiring MCOs conduct a PIP focusing on Primary Care Coordination and Emergency and Post-stabilization Services.***
- ***To help facilitate coordination of care, MPA needs to work with DBHR to ensure that an MCO is notified when a Healthy Options enrollee receives inpatient mental health services through an RSN.***

Data completeness. This issue is relevant when MCOs deliver capitated services 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 for completeness and accuracy, and maintain formal reconciliation processes to ensure the integrity of data transfer between MCOs and their vendors***

MPA 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 reported data. In 2010, several MCOs categorized large percentages of enrollees as having "unknown" ethnicity and race. MCOs should consider capturing race and ethnicity data from the state's enrollment files or from alternative sources such as member surveys and enrollment applications to help ensure that the HEDIS measure accurately reflects the diversity of MCO enrollees.

- ***MPA 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

Washington has established the goal of integrating primary care, mental health, chemical dependency, and long-term care services. As a fully integrated program, the WMIP can provide valuable lessons in integration to help the RSNs progress beyond initial steps toward that goal.

- ***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 MPA should meet with the EQRO's mental health team to share best practices in care coordination, discuss outcomes, and explore ways to improve care processes to meet the common needs of Medicaid service populations.***
- ***MHW should discuss with NSMHA or with 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 routine services after psychiatric hospitalizations.***

Acumentra Health offers this additional recommendation:

- ***MPA should explore opportunities to promote the WMIP program as an approach that supports the medical or health home model.***

Introduction

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

DSHS units administer services for these enrollees through contracts with medical MCOs and mental health RSNs. The MCOs and RSNs, in turn, contract with health care practitioners to deliver clinical services. Currently, DSHS's Medicaid Purchasing Administration (MPA) oversees the MCO contracts and monitoring functions, and the Division of Behavioral Health and Recovery (DBHR) within the Aging and Disability Services Administration oversees the RSN contracts and monitoring.

In the face of severe budget pressures, DSHS remains committed to integrating primary care and mental health/substance abuse services by incorporating primary care capacity into behavioral health specialty settings and behavioral health into primary care settings. As of the writing of this annual report, DSHS was drafting a policy framework to guide integration efforts.

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 MPA and DBHR, presents this report to fulfill the federal EQR requirements. The report evaluates access to care for Medicaid enrollees, the timeliness and quality of care delivered by health plans and their providers, and the extent to which each health plan addressed the previous year's EQR recommendations.

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

- **compliance monitoring**—site reviews of the health plans to determine whether they meet regulatory and contractual standards governing managed care
- **validation of performance improvement projects (PIPs)** to determine whether the health plans meet standards for conducting these required QI studies
- **validation of performance measures** reported by health plans or calculated by the state, including
    - Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures of clinical services provided by MCOs
    - 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, MPA 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 statewide performance measures, 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 DSHS can help the plans improve the quality of their services.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance.

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)—currently, $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 Children's Health Insurance Program (CHIP), covering families who earn too much money to qualify for Medicaid, yet cannot afford private insurance.

Currently, Washington provides medical care for roughly 700,000 Medicaid enrollees in managed care. More than 80 percent of Healthy Options enrollees are younger than 19 years old. The state also purchases primary care and other physical health services for about 450,000 Medicaid fee-for-service (FFS) recipients—primarily the aged, blind, disabled, and children in foster care.

Managed mental health care

The RSNs cover almost 1 million enrollees in managed mental health care. In 2008 and part of 2009, Medicaid recipients in Pierce County received state-administered FFS mental health services. During 2009, OptumHealth, a subsidiary of UnitedHealth Group headquartered in Tacoma, began operating as an RSN in Pierce County. Acumentra Health reviewed the operations of this RSN for the first time in 2010.

Washington Medicaid Integration Partnership (WMIP)

This Medicaid project, aimed at improving care for adult residents of Snohomish County who have complex health care needs, began in January 2005. WMIP seeks to coordinate Medicaid-funded medical, mental health, substance abuse, and long-term care within a patient-centered framework. Molina Healthcare of Washington (MHW) coordinates services for WMIP enrollees. As of October 2010, about 3,800 beneficiaries were enrolled in WMIP.

State quality improvement activities

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

Managed Care Quality Strategy

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

As noted above, DSHS is drafting a discussion document to guide the integration of managed physical and behavioral 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, to establish confidence in the reported improvements. The PIPs must include

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

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 well-child care (WCC) rates if the MCO's rates fall below established benchmarks. MPA validates the PIPs' compliance with CMS standards through the TEAMonitor reviews.

For the WMIP program, MHW conducted five PIPs in 2010, targeting improvements in care and nonclinical services. Three projects were carried over from previous years, including two on chemical dependency topics, as required by contract. MHW also began two new clinical PIPs seeking to increase influenza vaccinations and depression assessments.

Each RSN must conduct one clinical and one nonclinical PIP annually. Acumentra Health validates the PIPs using a review protocol adapted from the CMS protocol. During 2010, six RSNs conducted PIPs on a common topic, improving the timeliness of outpatient service appointments following an enrollee's discharge from inpatient psychiatric care.

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 the NCQA accreditation standards related to quality management and improvement, utilization management, and enrollee rights/responsibilities. Specific contract provisions apply to the performance measures described below.

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

For reporting year 2010, MPA required each MCO to report HEDIS measures of:

- 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, 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

MHW also calculated four non-HEDIS measures for the WMIP: chronic dementia, falls, depression, and transition of care. The results of those four measures are not analyzed in this annual report.

To ensure data integrity, NCQA requires certification of each health plan's data collection process by a certified HEDIS auditor. MPA funded the 2010 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 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 health care system.

As in 2008, the CAHPS survey in 2010 collected responses from a statewide sample of CHIP enrollees, WMIP enrollees, and a comparison group of FFS clients, 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. If the RSN does not meet defined improvement targets on any measure, the RSN must submit a performance improvement plan. For 2010, five performance measures were in effect (see page 44).

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. 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. In 2010, Acumentra Health evaluated the RSNs' response to findings from the 2009 EQR report.

Compliance monitoring

MPA participates in TEAMonitor with the state Department of Health, Health Care Authority, and Aging and Disability Services Administration in overseeing 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 2010, TEAMonitor evaluated the 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 review methods adapted from the CMS protocol. In 2010, Acumentra Health reviewed each RSN's response to the specific 2009 EQR findings for which DBHR required the RSN to perform corrective action.

Value-based purchasing

Washington was one of the first states to incorporate value-based purchasing into its managed care contract. Beginning in 2005, MPA provided incentive payments for improvement in WCC and childhood immunization rates, setting aside $1 million per year for each measure. The incentive system rewarded MCOs 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. However, because of current budget constraints, the state legislature has defunded the incentive program.

Quality oversight

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

EQR activities

Table 1 summarizes the mandatory and optional EQR activities that DSHS pursues, 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 on-site 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 on-site reviews
Optional		
Administration or validation of consumer or provider surveys of quality of care	CAHPS survey by EQRO	MHSIP survey
Encounter data validation	Not conducted	EQRO study
Focused quality study	Not conducted	Quality Management Study

Methods

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

- 2010 HEDIS report of MCO performance in key clinical areas[1]
- 2010 TEAMonitor reports on MCOs' compliance with BBA regulations and state contractual requirements
- Acumentra Health reports on individual RSNs' regulatory and contractual compliance, PIP validation, and ISCA follow-up, submitted throughout 2010

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

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

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

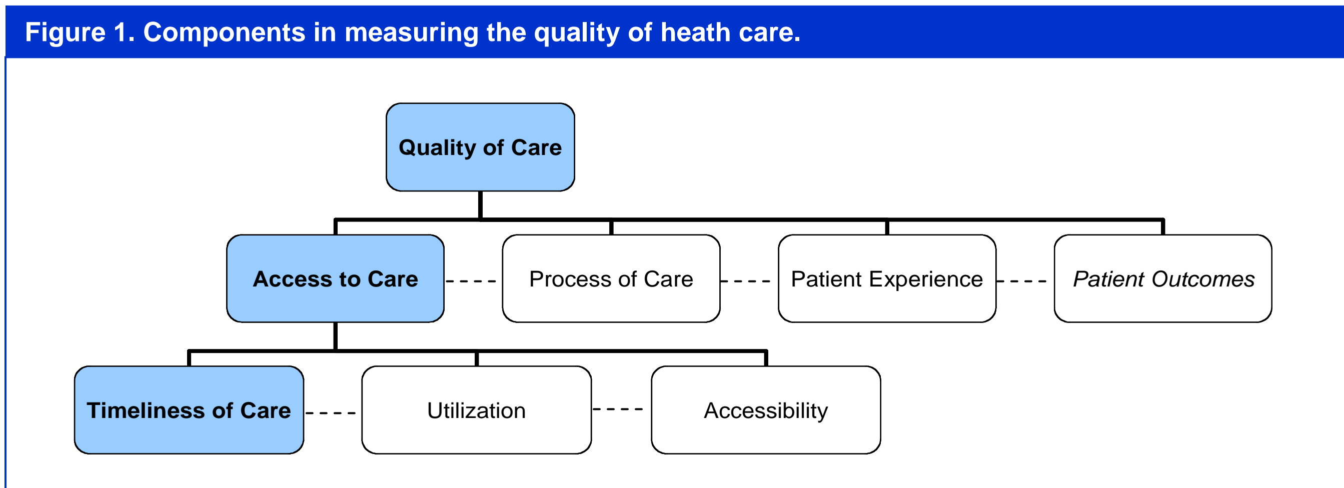
Quality of care encompasses access and timeliness as well as the *process* of care delivery (e.g., using evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall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

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

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

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

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



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

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

Mental Health Care Delivered by RSNs

Currently, DBHR contracts with 13 RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs, in turn, 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.

Each RSN is 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 mental health consumers and their family members. The QRT may monitor consumer satisfaction with services and may work with consumers, service providers, the RSN, and DBHR to improve services and resolve problems. In addition, many RSNs contract with third-party administrators for utilization management services, including initial service authorization.

Table 2 shows the approximate number of enrollees assigned to each RSN and the RSN's percentage of statewide enrollment as of October 2010.

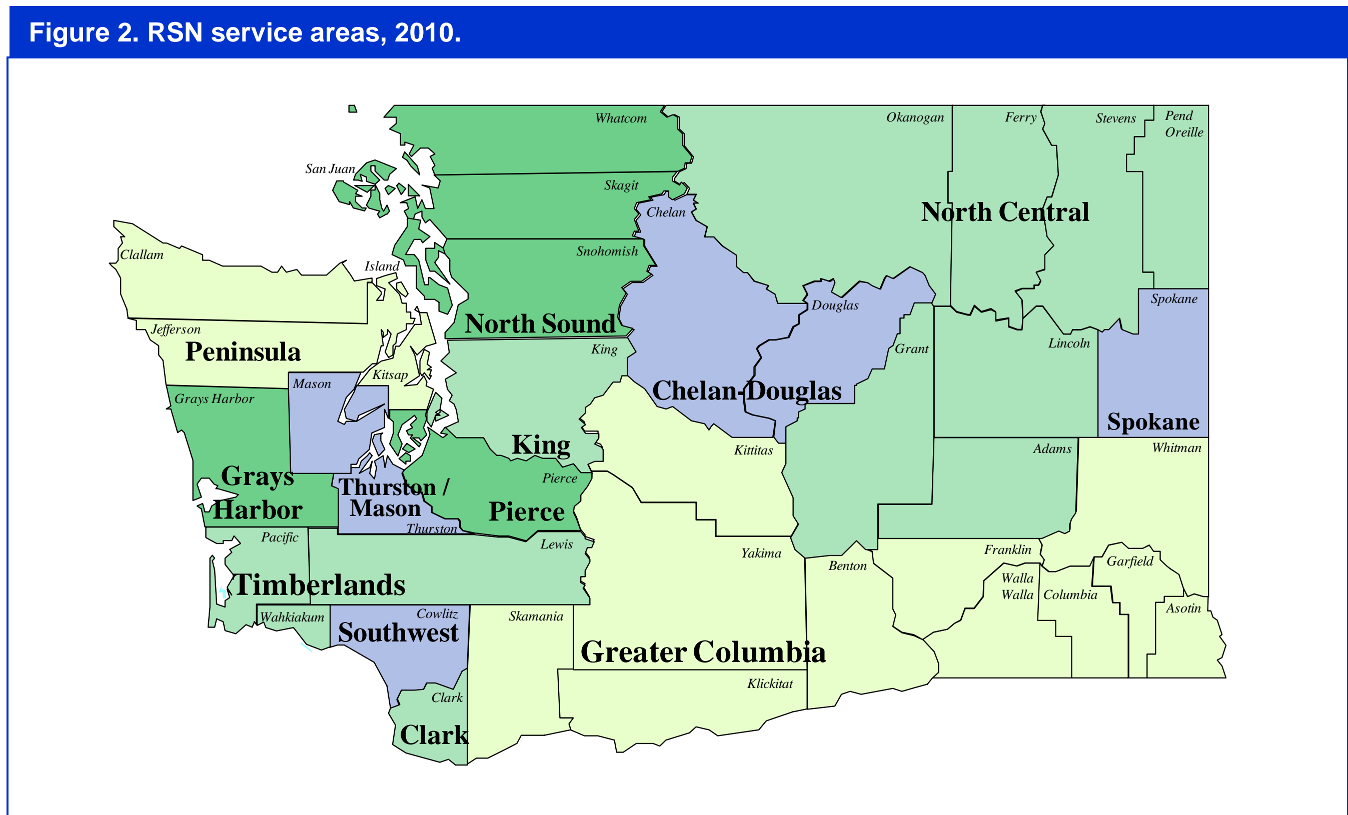
Table 2. Mental health regional support networks and enrollees, October 2010.[a]

Health plan	Acronym	Number of enrollees	% of all enrollees
Chelan-Douglas RSN	CDRSN	21,605	2.2
Clark County RSN	CCRSN	65,103	6.6
Grays Harbor RSN	GHRSN	14,917	1.5
Greater Columbia Behavioral Health	GCBH	147,910	15.1
King County RSN	KCRSN	209,270	21.3
North Central Washington RSN	NCWRSN	53,877	5.5
North Sound Mental Health Administration	NSMHA	141,544	14.4
Peninsula RSN	PRSN	42,414	4.3
OptumHealth Pierce RSN	OPRSN	120,098	12.2
Southwest RSN	SWRSN	21,042	2.1
Spokane County RSN	SCRSN	82,302	8.4
Thurston-Mason RSN	TMRSN	40,671	4.1
Timberlands RSN	TRSN	19,869	2.0
Total		**980,622**	**100.0**

[a] Source: DSHS. Percentages do not add to 100.0 because of rounding.

Figure 2 shows the counties served by each RSN.

Figure 2. RSN service areas, 2010.



For all RSNs except OPRSN, Acumentra Health conducted the compliance review and PIP validation during 2008–2009, and conducted the full ISCA for each RSN in 2009. Acumentra Health also conducted a baseline encounter data validation and clinical record review for all RSNs except OPRSN in 2008. Together, these activities addressed the following questions:

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

In 2010, the third year of the current EQR cycle, Acumentra Health conducted a special focused study of managed care quality management in conjunction with RSN site reviews. DBHR identified specific quality indicators on which the EQRO was to assess RSN performance. In addition to data from the standard EQR activities, the Quality Management Study drew on information from focus groups with consumers, Ombuds, and QRTs; interviews with local law enforcement, community hospital, and E&T facility staff; a teleconference with designated mental health professionals (DMHPs); and a review of clinical records at each RSN. This EQR Annual Report reports high-level findings of the

special focused study; detailed results appear in a separate report delivered to DBHR.

For each RSN in 2010, Acumentra Health validated PIPs and conducted an encounter data validation and clinical record review. For OPRSN, DBHR directed Acumentra Health not to conduct the regulatory/contractual compliance review in 2010, but to wait until 2011, the beginning of the next EQR cycle, so that all RSNs can be evaluated for compliance on the same schedule. However, Acumentra Health did validate OPRSN's PIPs and conducted a full ISCA, encounter data validation, and clinical record review, as for all other RSNs.

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

- *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 DBHR.

The following sections summarize the results of individual EQR reports for 13 RSNs completed during 2010. These results represent established measurements against which DBHR will compare the results of future reviews to assess the RSNs' improvement. Individual RSN reports delivered to DBHR during the year present the specific review results in greater detail.

Access to mental health care

These observations and recommendations arose from the Quality Management Study associated with the RSN site reviews during 2010.

Strengths

- Several RSNs have integrated peers and "parent partners" into their crisis response teams.
- Two RSNs have contracted with Recovery Innovations for crisis response services. More than half of this provider's staff members are recovering consumers.
- All RSNs have access to child mental health specialists.
- RSNs in some areas of the state have ethnic-specific service providers.
- Most RSNs offer well-developed crisis and stabilization resources for 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. In 2009, SCRSN developed six less restrictive alternatives to hospitalization.

Opportunities for improvement

A report by TriWest Group for DSHS in 2010 looked at disparities in access to and quality of mental health services in Washington, with a special focus on issues surrounding the role of mental health specialists.[6] The report identified issues related to the specialist workforce, including (1) too few specialists to provide needed consultation, across all subpopulations; (2) lack of adequate clinical expertise and of consultation skills among the workforce as a whole, (3) barriers to recruiting and retaining specialists, including lack of differential pay, lack of encouragement by provider agencies, and excessive documentation requirements; and (4) spotty access to interpreters in rural areas. Among regulatory and infrastructure issues, the report noted that RSNs vary in the quality of their administrative oversight of specialist standards. The findings of this report are consistent with the following observations from Acumentra Health's 2010 site visits.

- The entire RSN system continues to struggle with lack of access to minority mental health specialists.
- RSNs express a need for specialists in cultures that are not ethnic or age-related (e.g., gay/lesbian, bisexual, transgender).
- Some RSNs need specialists who can work with Russian-speaking consumers and recent immigrants from Eastern Europe, and/or with consumers who are deaf or hearing-impaired.
- Most RSNs lack adequate access to geriatric mental health specialists.
    - ***DBHR needs to work with the RSNs to ensure an adequate number of certified mental health specialists to provide consultations for enrollees in special populations, or revise the mental health specialist certification requirements.***

  The TriWest report recommended using telemedicine to expand access for rural areas lacking specialists, and for more highly populated areas needing access to more specialized or higher-quality expertise. Disseminating information about specialist availability across RSNs could help ameliorate shortages in certain areas of the state.

- Most RSNs report a shortage of bilingual and bicultural staff among their regional community mental health agencies.
    - ***DBHR needs to work with the RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural.***

- Most RSNs report a lack of children's respite services, as well as limited access to acute care services for children.
  - ***DBHR needs to work with the RSNs and community mental health agencies to provide adequate community based services as an alternative to acute care for children in the RSN system.***
- Most RSNs lack programs designed to serve the needs of transition-age youth (age 18–21), particularly young people aging out of the foster care system.
  - ***DBHR needs to encourage RSNs to develop resources for transition-age youth.***
- Across the state, the scarcity of step-down resources for geriatric patients with dementia and co-occurring medical conditions leads to long stays in acute care settings.
  - ***DBHR needs to work with the state agencies that license geriatric facilities to ensure that those facilities are able and willing to accept enrollees discharged from the State Hospital and community hospitals.***
- Scarce housing resources for consumers involved in the criminal justice system also inhibit consumers' ability to recover.

Timeliness of mental health care

These observations and recommendations arose from the Quality Management Study associated with the RSN site reviews during 2010.

Strengths

- The RSNs generally can provide child mental health consultations in a timely manner.
- All RSNs monitor their provider agencies to determine whether they offer timely access to specialist consultations.
- Community hospitals report that DMHPs see consumers in crisis in a timely manner.
- Some RSNs are conducting PIPs aimed at improving the timeliness of care delivery.
  - Six of the 13 RSNs are studying ways to improve the timeliness of outpatient follow-up appointments for enrollees discharged from psychiatric hospitals.
  - NSMHA is studying ways to improve the timeliness of enrollees' access to medication evaluation appointments.
  - CCRSN, NCWRSN, and TMRSN are conducting PIPs aimed at ensuring access to routine services within 14 days of a service request.

Opportunities for improvement

- RSNs have difficulty consistently meeting the 30-day timeline for minority mental health specialist consultations. DSHS is re-examining the requirement for mental health specialist consultations. As suggested in the 2009 EQR annual report, modifying the qualifications for becoming a mental health specialist could help resolve timeliness issues.
  - ***DBHR 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.***
- Due to lack of acute care resources, consumers in crisis often are "boarded" at community hospitals until appropriate placement can be found. Hospitals report that stays in the emergency room can be as long as 72 hours.
- Since several RSNs began performing service authorizations in-house during 2009, a few RSNs have reported delays in completing authorization requests.
- Acumentra Health's review of nearly 1,300 clinical records found that only 60 percent of enrollees had had comprehensive assessments completed within the past two years. For 13 percent of enrollees, the most recent assessment was more than five years old.
  - ***DBHR needs to work with RSNs to ensure timely assessment of enrollees' skills, strengths, and needs.***

Quality of mental health care

These observations and recommendations arose from the Quality Management Study and follow-up on RSN corrective actions conducted by Acumentra Health as part of the RSN site reviews in 2010.

Evidence-based practices (EBPs)

- The 2010 clinical record review revealed that RSNs across the system use cognitive behavioral therapy (CBT). Several RSNs offer children's wraparound services.
- 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 services for people with severe and persistent mental illnesses and co-occurring disorders. Other RSNs report having "PACT-like" programs.

Strengths

Quality management (QM) programs

- Follow-up on the 2009 compliance review showed improvement in the RSNs' QM programs. DBHR offered training on this topic for the RSNs during 2010.
- RSNs use diverse strategies to monitor the quality and appropriateness of care delivered by provider agencies. Methods include performing annual administrative audits, reviewing clinical records, and analyzing grievance reports and surveys.

Enrollee and family voice

- The majority of consumers in the focus groups agreed that they felt involved and supported in their treatment process.
- A few RSNs have integrated recovering consumers into their staff.
- Several RSNs have active advisory boards that provide input into RSN functions.
- Many RSNs value the contributions of the QRTs to the RSN system.
- NSMHA has convened a Dignity and Respect workgroup to address related complaints and grievances.
- All RSNs monitor for "enrollee voice" in their clinical record audits.

Age-appropriate services

- Most RSNs' advisory boards include advocates for children's services.
- Many RSNs participate on committees with child and senior service agencies in their regions.
- KCRSN has implemented a practice guideline for "developmentally appropriate services," and pays providers an incentive for services that meet the practice guideline.
- Several RSNs have providers who deliver services, including medication management, in nursing homes, adult foster homes, and senior centers.

Culturally and linguistically appropriate services

- Several RSNs require staff to attend cultural competency training, and/or offer training to their provider network annually.
- Several RSNs have collaborated successfully with the tribes in their service areas to coordinate care. NSMHA holds an annual tribal conference.
- Several RSNs offered culturally competent trainings in 2009. SCRSN cosponsored a conference with a tribe related to mental health services for Native American consumers. CCRSN's administration provides statewide leadership regarding culturally competent services.

Least restrictive environment

- In collaboration with the RSN's advisory board, local hospitals, and contracted providers, the Ombuds at TMRSN developed a "passport" for consumers to use during a crisis. The passport includes the consumer's crisis plan, emergency contacts, advance directive, and durable power of attorney and/or guardianship, if appropriate. As of August 2010, TMRSN enrollees had completed 40 passports.
- Law enforcement officers consider Crisis Intervention Training (CIT) a successful strategy to ensure that consumers are treated in the least restrictive environment. DMHPs report a positive working relationship with law enforcement as a consequence of CIT training.

Recovery and resilience

- Consumers in the focus groups consistently emphasized the value of peer-run services such as clubhouses.
- Several RSNs' newsletters for consumers focus on recovery issues. OPRSN has a "recovery portal" on its website.
- TMRSN uses a "recovery index" to monitor whether families are building resilience.
- KCRSN has implemented an incentive program for services that support and build on recovery and resilience.

Coordination and continuity of care

- RSNs use memos of understanding (MOUs) to clarify roles between agencies and providers who also serve their enrollees. OPRSN has negotiated MOUs with more than 40 agencies and non-governmental organizations.
- Several RSNs are adept at pooling resources with allied agencies to develop creative and flexible services for enrollees involved in multiple systems.
- DMHPs and staff of E&T facilities and community hospitals report successful collaboration to ensure serving consumers in the least restrictive environment.

Clinical quality PIPs

- CDRSN, KCRSN, and PRSN focused their 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 PIPs on using the PACT team to reduce hospital utilization.
- TMRSN focused its PIP on implementing Multisystemic Therapy, a family-centered intervention for enrollees under age 18 with chronic violent and/or substance-abusing behaviors.

Opportunities for improvement

Consumer voice in system planning

- Some RSNs struggle with recruiting and keeping QRT members. Several said they need to restructure, redirect, and revitalize their QRTs. A few RSNs expressed difficulty with maintaining the balance between QRT members' independence and ensuring constructive input.

  The majority of QRTs seek more involvement and influence in meetings and system decisions. Some teams feel that their suggestions and input are not pursued or taken seriously. In the focus group, six QRT members requested that the RSN contract incorporate stronger language related to QRTs.

  - ***DBHR needs to facilitate discussion between the RSNs and QRTs to determine how to incorporate QRT input into the RSN delivery system.***

RSN board and committee representation

- Several RSNs' boards and committees provide little representation for consumers and family advocates. One RSN's advisory board includes no consumers.
- Most RSNs' advisory boards do not represent all age groups, and most do not represent the ethnic and minority enrollee populations in their service area. In particular, most RSNs have difficulty ensuring tribal participation on boards and committees.
- One RSN's advisory board includes no representation from allied agencies, making it difficult to ensure coordination and continuity of care.
  - ***DBHR needs to work with the RSNs to ensure that RSN advisory boards represent all enrollees and, as needed, represent allied agencies.***

Least restrictive environment

- The RSNs are financially responsible for psychiatric inpatient care for enrollees of Healthy Options and of General Assistance for the Unemployed. The RSNs are not always involved in authorizing hospital stays before admission, and thus cannot intervene to offer alternatives to hospitalization, if appropriate.
  - ***DSHS needs to work with the RSNs and the Healthy Options plans to improve collaboration and ensure that Medicaid enrollees receive mental health care in the least restrictive environment.***
- Some RSNs struggle to keep the census at the State Hospital below their approved levels. Penalties for census over the RSNs' cap of State Hospital beds reduce the revenue that RSNs could use to develop less restrictive local resources.
  - ***DBHR needs to work with the RSNs to maintain a continuum of community-based services and alternatives to acute care to ensure that enrollees are served in the least restrictive environment.***
- Only about half of the consumers in the focus groups had crisis plans, and most of those consumers did not feel that their plans were helpful during crises. The vast majority of crisis plans reviewed in 2010 primarily listed mental health resources and services, and did not include techniques that consumers can use to calm themselves.
  - ***DBHR needs to work with the RSNs, providers, and consumers to build consensus regarding effective crisis plans.***
- A few RSNs have not implemented Crisis Intervention Training (CIT) for law enforcement.
  - ***DBHR needs to encourage all RSNs to implement CIT to ensure the ability of law enforcement staff to intervene effectively with consumers in crisis.***

Recovery and resilience

- Budget constraints have forced several RSNs to cut back on supported employment programs and peer-run services, which are highly valued by consumers.
  - ***DBHR is encouraged to identify creative solutions, such as cross-system funding, to ensure that these services are available.***

Mental health regulatory and contractual standards

During 2009, Acumentra Health reviewed the RSNs' compliance with 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. QAPI Program
8. Certification and Program Integrity

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

The compliance reviews 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 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.

In 2010, Acumentra Health reviewed each RSN's response to the specific 2009 EQR findings for which DBHR required the RSN to perform corrective action. Table 3 summarizes the results of this follow-up review.

The largest number of corrective actions applied to the standards related to the Delivery Network (timely access, service availability, and network sufficiency), Provider Selection (credentialing/ recredentialing and screening for exclusion from participation in federal health care programs), and the QAPI Program (annual program evaluation, monitoring for over- and underutilization).

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Table 3. Status of RSN corrective actions identified in 2009.				
Compliance area	**42 CFR citation (see Appendix C)**	**Number of issues**	**RSN**	**Status of corrections**
Delivery Network	*438.206(b)(1)*	3	GCBH	Resolved
			NCWRSN	In progress
			TRSN	Resolved
	438.206(b(3)	1	TRSN	Resolved
	438.206(b)(4)	3	GCBH (2)	Resolved
			TRSN	Resolved
	438.206(c)(1)	5	CCRSN	Resolved
			GHRSN	In progress
			KCRSN	Resolved
			NCWRSN	In progress
			PRSN	Resolved
	438.206(c)(2)	1	SWRSN	Resolved
Coordination/Continuity of Care	*438.208(b)*	3	GHRSN	Resolved
			TRSN	Resolved
			TMRSN	Resolved
	438.208(c)(1–2)	1	TRSN	Resolved
	438.208(c)(3)	2	GHRSN	Resolved
			TRSN	Resolved
Coverage and Authorization of Services	*438.210; 438.114*	1	TRSN	Resolved
	438.210(b)–(c)	1	CCRSN	Resolved
	438.210(e)	1	CCRSN	Resolved
Provider Selection	*438.214(a)–(b)*	7	CCRSN	Resolved
			GHRSN	Resolved
			NCWRSN	In progress
			PRSN	Resolved
			SWRSN	Resolved
			TRSN	Resolved
			TMRSN	Resolved
	438.214(d)	6	CCRSN	Resolved
			CDRSN	Resolved
			GHRSN	Resolved
			GCBH	Resolved
			KCRSN	Resolved
			SWRSN	Resolved
Subcontractual Relationships/Delegation	*438.230*	1	TRSN	Resolved

Table 3. Status of corrective actions identified in 2009 (cont.).				
Compliance area	**42 CFR citation (see Appendix C)**	**Number of issues**	**RSN**	**Status of corrections**
Practice Guidelines	*438.236(c)*	2	CDRSN	Resolved
			TRSN	Resolved
	438.236(d)	2	GHRSN	Resolved
			SCRSN	Resolved
QAPI Program	*438.240*	1	TRSN	Resolved
	438.240(a)–(b)(1); (d)–(e)	4	GCBH	Resolved
			GHRSN	Resolved
			NCWRSN	In progress
			SCRSN	Resolved
	438.240(b)(2)–(c)	3	GCBH	Resolved
			GHRSN	Resolved
			NCWRSN	In progress
	438.240(b)(3)	5	CDRSN	Resolved
			GCBH	Resolved
			GHRSN	Resolved
			NCWRSN	In progress
			TRSN	Resolved
	438.240(b)(4)	2	GCBH	Resolved
			TRSN	Resolved
	438.242(a)	3	GCBH	Resolved
			NCWRSN	In progress
			TRSN	Resolved
	438.242(b)	1	NCWRSN	In progress

Mental health PIP validation

Acumentra Health evaluated the RSNs' PIPs for the first time in 2008, and again in 2009 and 2010. 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 DBHR, 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 is assessed and measured
- an analysis plan that addresses project objectives, clearly defines the study indicators and population, identifies data sources and collection procedures, and discusses the methods for analyzing the data and performing statistical tests
- if applicable, a sampling methodology that yields a representative sample
- in the case of data collection that involves a clinical record review, procedures for checking inter-rater reliability
- validation of data at the point of data entry for accuracy and completeness
- when claims or encounter data are used for population-based analysis, assessment of data completeness
- a summary of the results of all data collection and analysis, explaining limitations inherent in the data and methodologies and discussing whether the strategies resulted in improvements

PIP scoring

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 DBHR. The scoring procedure involves rating the RSN's performance on as many as 10 standards, listed in Table 4 on the next page. 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. Total points for each standard are weighted and combined to determine an overall PIP score. The overall score 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 (Standards 1–8), with a maximum score of 80 points. If the PIP has progressed to two or more remeasurements, enabling the reviewers to assess sustained improvement (Standards 9–10), the maximum overall score is 100 points.

Most PIPs submitted by the RSNs for review in 2010 were scored on the 80-point scale. However, five RSNs had at least one PIP scored on the 100-point scale. 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 5 shows the compliance ratings and associated scoring ranges for PIPs graded on the 80-point and the 100-point scale. Appendix D presents a sample scoring worksheet.

Table 4. Standards for RSN PIP validation.

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

Table 5. PIP scoring ranges.

Compliance rating	Description	100-point scale	80-point scale
Fully met	Meets or exceeds all requirements	80–100	70–80
Substantially met	Meets essential requirements, has minor deficiencies	60–79	55–69
Partially met	Meets essential requirements in most, but not all, areas	40–59	40–54
Minimally met	Marginally meets requirements	20–39	25–39
Not met	Does not meet essential requirements	0–19	0–24

Table 6 shows the topics of the PIPs submitted by each RSN for 2010.

Table 6. PIP topics by RSN, 2010.

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: Improving Early Engagement In Outpatient Services
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
OPRSN	Clinical: Consumer Partnership in Treatment Planning
	Nonclinical: Increasing Consumer Employment
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: Increased Incident Reporting Compliance
TMRSN	Clinical: Multisystemic Therapy
	Nonclinical: Increasing Percentage of Medicaid Clients Who Receive an Intake Service Within 14 Days of Service Request
TRSN	Clinical: Improving Treatment Outcomes for Adults Diagnosed With a New Episode of Major Depressive Disorder
	Nonclinical: Improving Coordination of Care and Outcomes

Summary of 2010 PIP validation results

During 2010, most RSNs continued the same projects that Acumentra Health reviewed in 2009. However, GCBH, SWRSN, and TMRSN began work on new nonclinical PIP topics, and TRSN began work on a new clinical topic. Both PIPs conducted by OPRSN in 2010 were new.

Progress on statewide PIP topic: Six of the 13 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 discharged Medicaid enrollees to be offered non-crisis services within seven days.

Since 2008, DBHR and the RSNs have worked to resolve discrepancies between state and local data on enrollees seen for follow-up within seven days. The EQRO advised RSNs that they needed to continue making progress with the PIP regardless of the status of the DBHR data. Of the six RSNs that have continued this PIP, three elected to use the data provided by DBHR to calculate their study indicators, and three elected to use local or other data sources (e.g., DBHR intranet files).

As of 2010, of the six RSNs involved in the statewide PIP:

- 4 had developed an intervention strategy
  - 3 RSNs designated 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
  - the other RSN provided hospitals with status reports detailing the rates of enrollee follow-up, rates of requests for services, and which enrollees did not receive follow-up care
- 5 had reported baseline data
- 4 had reported remeasurement data and results of a statistical analysis
- GHRSN and NSMHA had reported a second remeasurement
  - GHRSN concluded that the PIP achieved statistical *and* clinical improvement at the first remeasurement, but not at the second
  - NSMHA concluded that it achieved statistical but not clinical improvement at both the first and second remeasurement

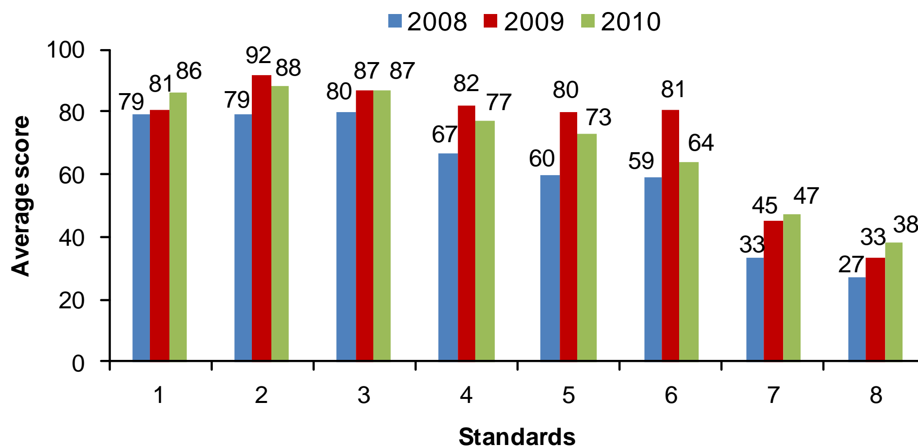
GHRSN and NSMHA made important progress toward determining whether a given intervention strategy could improve the timeliness of outpatient follow-up. Although both RSNs improved their follow-up rates, both remained below the state benchmark. The remaining four RSNs made no progress on the statewide PIP in 2010.

PIP scores by validation standard: Figure 3 shows the change in average scores by individual validation standard for all RSNs' PIPs from 2008 through 2010.

Across most standards, the RSNs have considerably improved their study documentation and, thus, their scores since 2008. As a group, the RSNs in 2010 *substantially* met Standards 1–5, addressing the study topic, question, indicators, population, and data collection and analysis plan, and *partially* met Standards 6 and 7, addressing intervention goals and strategies and interpretation of the study results. The RSNs improved their documentation of Standards 7 and 8. On average, however, the RSNs only minimally met Standard 8, which involves demonstrating whether the PIP resulted in real improvement.

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 10 standards. As of 2010, more than half of all PIPs had progressed to a first remeasurement, and six PIPs had progressed to the stage at which they would be scored on 10 standards.

Figure 3. Average scores by validation standard for clinical and nonclinical PIPs, 2008–2010.



Overall PIP scores: Figures 4 and 5 depict the change in overall scores from 2009 to 2010 for the RSNs' clinical and nonclinical PIPs that were graded on the 80-point scale. As shown, the majority of RSNs improved their clinical PIP scores, while the trend was less positive for nonclinical PIPs.

Figure 4. RSN scores on clinical PIPs, 2009–2010.

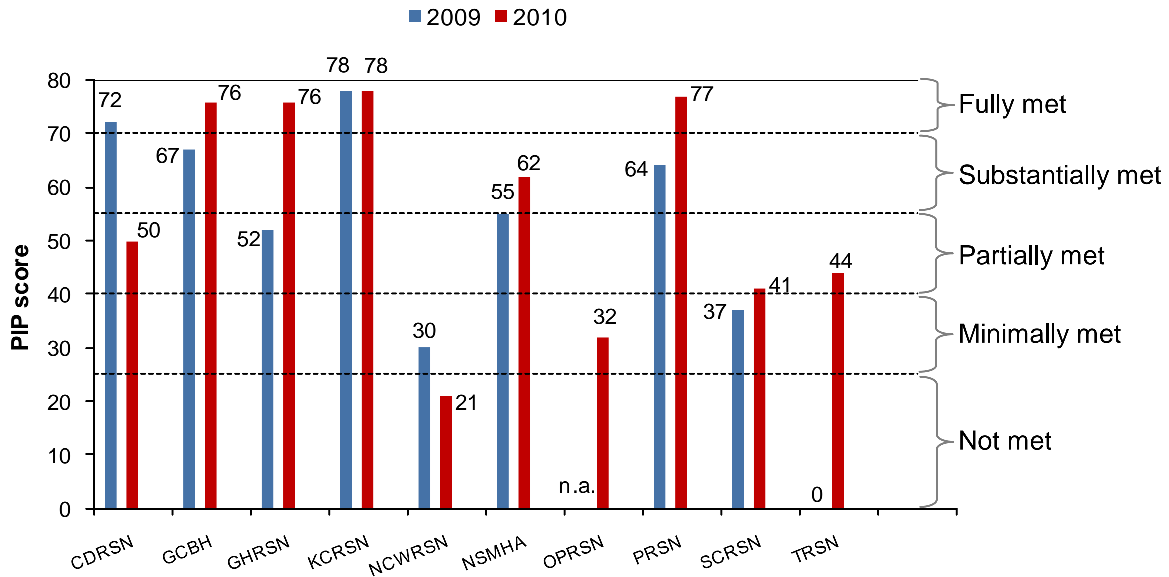
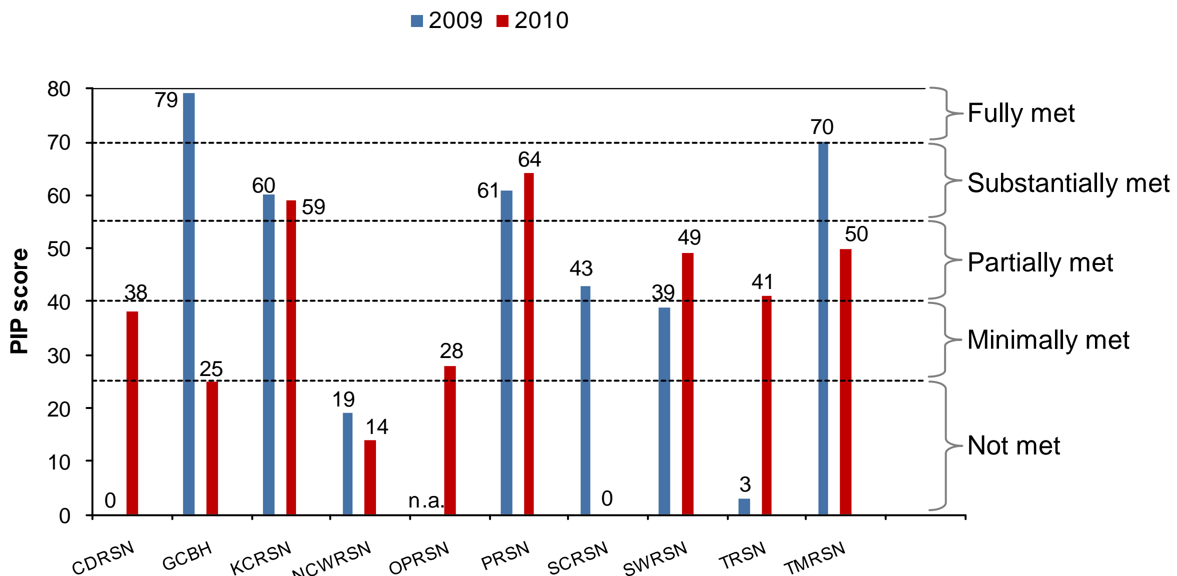


Figure 5. RSN scores on nonclinical PIPs, 2009–2010.

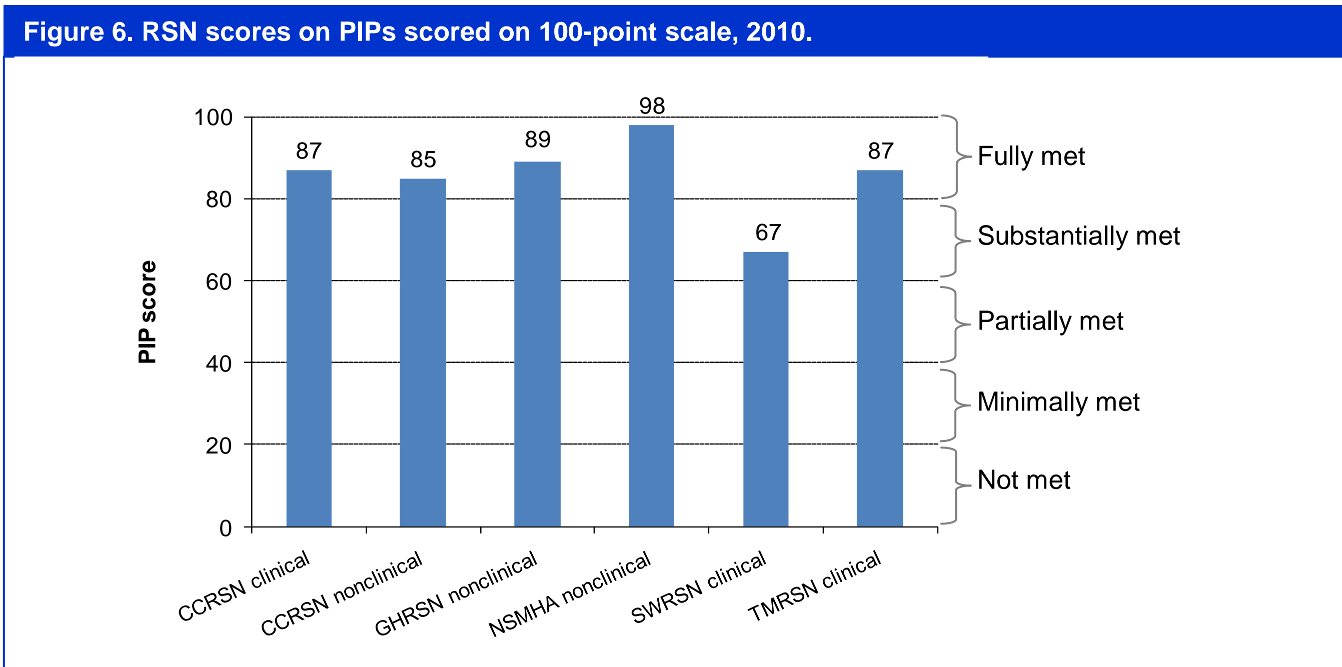


Certain RSNs scored worse in 2010 than in 2009 because the RSN

- submitted new documentation for 2010 that did not adequately address the standard(s) or the previous EQR recommendations (NCWRSN, SCRSN)
- made little or no progress on the PIP during 2010 (KCRSN, PRSN)
- began a new PIP in 2010 (GCBH, TMRSN)

Figure 6 depicts the scores for PIPs that were scored on the 100-point scale in 2010. As shown, both of CCRSN's PIPs fully met the CMS standards, as did GHRSN's and NSMHA's nonclinical PIPs and TMRSN's clinical PIP, while SWRSN's clinical PIP substantially met the standards.

Figure 6. RSN scores on PIPs scored on 100-point scale, 2010.



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

- Describe the process for selecting and prioritizing the study topic and the topic's relevance for the local Medicaid population. The RSN should provide data and discussion to demonstrate that the topic is a priority in its network.
- Describe clearly how data are collected, including the data sources, specific elements, and calculations used to select the study population and derive the study indicators. The RSN should consider using a table to display each inclusion and exclusion criterion, with associated elements, sources, and calculations.
- Develop procedures to validate that all study data are accurate and reliable. This usually involves corroborating data against a second data source. The RSN should then report on the level of accuracy and completeness of the data.
- Develop a detailed data analysis plan, defining the study time periods, the planned comparisons (e.g., 2009 to 2010), a rationale for selecting a given statistical test, and the probability level used to determine statistical significance.
- Select a study intervention that directly addresses the quality problem identified under Standard 1, and that will influence the study indicator and outcomes for the targeted study population. After selecting the intervention, the RSN should report on its implementation.
- In interpreting the success of the PIP, consider the entire PIP process, including successes and barriers related to the study methodology, implementation of the intervention, and any confounding factors (e.g., interventions outside the scope of the study).
- Incorporate lessons learned (e.g., barriers, confounding factors) into the next year's PIP activities.

PIP descriptions and discussion

Clark County RSN

Clinical: Employment Outcomes for Adult Consumers. This PIP, initiated in 2008, seeks to increase the employment rate for adult RSN enrollees. The intervention strategy targets enrollees, service providers, and community employers to increase awareness of, and influence attitudes toward, employing people served by the mental health system. Remeasurement data showed that the employment rate rose from 8.5 percent to a peak of 10 percent in the second remeasurement quarter. Although the change was not statistically significant, CCRSN concluded that it achieved clinical improvement. Overall, CCRSN has done an excellent job of documenting this PIP, but still needs to discuss whether it plans to modify the PIP's direction in light of lessons learned to date.

Nonclinical: Timeliness of Access to Outpatient Services. CCRSN has modified this PIP on an ongoing basis since 2006. The current objective is to measure whether a network-wide notification and referral process can increase the percentage of enrollees offered an intake appointment within 10 days of requesting routine services. In 2009, remeasurement data showed that the percentage of enrollees offered timely intake actually fell after implementation of the intervention. CCRSN identified barriers to improvement and revised its intervention strategy for 2010. As with its clinical PIP, CCRSN submitted thorough documentation of all steps taken on the nonclinical PIP.

Chelan-Douglas RSN

Clinical: Metabolic Syndrome Screening and Intervention. The goal of this PIP, initiated in 2007, is to reduce the risk of developing metabolic syndrome in enrollees with schizophrenia who use atypical antipsychotic medications. Previous interventions, aimed at reducing the number of eligible enrollees with metabolic syndrome symptoms above an established threshold, failed to achieve significant improvement. After a barrier analysis, CDRSN decided to refocus the PIP on increasing the number of laboratory screening referrals completed by enrollees. At the time of the PIP review, CDRSN had not completed baseline or remeasurement data collection. CDRSN has done a good job of documenting the technical aspects of Standards 1–5. The RSN still needs to define its intervention in greater detail, implement the intervention, and observe whether it causes any improvement in the study indicator.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. Baseline data for 2006–2007 indicated that more than half of CDRSN's eligible enrollees were *not* offered a timely outpatient follow-up appointment. In response, CDRSN decided to evaluate its hospital liaison process and determine whether further training and/or process improvement could improve the timeliness of outpatient follow-up. At the time of the PIP review, CDRSN had not implemented a specific intervention aimed at improving timeliness. The RSN reported follow-up data for an unspecified period, indicating some improvement, but without linking the results to an intervention. CDRSN declared its intention to retire this PIP and choose a new topic for its nonclinical PIP.

Grays Harbor RSN

Clinical: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder. Because of the high prevalence of major depressive disorder (MDD) among its enrollees, GHRSN has implemented a treatment guideline and is monitoring the clinical outcomes of enrollees treated for MDD. The first phase of this PIP sought to encourage the use of a standardized questionnaire, the PHQ-9, to measure depressive symptoms at intake and six weeks post-treatment. GHRSN found that nearly all enrollees were administered the PHQ-9 at intake, but that administration dropped below 50 percent after six weeks. The second phase aimed to determine whether implementing the treatment guideline would reduce enrollees' clinical symptomatology, as reflected by PHQ-9 scores. GHRSN found no improvement from

intake to six weeks post-treatment during the first measurement period, but noted a statistically significant reduction in symptomatology in the second measurement period. The RSN discussed factors that may have contributed to the success of the intervention, as well as confounding factors that could negate its clinical impact.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. This PIP seeks to determine whether GHRSN can improve performance by assigning a clinician at the time of hospital admission to arrange non-crisis follow-up for the enrollee. GHRSN reported a significant improvement at the first remeasurement, but performance declined in the second remeasurement period. GHRSN attributed the decline to poor adherence to the intervention protocol. The RSN plans to use lessons learned to bolster the intervention in the next phase of the PIP.

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. Remeasurement in 2010 indicated that the PACT intervention has significantly reduced the average number of psychiatric inpatient days for enrollees in the study. GCBH needs to demonstrate more explicitly how its intervention was responsible for the improvement in the study indicator, and describe any lessons learned at this stage. The RSN noted some concerns related to data availability and the PACT enrollment rate that may make it necessary to retire this PIP.

Nonclinical: Improving Early Engagement in Outpatient Services. State and local utilization data indicate that GCBH's enrollees receive services at a lower rate than do most other RSNs' enrollees. GCBH initiated this PIP in 2010, aimed at increasing the share of enrollees who are engaged in treatment (defined as having received at least six service encounters) within 90 days following intake. GCBH defined a baseline measurement period ending in September 2010, but at the time of the PIP review, the RSN had not yet selected an intervention or fully defined its study population, and the PIP documentation was largely incomplete.

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 take atypical antipsychotic medications. Early results of this PIP, initiated in 2007, suggested that screening enrollees for metabolic syndrome must become routine clinical practice for providers to intervene successfully to reduce enrollees' risk. For 2009, KCRSN refocused the PIP on increasing the ratio of eligible enrollees who received screening over those who did not. KCRSN implemented a policy and procedure requiring providers to perform annual metabolic screening for all enrollees with schizophrenia who take atypical antipsychotic medications, and made providers responsible for developing specific evidence-based interventions. Unexpectedly, remeasurement showed a dramatic drop in the ratio of enrollees screened over those not screened. The RSN thoroughly documented its PIP, with only minor gaps in its documentation related to data verification.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. To improve the timeliness of follow-up, KCRSN formed a Cross-System Diversion Team to review discharge planning, identify needed resources, and ensure continuity of care between inpatient and outpatient services. In January 2010, KCRSN began an intervention with Navos, the provider with the majority of Medicaid enrollee hospital discharges. If this intervention succeeds, KCRSN may expand it to other network hospitals. KCRSN has done a good

job of documenting the technical aspects of this PIP. The RSN has adjusted the study time frames several times while awaiting essential data from the state. Consequently, KCRSN still needs to assemble and analyze its baseline and remeasurement data, test any changes for statistical significance, and determine whether the intervention succeeds in improving the timeliness of follow-up care.

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 and 2010. The 2010 PIP documentation did not describe a specific intervention aimed at improving follow-up timeliness. Baseline data showed NCWRSN performing well above the statewide average, raising the question of whether a performance issue exists relative to this topic. A second wave of data collected during 2009–2010 showed a performance level of 74 percent, compared with the baseline level of 88 percent. NCWRSN did not address the 2009 EQR recommendations, describe its intervention strategy, or present a formal data analysis.

Nonclinical: Improved Access to Services—Intakes Provided Within 14 Days of a Service Request. According to state data, during 2008, 86 percent of NCWRSN's Medicaid enrollees were seen within 14 days of a service request. This PIP seeks to improve the timeliness of access to routine care. NCWRSN referred to its improvement strategy as "feedback to provider agencies and local data monitoring," but the 2010 PIP documentation did not describe a specific intervention. It is not clear that timely access to routine care represents a significant quality issue in NCWRSN's service area. The RSN has not proposed a study question or described a specific intervention to address the topic. Baseline data, collected from September 2008 through February 2009, showed performance at 74 percent, and a second data point between March and August 2009 showed the same performance rate. In the absence of an intervention, the lack of improvement in the indicator is not surprising.

North Sound MHA

Clinical: Decrease in the Days to First Prescriber Appointment After Request for Service. This PIP, initiated in 2009, seeks to reduce the time between an enrollee's request for service and the first medication evaluation appointment. In 2008, enrollees waited an average of 64.5 days for their first prescriber appointment following a request for service. NSMHA decided to intervene at an enrollee's first ongoing outpatient appointment. Clinicians will use a "decision tree" to determine whether an enrollee needs a medication evaluation appointment and, if so, to make a referral. NSMHA began its intervention in July 2010, and at the time of the PIP review, had not yet collected or reported on its remeasurement data. The PIP documentation reflects a sound study design and close attention to technical details.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. Seeking to improve its seven-day follow-up rate from a baseline level of 50 percent, NSMHA has conducted two separate interventions since 2008. The most recent, initiated in July 2009, involves providing hospitals with status reports on the number of hospitalized enrollees who received follow-up care within seven days, in an effort to identify barriers to follow-up. According to NSMHA's analysis, although the overall follow-up rate has improved to 55 percent, neither intervention was responsible for the observed improvement. The RSN has done an excellent job of documenting the design and implementation of this PIP, establishing high confidence in the validity and reliability of the findings.

OptumHealth Pierce RSN

Clinical: Increasing Consumer Employment. As of October 2010, available data on OPRSN's Medicaid enrollees showed that only 6 percent were known to be employed, well below the state and national norms for mental health consumers. However, the actual employment rate may be higher, as large gaps exist in the data on consumer employment reported by OPRSN's provider agencies. This PIP seeks to improve the quality and completeness of employment data submitted by the agencies. OPRSN plans to collect baseline data on agencies' performance in April 2011 and implement an intervention in July 2011. As now planned, this PIP represents an administrative activity not directly related to enrollee outcomes. OPRSN must focus the next iteration of this PIP on improving enrollee employment or on another topic directly related to enrollee outcomes.

Nonclinical: Consumer Partnership in Treatment Planning. Consumers' participation in developing and implementing their own treatment plans is recognized as an essential factor in recovery from mental illness. OPRSN's clinical record review found that three of the four provider agencies scored below the state's 90 percent benchmark for overall treatment planning, based on criteria that include consumer/provider collaboration and development of measurable goals. OPRSN initiated this PIP with the goal of increasing consumer participation in treatment planning. At the time of the PIP review, the RSN had not selected a specific intervention by which to pursue that goal.

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 will screen eligible enrollees for symptoms of metabolic syndrome and, where deemed necessary, will intervene with strategies that include educating enrollees on a healthy lifestyle, diet, exercise, and tobacco use, and linking them with primary care physicians (PCPs). During the baseline period, PRSN screened eligible enrollees for symptoms and found that 88 percent of those with a complete set of measures had at least one symptom. Following the intervention, RSN reported remeasurement results indicating that the overall prevalence of consumers who had any metabolic syndrome did not change. The most notable difference was the worsening of hypertension over time. PRSN identified and discussed barriers to improvement, as well as confounding factors that compromised the RSN's ability to draw clear conclusions about the effectiveness of the intervention. Among other factors, PRSN's providers appear to have applied the intervention protocol inconsistently.

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization. In 2008, PRSN performed below the state benchmark for timely follow-up. PRSN asked each provider agency to assign a hospital liaison to coordinate discharge planning for enrollees. Baseline data showed that 83 percent of enrollees discharged from E&T facilities received timely follow-up care, versus 67 percent of those discharged from community hospitals. Agency interventions have been in place since January 2009. PRSN planned to compile remeasurement data in January 2010, but the implementation of PRSN's new electronic medical record system in April 2009 delayed remeasurement. Thus, no real progress is evident on this PIP since 2009.

Southwest RSN

Clinical: Using Assertive Community Treatment to Decrease Consumer Hospital Utilization. The goal of this PIP is to evaluate the success of the PACT model in reducing the hospitalization of enrollees with severe and persistent mental illness. The PIP compares hospitalization data for seven enrollees before and after their admission to the PACT in 2007. Upon analyzing the remeasurement data, SWRSN concluded that the PIP had achieved statistical and clinical improvement. However, the supporting evidence was weak as SWRSN had not measured

the providers' fidelity in implementing the PACT model, and had not considered confounding factors that may have affected the results. In moving forward with this PIP, SWRSN needs to periodically review barriers and lessons learned to identify ways to improve the intervention or other aspects of the study.

Nonclinical: Increased Incident Reporting Compliance. This PIP, initiated in 2009, seeks to improve provider agencies' compliance with requirements for timely reporting of incidents involving RSN enrollees. SWRSN conducted several trainings and reviewed the reporting requirements with provider agency directors, managers, and staff. The RSN also required corrective actions by agencies out of compliance. At the time of review, this PIP had not progressed to remeasurement. SWRSN appears to have planned an appropriate intervention to achieve the desired improvement. However, the PIP documentation lacks some important details regarding the selection and prioritization of study topics, the definition of study indicators and populations, and the plans for collecting and analyzing data.

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. However, SCRSN has failed to connect clinical competency in MI with enrollee outcomes, and to explain how training a small percentage of its clinicians in MI will increase enrollees' feelings of respect and their involvement in treatment. It is unclear whether this PIP actually focuses on improving such outcomes, as distinct from simply implementing an evidence-based practice in the RSN system. The PIP does not follow the necessary steps to measure improvement relative to an identified quality problem.

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 based on guidelines established by DBHR. This PIP has sought to reduce reporting errors associated with the use of specific service codes. SCRSN launched interventions in 2007 to clarify the reporting guidelines for these modalities. The 2009 EQR report cautioned that the topic was not valid because SCRSN had not established a link between improved service reporting and better enrollee outcomes, and because Rehab Case Management, one of the service modalities in question, is not a Medicaid-funded service. SCRSN submitted the same nonclinical PIP for 2010, but did not sufficiently address the drawbacks outlined in the 2009 EQR report. Per federal regulations and the CMS protocol, all PIPs must have the potential to improve enrollee health, functional status, or satisfaction. As a result, this PIP was scored as Not Met.

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 the use of Multisystemic Therapy, a community-based, family-centered care model. For the cumulative remeasurement period 7/1/2007 to 6/30/2009, data for 60 enrollees showed a significant improvement in the indicators for school attendance, substance abuse, and arrests, and a trend toward a reduction in suicide attempts. TMRSN planned a final remeasurement in late 2010 to determine whether improvements were being sustained. Evidence to date indicates that the intervention has succeeded in improving enrollees' outcomes. To strengthen confidence in

the reported results, TMRSN needs to present separate results for each remeasurement period compared to baseline results, and present an argument for sustained improvement.

Nonclinical: Increasing Percentage of Medicaid Clients Who Receive an Intake Service Within 14 Days of Service Request. This PIP, initiated in 2010, aims to shorten the period between a request for service and intake for Medicaid enrollees—specifically, those served by Behavioral Health Resources (BHR), which provides 95 percent of the RSN's outpatient services. TMRSN's intervention plan involves a single-point-of-contact Access Center for entry into outpatient services, and a procedural change, scheduling next-day appointments for Medicaid-eligible and state-funded high-risk/high-utilizing enrollees at the time of their request for service. The RSN gathered and reported baseline data showing a performance rate of 71 percent. At the time of the PIP review, TMRSN had not yet implemented the intervention. TMRSN needs to define its intervention strategy in greater detail, and describe how the RSN will track the effectiveness of implementing the intervention. Some gaps also remain in the documentation of the data collection and analysis plan.

Timberlands RSN

Clinical: Improving Treatment Outcomes for Adults Diagnosed With a New Episode of Major Depressive Disorder. Because of the high prevalence of MDD among TRSN enrollees, the RSN chose to implement a practice guideline and monitor the clinical outcomes of adult enrollees treated for MDD. The first phase of this PIP sought to encourage the use of the standardized PHQ-9 questionnaire to measure depressive symptoms at intake and six months post-treatment. The second phase aimed to determine whether implementing the MDD guideline would reduce clinical symptomatology for enrollees, as indicated by PHQ-9 scores. At the time of evaluation, TRSN had not yet finished collecting remeasurement data for the first study indicator and had not begun collecting data for the second study indicator. The evaluation identified some gaps in the PIP documentation, particularly relating to the description of the second study indicator (improvement in PHQ-9 scores) and of the data collection and analysis plan.

Nonclinical: Improving Coordination of Care and Outcomes. TRSN has identified a need to improve coordination of care between mental health clinicians and PCPs for its Medicaid enrollees. This PIP seeks to increase the percentage of qualified enrollees who receive coordinated care. TRSN planned to track the provision of these services through the use of two new service codes and through monitoring by program managers during clinical supervision and review. The RSN needs to describe in greater detail how it plans to collect and verify the accuracy of data used in computing the indicator; analyze and interpret the study data; and track the implementation of its interventions. At the time of the PIP review, TRSN's providers had not yet begun direct service interventions. A potential complication is that the intervention timeline overlaps the period identified for baseline data collection; TRSN needs to gather baseline data from a period that predates the intervention.

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.

Five statewide core performance measures were in effect for 2010:

1. The RSN must offer a routine outpatient service to an enrollee within seven days of discharge from a psychiatric inpatient hospital or E&T facility.
2. Time from a service request to the first routine service may not exceed 28 days.
3. Time from a service request to an intake service may not exceed 14 days.
4. RSN must submit consumer periodic data to DBHR within 60 days of collection or receipt from subcontracted providers.
5. RSN must submit outpatient encounters to DBHR within 60 days of the close of the service month.

During 2010, 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? That is, 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 2009 review found that the data challenges that prevented DBHR from calculating valid performance measures and assigning the measures to RSNs during 2008 persisted. Looking Glass Analytics calculated only the first measure listed above, the timeliness of outpatient follow-up after discharge from psychiatric hospitalization. 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 Medicaid eligibility. During 2010, DBHR dropped patients discharged from state hospitals from this measure.

Acumentra Health could validate only one of the five performance measures in 2010. DBHR submitted for review the calculation of measure 4, and the calculation met criteria for that measure. DBHR reported having calculated measure 5, but as of the publication of this report, DBHR had not submitted that measure for review. According to DBHR, problems with extracting encounter data from ProviderOne, the state's new Medicaid Management Information System (MMIS), have prevented DBHR from being able to calculate measures 1–3 since late 2009.

DBHR provided Acumentra Health with a text file describing each measure, the numerators and denominators, and data notes for use in validation. However, except for measure 4, DBHR provided no sample data from the source data tables, limiting the analyses and validation procedures that Acumentra Health could conduct, including the analysis of inclusion and exclusion criteria. In addition, discussions with DBHR staff revealed that DBHR had no documented routine process to monitor or verify the calculation of performance measures by Looking Glass Analytics.

Table 7. Performance measure validation ratings, 2010.

Performance measure	Status	Rating
RSN must offer routine outpatient service to a Medicaid enrollee within seven days of discharge from a psychiatric inpatient hospital or E&T facility.	Not calculated	Not met
Time from request for service to the first routine service may not exceed 28 days.	Not calculated	Not met
Time from a service request to an intake service may not exceed 14 days.	Not calculated	Not met
RSN must submit consumer periodic data to DBHR within 60 days.	Calculated	Met
RSN must submit outpatient encounters to DBHR within 60 days of the close of the service month.	Calculated but not submitted	Not met

Finding

42 CFR §438.358 requires the annual validation of performance measures for managed care entities that serve Medicaid enrollees. For 2010, DBHR met the validation criteria for only one of its five statewide performance measures.

Information Systems Capabilities Assessment follow-up

Acumentra Health conducted a full ISCA for all RSNs except OPRSN in 2009, and for OPRSN in 2010. These reviews examined each RSN's information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable state performance measures and the capacity to manage enrollees' mental health care. The assessment followed the CMS protocol and was organized in two main sections with eight subsections.

In 2010, Acumentra Health reviewed each RSN's response to specific findings and recommendations of the 2009 EQR report. Table 8 summarizes the results of this follow-up review. Note: Because of the implementation of ProviderOne, the state's new Medicaid Management Information System, during 2010, Acumentra Health did not conduct a state-level ISCA follow-up.

The full ISCA results for OPRSN are presented in the RSN profile in Appendix A.

Acumentra Health's 2010 follow-up reviews identified the following themes.

- RSNs have made improvements in the area of IT governance but are still working to implement IT control frameworks, IT steering committees, and management reports. RSNs continue to struggle with oversight of functions delegated to third-party data administrators, application service providers, and vendors.
- RSNs' disaster recovery plans are maturing as more RSNs move toward regular review, auditing, and testing.
- During 2008, many RSNs maintained incomplete provider profile directories. By 2010, most RSNs had enhanced their provider directories to enable enrollees to make informed choices among network providers.
- Some RSNs still lack robust documentation of IT systems, staffing, and data processing and reporting procedures. Insufficient documentation can create problems related to data recovery, staff turnover, and system supportability.
- Most RSNs have successfully addressed the previously identified issues related to encrypting and securely transporting backup data files.

Table 8. Status of ISCA findings and recommendations identified in 2009.			
Finding/recommendation	**RSN**	**Number of issues**	**Status**
Information systems			
	CDRSN	1	Corrective action complete.
	GCBH	5	Corrective action in progress. Two recommendations implemented and two in progress.
	GHRSN	1	Corrective action complete.
	NCWRSN	5	Corrective action complete. One recommendation implemented and one in progress, leaving two to be addressed.
	NSMHA	1	Recommendation needs to be addressed.
	PRSN	1	Recommendation needs to be addressed.
	SCRSN	1	Corrective action complete.
	SWRSN	1	Recommendation implemented.
	TMRSN	2	Recommendations in progress.
	TRSN	2	One corrective action complete, one recommendation implemented.
Staffing			
	GCBH	2	Two recommendations in progress.
	GHRSN	1	Recommendation implemented.
	NCWRSN	2	One recommendation implemented, one in progress.
	SWRSN	3	All recommendations implemented.
	TMRSN	1	Recommendation in progress.
	TRSN	1	Recommendation implemented.
Hardware systems			
	GHRSN	3	Corrective action complete. Two recommendations need to be addressed.
	NCWRSN	5	Corrective action complete. All four recommendations implemented.
	NSMHA	1	Recommendation needs to be addressed.
	PRSN	3	All corrective actions complete.
	SCRSN	1	Corrective action complete.
	SWRSN	1	Recommendation needs to be addressed.
Security			
	CCRSN	1	Recommendation implemented.
	CDRSN	4	Corrective action complete. Two recommendations implemented and one in progress.
	GCBH	3	Corrective action complete. One recommendation implemented, one still needs to be addressed.
	GHRSN	4	Two corrective actions complete. Two recommendations need to be addressed.
	KCRSN	1	Recommendation needs to be addressed.

Table 8. Status of ISCA findings and recommendations identified in 2009.			
Finding/recommendation	**RSN**	**Number of issues**	**Status**
	NCWRSN	5	Corrective action complete. One recommendation implemented and one in progress, leaving two to be addressed.
	NSMHA	4	Two recommendations implemented and one in progress, leaving one to be addressed.
	PRSN	1	Recommendation needs to be addressed.
	SCRSN	6	Corrective action complete. One recommendation implemented and four in progress.
	SWRSN	5	Two recommendations implemented and one in progress, leaving two to be addressed.
	TMRSN	2	One recommendation in progress, one still needs to be addressed.
	TRSN	6	Two corrective actions complete. Three recommendations implemented and one in progress.
Administrative data			
	CCRSN	1	Recommendation implemented.
	GCBH	1	Recommendation implemented.
	KCRSN	1	Recommendation implemented.
	NCWRSN	3	Recommendations in progress.
	NSMHA	3	One recommendation implemented, leaving two to be addressed.
	SWRSN	1	Recommendation implemented.
Enrollment systems			
	NSMHA	1	Recommendation needs to be addressed.
Provider data			
	CDRSN	1	Recommendation in progress.
	GHRSN	1	Recommendation in progress.
	KCRSN	1	Recommendation implemented.
	NCWRSN	2	Corrective action in progress. Recommendation implemented.
	NSMHA	1	Recommendation implemented.
	PRSN	1	Recommendation needs to be addressed.
	SWRSN	1	Recommendation implemented.
	TMRSN	1	Recommendation implemented.
	TRSN	1	Recommendation implemented.

Mental health encounter data validation

In 2008 and again in 2010, Acumentra Health performed an encounter data validation for all RSNs and for DBHR. This activity involved

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

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

Acumentra Health analysts then drew random samples of records from the total encounter data file for analysis. The analysts requested clinical records for 130 enrollees from each RSN, which typically would yield at least the required number of encounters. After drawing a random sample of clients whose encounter records totaled at least the desired sample size, analysts compared the information in the clinical records against the information in the state data set.

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

1. Review the state's requirements for collecting, processing, and submitting encounter data, based on specifications in the RSN contract, the state's data dictionary, and other information furnished by the state.
2. Review results of the previous encounter data validation study (conducted in 2008) to identify follow-up needs.
3. Review the capability of each RSN's information system to capture accurate and complete encounter data, drawing on findings of the 2009 ISCA review and on interviews with RSN personnel.
4. Analyze electronic encounter data to establish the magnitude of missing data, types of potentially missing data, overall data quality issues, and problems with how the RSN compiles and submits encounters to the state. Subtasks include:
    - Apply general edit and consistency checks, such as verifying that critical fields contain values that are consistent across fields.
    - Inspect data fields for general validity, including a review of each data element and of the volume of data by type or place of service.
    - Using standard statistical procedures, analyze data to obtain a validity overview of the RSN's encounter data. This step involves analyzing and interpreting the data in submitted fields, the volume and consistency of encounter data, and utilization rates, both overall and by specific diagnosis, procedure, service, and provider types.
    - Compare the RSN's encounter data with state standards and/or benchmarks.
5. If necessary, review clinical records to confirm findings of the above analysis.

Review results

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

Electronic data checks

Acumentra Health analysts checked fields in 2,842,713 *outpatient* encounters (all encounters reported for the RSNs from July 2008 through June 2009) for missing and out-of-range data and logic problems. The fields included RSN ID, provider ID, consumer ID, primary diagnosis, service date and location, minutes of service, provider type, procedure code, and claim number. All fields contained complete data with values conforming to the state's specifications, except that fewer than 0.1 percent of the records omitted the provider type.

Analysts also examined whether procedure codes and service minutes conformed to the state's service reporting instructions. All codes in the outpatient data were valid according to the service reporting instructions, but in 226,737 records (8.0 percent), the number of minutes coded exceeded the maximum recommended by the state for the procedure code.

Analysts examined 4,476 *inpatient* encounters (all encounters reported for the RSNs from July 2008 through June 2009) for missing and out-of-range data and logic problems. The fields examined were admission and discharge date, provider ID, RSN ID, primary diagnosis, and legal status (whether admission was voluntary or involuntary). An example of the logic checks performed was determining whether any discharge date preceded the admission date. Analysts discovered 689 records (15.4 percent) omitting data on legal status, an optional field.

Next, analysts performed data checks on the *demographic* data set, examining 435,544 records. The fields examined included the enrollee's first and last name, consumer ID, date of birth, gender, ethnicity, Hispanic origin, language preference, Social Security number (SSN), sexual orientation, and the RSN ID. Considering mandatory fields, analysts found 935 records (0.2 percent) omitting ethnicity data. Considering optional fields, 54,139 records (12.4 percent) omitted the SSN, and 193 records omitted the birth date. Analysts also found 12,015 records (2.8 percent) with an RSN ID code that did not match the ID code for the particular RSN, and 5,419 records (1.2 percent) with out-of-range SSN values.

Analysts examined 1,039,679 records in the *periodic* data set, including employment and education status, grade level, living situation, county of residence, annual income, number of dependents, Global Assessment of Functioning (GAF) score, and Clinical Global Assessment Scale (CGAS) score. Analysts checked each of these fields, as well as RSN ID, consumer ID, priority code, and impairment, for missing and out-of-range values. Among mandatory fields, 8,406 records (0.8 percent) omitted the GAF or CGAS score, and fewer than 0.1 of records omitted the impairment. Among optional fields, 6.6 percent of records omitted annual income, 3.8 percent omitted dependent data, and 0.3 percent omitted education status.

Table 9 summarizes the results of electronic data checks for the outpatient, inpatient, demographic, and periodic data sets.

Table 9. Results of 2010 electronic data checks.

Field	State standard	% complete[a]
Outpatient encounter data		
RSN ID	100% complete (non-missing values), with values known to DBHR	100.0
Consumer ID	100% complete (non-missing values), with values known to DBHR	100.0
Agency ID	100% complete (non-missing values)	100.0
Primary diagnosis	100% complete (non-missing values), one diagnosis must be present	100.0
Service date	100% complete (non-missing values), must be in valid date format	100.0
Service location	100% complete (non-missing values), with values specified in data dictionary	100.0
Provider type	100% complete (non-missing values), with values specified in data dictionary	100.0
Procedure code	100% complete (non-missing values), with values specified in service instructions	100.0
Claim number	100% complete (non-missing values)	100.0
Minutes of service	100% complete for records with no per diem CPT/HCPCS codes	100.0
Inpatient encounter data		
RSN ID	100% complete (non-missing values), with values known to DBHR	100.0
Provider ID	100% complete (non-missing values), with values known to DBHR	100.0
Admit date	100% complete (non-missing values)	100.0
Discharge date	Optional at original submission	100.0
Primary diagnosis	100% complete (non-missing values)	100.0
Legal status	Optional per the state's Data Dictionary	84.6
Demographic data		
RSN ID	100% complete (non-missing values), with values known to DBHR	100.0
Consumer ID	100% complete (non-missing values)	100.0
First name	100% complete (non-missing values)	100.0
Last name	100% complete (non-missing values)	100.0
Date of birth	Optional per the state's Data Dictionary	100.0
Gender	Optional per the state's Data Dictionary	100.0
Ethnicity	100% complete (non-missing values)	99.8
Hispanic origin	100% complete (non-missing values)	100.0
Language preference	100% complete (non-missing values)	100.0
Social Security number	Optional per the state's Data Dictionary	87.6
Sexual orientation	100% complete (non-missing values)	100.0
Consumer periodic data		
RSN ID	100% complete (non-missing values), with values known to DBHR	100.0
Consumer ID	100% complete (non-missing values)	100.0
Employment status	Optional per the state's Data Dictionary	100.0
Education status	Optional per the state's Data Dictionary	99.7
Grade level	Optional per the state's Data Dictionary	99.7
Living situation	100% complete (non-missing values), with values specified in data dictionary	100.0
County of residence	100% complete (non-missing values), with values specified in data dictionary	100.0
Annual income	Optional per the state's Data Dictionary	93.4
Number of dependents	Optional per the state's Data Dictionary	96.2
GAF/CGAS score	Record must contain either GAF or CGAS score	99.2
Impairment kind	100% complete (non-missing values)	100.0
Priority code	100% complete (non-missing values)	100.0

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

Comparison of electronic records with clinical chart documentation

Acumentra Health analysts audited data fields in 5,820 encounter records across the RSNs, reported in 1,359 charts. Analysts reviewed the encounter notes to verify that the procedure code accurately described the treatment provided. They also compared electronic data from the state's demographic and periodic data sets with the chart documentation for enrollees. Table 10 summarizes the comparison results for all fields reviewed.

Of the 5,820 encounters reviewed from the state's outpatient data set, 89.2 percent had procedure codes that matched the chart documentation; 87.0 percent had provider type data that matched the chart notes; 90.1 percent had matching data on minutes of service; 83.6 percent had matching data on service location; and 90.1 percent had procedure codes that matched the treatment described. Data on service location could not be located in more than 13 percent of charts.

In comparing demographic data, matching rates exceeded 97 percent except for ethnicity and Hispanic origin (91.5 percent) and preferred language (92.7 percent), which are mandatory fields. Considering periodic data, only about three-quarters of the charts contained GAF/CGAS scores that matched the state data set.

Table 10. Results of 2010 encounter data validation.

Field	Chart matches electronic data	Data in chart missing from state data	Missing from both chart and state data	Data could not be located in chart	Data found in chart do not match state data
Demographic information from each clinical record reviewed (N=1,359)					
First name	1,354 (99.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (0.4%)
Last name	1,357 (99.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (0.2%)
Date of birth*	1,348 (99.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	11 (0.8%)
Gender*	1,348 (99.2%)	0 (0.0%)	0 (0.0%)	8 (0.6%)	3 (0.2%)
Ethnicity	1,244 (91.5%)	6 (0.4%)	1 (0.1%)	24 (1.8%)	84 (6.2%)
SSN*	1,319 (97.1%)	0 (0.0%)	0 (0.0%)	22 (1.6%)	18 (1.3%)
Hispanic origin	1,243 (91.5%)	2 (0.2%)	1 (0.1%)	56 (4.1%)	57 (4.2%)
Preferred language	1,260 (92.7%)	5 (0.4%)	2 (0.2%)	77 (5.7%)	15 (1.1%)
Consumer periodic data from each clinical record reviewed (N=1,359)					
Primary diagnosis	1,298 (95.5%)	2 (0.2%)	0 (0.0%)	7 (0.5%)	52 (3.8%)
GAF/CGAS score	1,031 (75.9%)	54 (4.0%)	3 (0.2%)	23 (1.7%)	248 (18.2%)
Grade*	1,123 (82.6%)	55 (4.1%)	19 (1.4%)	23 (1.7%)	139 (10.2%)
Employment*	1,232 (90.6%)	47 (3.5%)	4 (0.3%)	14 (1.0%)	62 (4.6%)
Education*	1,206 (88.7%)	74 (5.4%)	2 (0.2%)	20 (1.5%)	57 (4.2%)
Results from multiple encounters and a mix of services (N=5,820)					
Procedure code	5,192 (89.2%)	24 (0.4%)	3 (0.1%)	326 (5.6%)	275 (4.7%)
Provider type	5,061 (87.0%)	3 (0.1%)	4 (0.1%)	469 (8.1%)	283 (4.9%)
Minutes of service	5,247 (90.1%)	74 (1.3%)	10 (0.2%)	368 (6.3%)	121 (2.1%)
Service location	4,864 (83.6%)	1 (0.0%)	5 (0.1%)	772 (13.3%)	178 (3.1%)
Procedure code agrees with treatment described	5,244 (90.1%)	n.a.	n.a.	n.a.	n.a.

*Optional fields; the state's data dictionary does not require complete reporting.

Acumentra Health compared the 2010 results with the results of the 2008 encounter data validation to identify issues that needed improvement. Table 11 shows the results of this comparison.

The percentage of matching between the state's electronic data and the chart data improved from 2008 to 2010 in the majority of fields examined. In particular, the matching rate rose for each of the four encounter data fields, with increases ranging from 1.8 to 4.7 percentage points. However, the matching rate remained below 90 percent for all fields except service minutes (90.1 percent). Also of note, the matching rate for ethnicity, a mandatory field, rose by 3.5 percentage points and now exceeds 91 percent.

Table 11. Comparison of 2008 and 2010 encounter data validation results.

Field	Chart matches electronic data		Percentage point change
Demographic/periodic information in clinical records	**2008**	**2010 (N=1,359)**	
First name (N=1,101)*	1,088 (98.8%)	1,354 (99.6%)	0.8 ↑
Last name (N=1,100)*	1,091 (99.2%)	1,357 (99.8%)	0.6 ↑
Date of birth (N=1,100)*	1,097 (99.7%)	1,348 (99.2%)	0.5 ↓
Gender (N=1,100)*	1,077 (97.9%)	1,348 (99.2%)	1.3 ↑
Ethnicity (N=1,101)*	969 (88.0%)	1,244 (91.5%)	3.5 ↑
SSN (N=1,097)*	1,070 (97.5%)	1,319 (97.1%)	0.4 ↓
Education (N=1,092)*	992 (90.8%)	1,206 (88.7%)	2.1 ↓
Results from multiple encounters	**2008**	**2010 (N=5,820)**	
Procedure code (N=5,472)*	4,623 (84.5%)	5,192 (89.2%)	4.7 ↑
Provider type (N=5,437)*	4,569 (84.0%)	5,061 (87.0%)	3.0 ↑
Minutes of service (N=5,445)*	4,809 (88.3%)	5,247 (90.1%)	1.8 ↑
Service location (N=5,417)*	4,327 (79.9%)	4,864 (83.6%)	3.7 ↑

* N for 2008.

Discussion and recommendations

For the RSNs as a group, electronic checks of all outpatient, inpatient, demographic, and periodic data generally found that all records contained complete data in mandatory fields, except that 0.8 percent of records omitted the enrollee's GAF/CGAS score and 0.2 percent of records omitted the enrollee's ethnicity.

Agreement between the RSNs' encounter data and the state's data set generally has improved since 2008, but needs to improve further. Beginning with the 2010–2011 contract year, DBHR will require that at least 95 percent of the RSNs' encounter data match the state data. Although some RSNs are performing better than others, the current aggregate matching rates for procedure code, provider type, service minutes, service location, and ethnicity remain well below the 95 percent threshold. Service location remains a particular concern, as the data in this field matched the state's data only 83.6 percent of the time in 2010.

- ***The RSNs need to continue to work with their providers to ensure that data in all encounter fields are as accurate and complete as possible.***

PHYSICAL HEALTH CARE DELIVERED BY MCOS

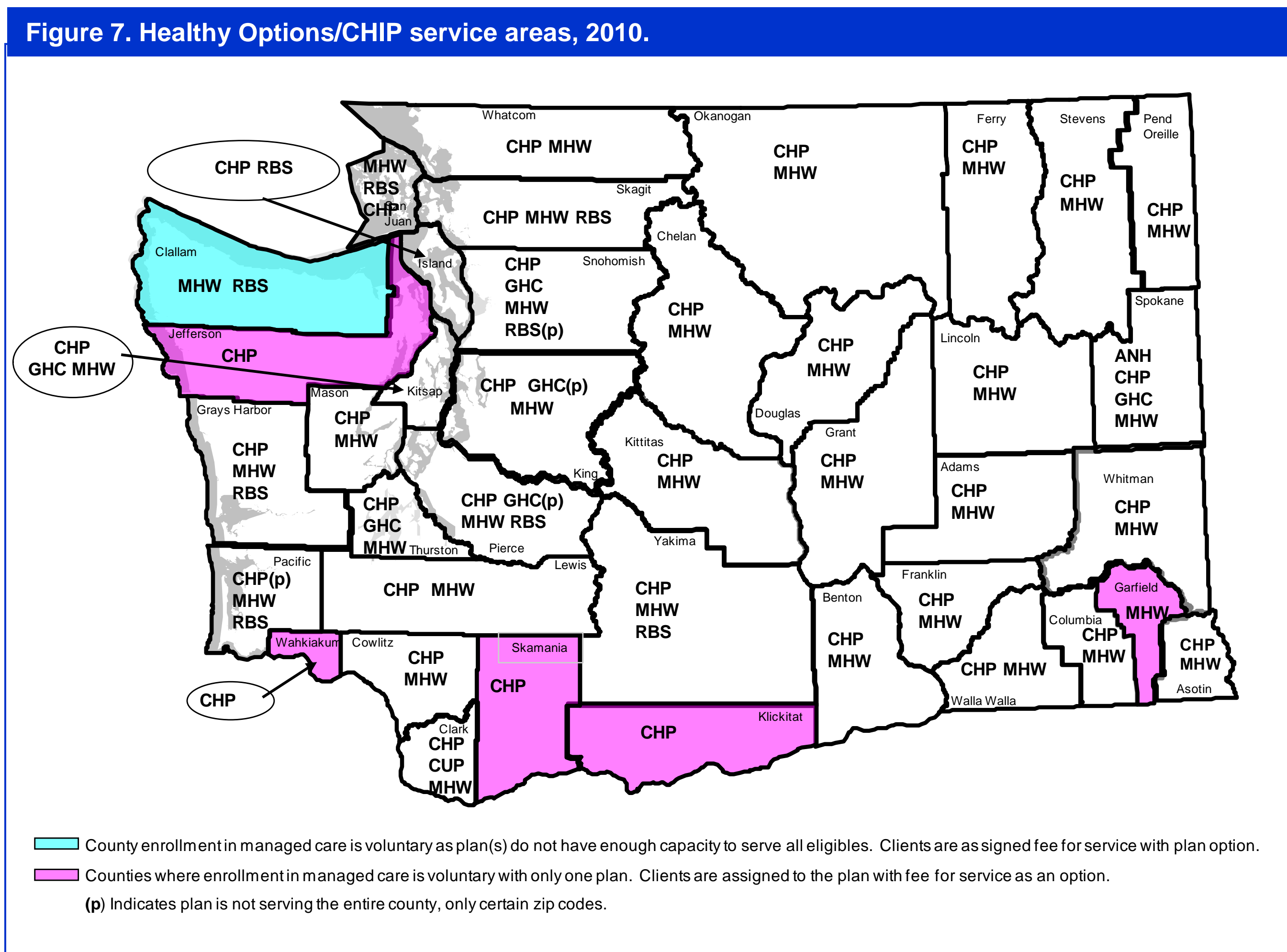
MPA contracts with seven MCOs to deliver physical healthcare services to Medicaid managed care enrollees. Table 12 shows the approximate number and percentage of enrollees assigned to each health plan as of October 2010. Figure 7 shows the counties served by each plan.

Table 12. Managed care organizations and Medicaid enrollees, October 2010.[a]

Health plan	Acronym	Number of enrollees	% of all enrollees
Asuris Northwest Health	ANH	2,880	0.4
Community Health Plan	CHP	215,372	32.7
Columbia United Providers	CUP	43,177	6.6
Group Health Cooperative	GHC	23,089	3.5
Kaiser Permanente Northwest	KPNW	621	0.1
Molina Healthcare of Washington	MHW	333,593	50.7
Regence BlueShield	RBS	38,945	5.9
Total		**657,677**	**100.0**

[a] Source: DSHS. Enrollment includes Healthy Options, CHIP, and Basic Health Plus.

Figure 7. Healthy Options/CHIP service areas, 2010.



County 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 where enrollment in managed care is voluntary with only one plan. Clients are assigned to the plan with fee for service as an option.

(p) Indicates plan is not serving the entire county, only certain zip codes.

At least one Healthy Options plan is 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.

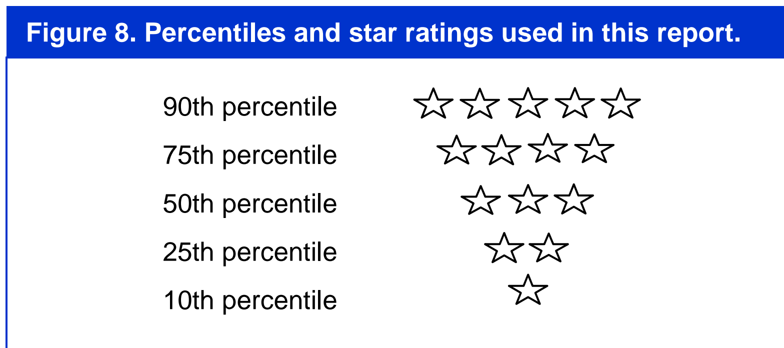
MPA uses the annual HEDIS measures and CAHPS survey results to gauge the MCOs' performance against national benchmarks. The Healthy Options contract contains specific provisions based on the health plans' HEDIS scores. Acumentra Health's subcontractor, Health Services Advisory Group, audits each MCO's 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 2010 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 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 2010 Medicaid averages from the NCQA *Quality Compass*.[7]

In this rating system, one star means that Washington scored within the 10th percentile of national scores; two stars, between the 10th and 25th percentile (below average); three stars, between the 25th and 50th percentile (average); four stars, between the 50th and 75th percentile, and five stars, above the 90th percentile (above average). Figure 8 shows the stars and the percentile ranges.

Figure 8. Percentiles and star ratings used in this report.



Access to physical health care

MPA has several mechanisms in place to monitor MCOs' success in providing access to care for Healthy Options enrollees. Through TEAMonitor, MPA assesses the MCOs' compliance with regulatory and contractual requirements related to access. (See Appendix C.) MPA also monitors MCO performance on the standardized clinical performance measures discussed below.

Compliance with access standards

The Healthy Options contract requires each MCO to demonstrate that its provider network has the 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. The plans must comply with regulations in 42 CFR §438 pertaining to Availability of Services, Furnishing of Services, Coverage and Authorization of Services, and Additional Services for Enrollees with Special Healthcare Needs (SHCN).

TEAMonitor's 2010 review found:

- As a group, the MCOs strengthened their compliance with elements of Additional Services for Enrollees with SHCN.
- Compliance scores declined for other standards, such as Availability of Services, Primary Care and Coordination, and Emergency and Post-stabilization Services. The main deficiencies involved inadequate and/or conflicting documentation of MCO policies, programs, and internal procedures.
- Only one health plan, KPNW, fully met the Primary Care and Coordination standard. Other MCOs needed to refine their care coordination/case management programs, or failed to document program outcomes sufficiently.

Performance on access measures

Three HEDIS measures related to prevention 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 visits:

- Infants in the first 15 months of life should receive *six or more* WCC visits.
- 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 13 compares access to WCC in Washington with the national Medicaid averages. The Healthy Options plans' average rate of delivering WCC visits for infants declined significantly in 2010, falling significantly below the national average. About 53 percent of Healthy Options infants received at least six visits in the first 15 months of life. Child and adolescent WCC visit rates in Washington, at 62 percent and 37 percent, respectively, remained significantly below the national averages.

Table 13. Washington scores and national averages for physical health access measures, 2010.

Measure	National average	Washington score	Washington rating
Infant WCC Visits (6 or more)	59%	53%*	☆☆
WCC Visit, 3–6 years	72%	62%*	☆☆
Adolescent WCC Visit	48%	37%*	☆

Stars represent Washington's performance compared with the 2010 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 14). Overall, MHW was the highest performing plan, with WCC visit rates significantly exceeding the state aggregates for infants and children.

Infants: About 60 percent of infants enrolled in MHW received at least six WCC visits in 2010, as did 55 percent of RBS enrollees. All other health plans' rates were below the state average.

Ages 3–6: KPNW reported the highest percentage of WCC visits for children in this age group—75 percent, significantly higher than the state average. MHW's percentage also significantly exceeded the state average. In contrast, ANH's visit rate of 48 percent was significantly below average.

Adolescents: KPNW, at 43 percent, was the best performer in getting adolescents seen for a WCC visit. No health plan's visit rate was significantly different from the state average of 37 percent.

Table 14. MCO and state scores for physical health access measures, 2010.

Measure	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
Infant WCC (6+ visits)	—	48%	51%	49%	—	60% ▲	55%	53%
Child WCC, 3 to 6 Years	48% ▼	66%	59%	59%	75% ▲	67% ▲	63%	62%
Adolescent WCC Visit	38%	33%	33%	37%	43%	38%	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.) MPA assesses compliance with these standards through TEAMonitor and also 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 certain 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.

TEAMonitor's 2010 review found that the Healthy Options MCOs demonstrated high levels of compliance with the timeliness standards, meeting all elements in most cases.

Performance on timeliness measure

The HEDIS measure of postpartum care 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 15 shows that slightly less than two-thirds of Healthy Options women are receiving timely postpartum care. The statewide average score for postpartum care has remained essentially the same for the past five years, while the rest of the nation has caught up with the Healthy Options plans' performance.

Table 15. Washington scores and national averages for physical health timeliness measure, 2010.

Measure	National average	Washington score	Washington rating
Postpartum Care	64%	63%	☆☆

Stars represent Washington's performance compared with the 2010 NCQA percentile rankings for Medicaid HEDIS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.

MCO results: Table 16 compares the performance of individual health plans with the statewide score on the timeliness measure. Among GHC's female enrollees, 68 percent of those who delivered a live birth received timely postpartum care, a significantly outperforming the state average of 63 percent. RBS (at 66 percent) slightly exceeded the state average, while other plans were slightly below average.

Table 16. MCO and state scores for physical health timeliness measure, 2010.

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Postpartum Care	60%	58%	68% ▲	—	62%	66%	63%

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

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. MPA 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 2010 review found that the Healthy Options MCOs, as a group, fully met most requirements related to Provider Selection, ensuring that their policies and procedures were based on NCQA guidelines. Compliance with other quality-related standards was less consistent.

Among the health plans, only KPNW fully met the QAPI standard in 2010. This standard calls for MCOs to measure and report 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. Utilization management proved a particular concern for most MCOs.

KPNW fully met the standards for Provider Selection, Practice Guidelines, and Primary Care and Coordination, and met nearly 90 percent of the elements for Enrollee Rights and Grievance Systems. On the whole, the other health plans demonstrated lower levels of compliance with these standards than in 2009.

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 17 compares Washington's performance on these quality measures with the nationwide performance.

Washington's Combo 2 immunization rate rose significantly in 2010, to 77 percent, and now significantly exceeds the national average. The statewide average shows a significant gain over

the past five 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, the statewide averages for all individual antigens in Combo 2 are above 90 percent, with the exception of DTaP at 81 percent.

The 2010 statewide average for Combo 3 was nearly 72 percent, up significantly from 2009 and significantly above the 2010 national average. Improvement in the PCV vaccination rate has stalled, leaving this indicator at 79 percent—well below the federal benchmark, though still higher than the national Medicaid average.

The statewide average for the diabetes care indicator in 2010 was nearly 84 percent—the highest since the inception of this indicator, and significantly above the national average.

Table 17. Washington scores and national averages for physical health quality measures, 2010.

Measure	National average	Washington score	Washington rating
Childhood Immunizations (Combo 2)	74%	77%*	☆☆☆
Childhood Immunizations (Combo 3)	69%	72%*	☆☆☆
Diabetes Care (annual HbA1c test)	81%	84%*	☆☆☆

Stars represent Washington's performance compared with the 2010 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 18 compares the performance of individual health plans with the statewide scores on the quality measures.

Combo 2 immunizations: RBS increased its immunization rate significantly in 2010, to 83 percent, and significantly exceeded the state average. CUP also reported a significant gain, yet remained significantly below the state average.

Combo 3 immunizations: As with Combo 2, both RBS and CUP increased their Combo 3 rates significantly in 2010, with RBS significantly exceeding the state average while CUP remained significantly below average.

Diabetes care: Plan performance in 2010 varied non-significantly around the statewide average of 84 percent. CUP and GHC reported the highest percentages at 87 percent.

Table 18. MCO and state scores for physical health quality measures, 2010.

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Childhood Immunizations (Combo 2)	78%	70% ▼	75%	—	77%	83% ▲	77%
Childhood Immunizations (Combo 3)	75%	63% ▼	70%	—	74%	77% ▲	72%
Diabetes Care (annual HbA1c test)	83%	87%	87%	—	82%	84%	84%

▲ 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

In the first half of 2010, TEAMonitor reviewers scored MCOs on their compliance with more than 60 required elements of BBA regulations and Healthy Options contract provisions. Reviewers 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 Coordination
- 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 77).

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

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

Numerator: the number of scored elements that received a Met score. Compliance is defined as fully meeting the standard, since the 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.

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

Summary of compliance review results

Table 19 breaks out the 2010 compliance scores assigned by TEAMonitor for each of 16 standards (excluding PIPs) by health plan. (TEAMonitor combines its review of RBS and ANH, since the two plans share administrative functions and resources.) Figure 9 shows the change in compliance scores on selected standards from 2008 through 2010.

The 2010 scores indicate slackening performance on most compliance standards, compared with 2009. As a group, the Healthy Options plans met 90 percent of the elements of Additional Services for Enrollees with SHCN, a notable improvement over the prior year, and all plans met the standard for Enrollment/Disenrollment. Otherwise, the overall 2010 compliance scores generally fell below the 2009 levels.

Marked declines occurred in compliance with Primary Care and Coordination, Coverage and Authorization of Services, Enrollee Rights, Practice Guidelines, and Subcontractual Relationships and Delegation. For example, on average, the health plans met only 61 percent of the elements for Practice Guidelines in 2010, compared with 95 percent the year before.

TEAMonitor added Patient Review and Coordination (PRC) as a new review standard in 2009. The PRC program requires MCOs to control overutilization and inappropriate use of medical services by Medicaid enrollees. On average, the Healthy Options plans fully met 62 percent of the elements of this standard in 2010, about the same as in 2009.

The 2010 TEAMonitor reviews focused more scrutiny on MCOs’ coordination of care for enrollees with mental/behavioral health issues—a key element of Emergency and Post-stabilization Services and of the QAPI program. TEAMonitor found that most MCOs failed to provide evidence of having incorporated mental/behavioral health into their utilization management programs and QI work plans.

Among health plans, KPNW achieved the best scores in 2010, complying fully with 11 of the 16 standards reviewed.

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 19 may not reflect the status of plan performance as of December 2010.

Table 19. MCO compliance scores for physical health regulatory and contractual standards.

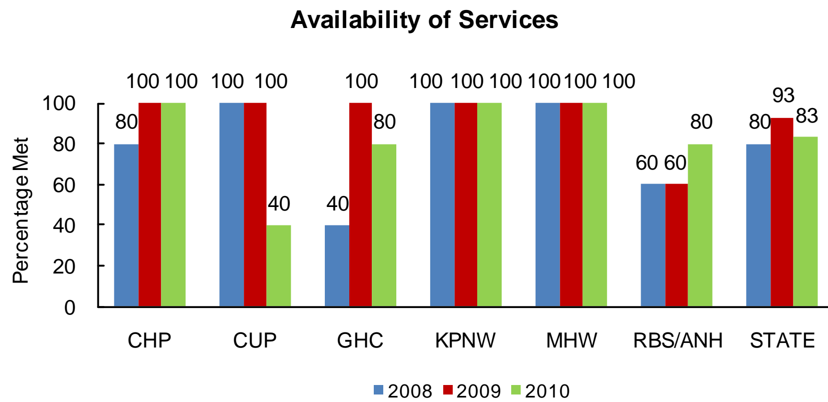
Standard (# of elements)	CHP			CUP			GHC			KPNW			MHW			RBS/ANH			State average		
	Percentage of elements Met, Partially Met, and Not Met																				
	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM
Availability of Services (5)	**100**	0	0	**40**	60	0	**80**	20	0	**100**	0	0	**100**	0	0	**80**	20	0	**83**	17	0
Furnishing of Services (2)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**50**	0	50	**92**	0	8
Program Integrity (2)	**50**	50	0	**50**	50	0	**100**	0	0	**100**	0	0	**50**	50	0	**100**	0	0	**75**	25	0
Claims Payment (1)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**0**	100	0	**83**	17	0
Primary Care and Coordination (1)	**0**	100	0	**0**	100	0	**0**	100	0	**100**	0	0	**0**	100	0	**0**	100	0	**17**	83	0
Additional Services for Enrollees with SHCN (5)	**80**	0	20	**100**	0	0	**80**	20	0	**100**	0	0	**80**	20	0	**100**	0	0	**90**	7	3
Patient Review and Coordination (8)	**75**	25	0	**88**	12	0	**25**	37	37	**100**	0	0	**0**	25	75	**88**	12	0	**62**	19	19
Coverage and Authorization of Services (4)	**50**	50	0	**75**	25	0	**25**	75	0	**75**	25	0	**75**	0	25	**25**	25	50	**54**	33	13
Emergency and Post-stabilization Services (2)	**50**	0	50	**0**	100	0	**50**	0	50	**50**	50	0	**50**	50	0	**0**	100	0	**33**	50	17
Enrollment/Disenrollment (1)	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0	**100**	0	0
Enrollee Rights (16)	**62**	19	19	**88**	12	0	**56**	31	13	**88**	12	0	**69**	31	0	**69**	25	5	**72**	22	7
Grievance Systems (19)	**74**	21	5	**89**	11	0	**53**	37	10	**89**	5	5	**58**	32	10	**74**	10	16	**73**	19	8
Practice Guidelines (3)	**67**	33	0	**33**	67	0	**100**	0	0	**100**	0	0	**33**	67	0	**33**	67	0	**61**	39	0
Provider Selection (3)	**100**	0	0	**67**	33	0	**67**	33	0	**100**	0	0	**100**	0	0	**100**	0	0	**89**	11	0
QAPI Program (5)	**60**	40	0	**20**	80	0	**40**	40	20	**100**	0	0	**80**	20	0	**40**	60	0	**57**	40	3
Subcontractual Relationships and Delegation (4)	**100**	0	0	**75**	25	0	**100**	0	0	**75**	25	0	**75**	25	0	**0**	50	50	**71**	21	8

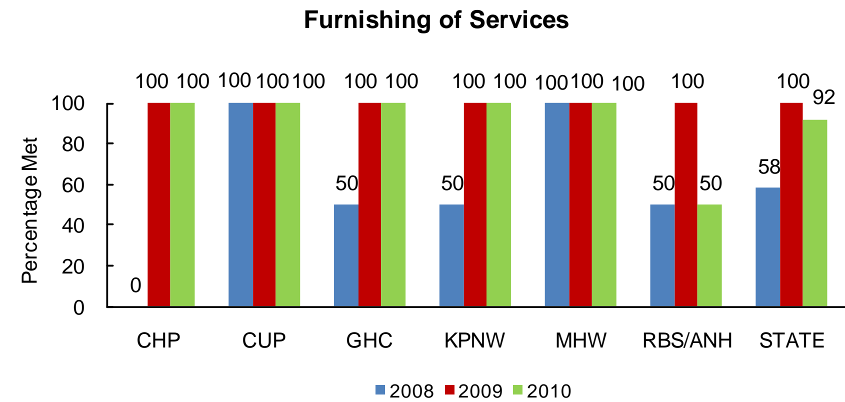
M=Met; PM=Partially Met; NM=Not Met

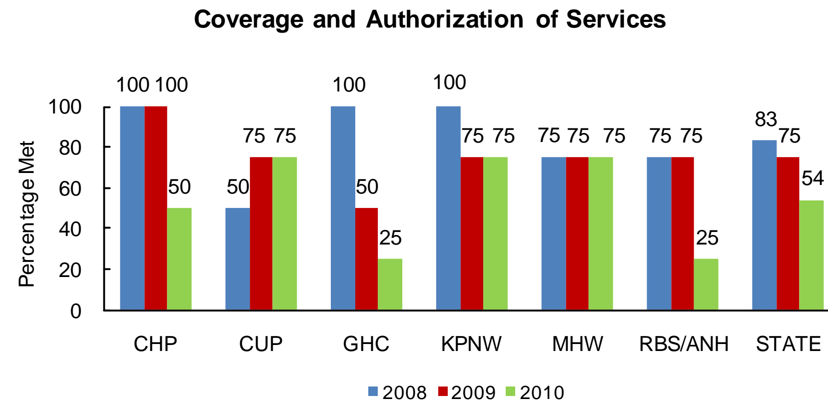
[a] These standards were scored during March–August 2010. Some “Partially Met” or “Not Met” scores were due to insufficient documentation to support compliance. Since then, health plans with a score of “Partially Met” or “Not Met” for any standard may have submitted corrective actions plans; therefore, the above scores may not reflect the status of plan performance as of December 2010.

Figure 9. Changes in compliance scores for selected physical health regulatory standards by MCO, 2008–2010.

Access Standards







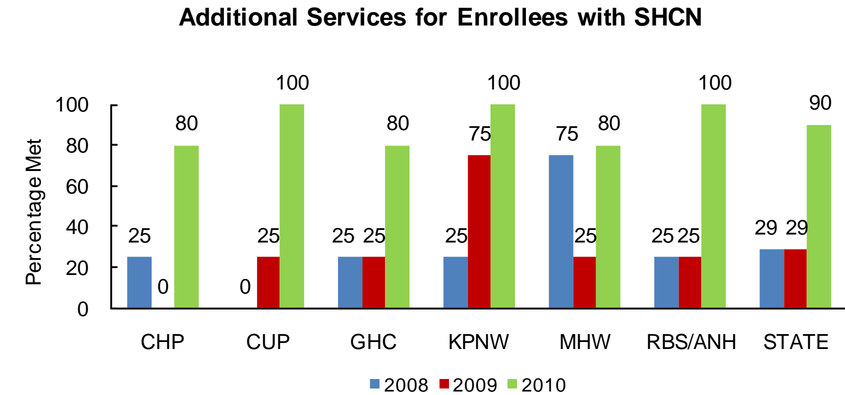
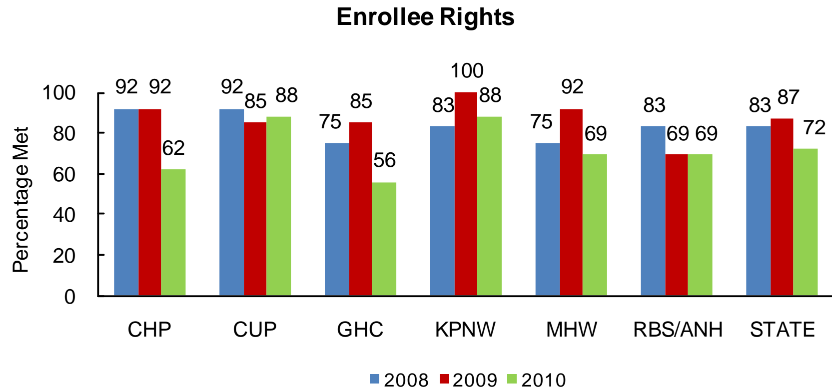
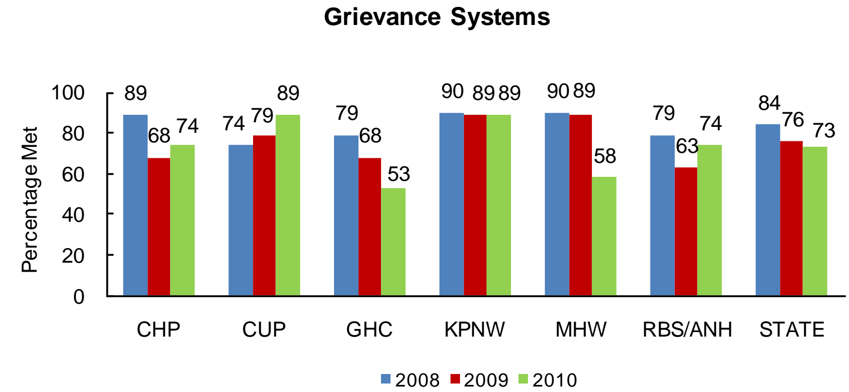
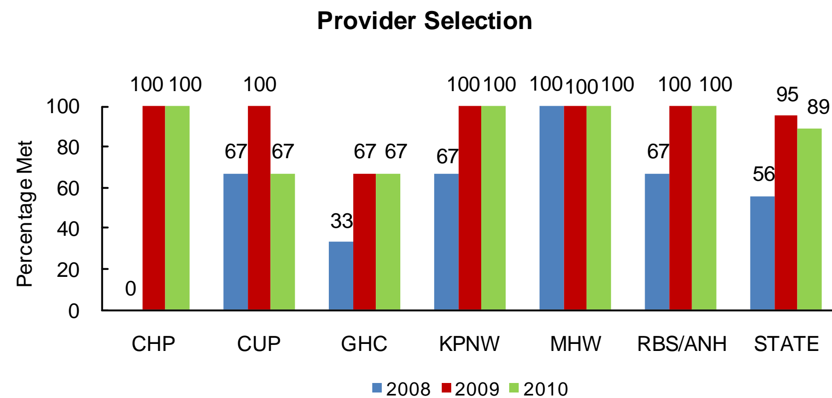


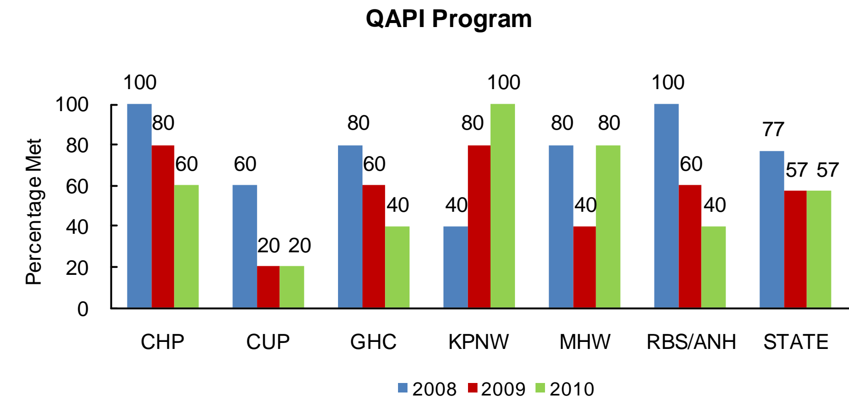
Figure 9. Changes in compliance scores for selected physical health regulatory standards by MCO, 2008–2010 (cont.).

Timeliness and Quality Standards









Corrective action plans

In 2010, TEAMonitor reviewed the MCOs' 2009 corrective action plans (CAPs), documenting resolution of corrective action as part of the review process. If, as part of the 2010 review, old or new findings were observed, TEAMonitor documented those findings and required corrective action. The state required a 2010 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 2009 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 20 shows the disposition of CAPs required in 2010.

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.

Table 20. Disposition of MCOs' corrective action plans.

Health plan	2010 CAPs required	2010 CAPs accepted	2010 percentage accepted	2009 CAP status not resolved
CHP	23	19	83%	1
CUP	22	19	86%	1
GHC	34	29	85%	6
KPNW	7	3	43%	1
MHW	31	29	94%	4
RBS/ANH	30	30	100%	1
WMIP	32	20	63%	5

Physical health PIP validation

The 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, describing 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 2010 review evaluated the PIPs each MCO conducted during 2009.

Table 21 shows the topics of the PIPs conducted by each MCO in 2010 and the scores assigned by TEAMonitor. As required by contract, all MCOs addressed WCC visits through their clinical PIPs, and CUP, MHW, and RBS each conducted an immunization PIP. The nonclinical PIP topics varied as shown. CHP and MHW earned a "Met" score for each PIP reported, while other MCOs achieved varying degrees of success.

A discussion of each MCO's PIPs follows. 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 21. PIP topics and scores by MCO, 2010.

Plan	PIP topic	Score
CHP	Clinical: Well-Child Exams: Improving HEDIS Measurement Rates	Met
	Nonclinical: Improving Call Resolution Performance	Not Met
CUP	Clinical: Improving Well-Child Visit Rates	Not Met
	Clinical: Improving Early Childhood Immunization Rates	Not Met
	Nonclinical: HEDIS Process Quality Improvement	Not Met
GHC	Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Met
	Nonclinical: Improving Practitioner Communication with Members	Not Met
KPNW	Clinical: Improving Well-Child Visit Rates	Met
	Nonclinical: Regional Appointment Center Call Answer Timeliness	Met
MHW	Clinical: Improving Well-Child Visit Rates	Met
	Clinical: Improving Childhood Immunization Rates	Met
	Nonclinical: Medicaid Pharmacy Authorization Turnaround Times	Met
RBS/ANH	Clinical: Well-Child Visits With a Disparity Aspect Involving Hispanic Population	Partially Met
	Clinical: Improving the Rate of Child Immunizations	Partially Met
	Nonclinical: Improving Employees' Understanding of Cultural Competency and Health Disparities	Partially Met

Community Health Plan

Table 22 displays the topics and scores of CHP's PIPs in the past three years. CHP carried over one clinical project from 2008 through 2010, aimed at improving WCC visit rates, as required by contract. The new nonclinical PIP, Improving Call Resolution Performance, began in May 2009.

Strengths

- CHP's Quality Grant Program to support providers in developing interventions is a best practice. All 19 community health centers have developed interventions to increase WCC visit rates. CHP supports the interventions with quarterly reports, incentives, and technical assistance.

Opportunities for improvement

- 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 needs to complete significance testing through 2009 for each measure, which likely would demonstrate significant improvement.
- For the nonclinical PIP, CHP needs to present more complete documentation, especially on the interventions, for the PIP to be evaluated.
- The nonclinical PIP groups Medicaid enrollees with all other enrollees. CHP needs to collect performance data uniquely for Medicaid enrollees in order to measure specific benefits for this population.

Table 22. Community Health Plan PIP topics and scores, 2008–2010.

Topic	2008	2009	2010
Clinical: Well-Child Exams: Improving HEDIS Measurement Rates	Partially Met	Met	Met
Clinical: Improve Clinical Outcomes for Members With a Diagnosis of Asthma	Partially Met	Not reported	Not reported
Clinical: Childhood Immunizations: Improving HEDIS Measurement Rates	Partially Met	Not reported	Not reported
Nonclinical: Improving Call Resolution Performance	Not conducted	Not conducted	Not Met
Nonclinical: Access to Care—A Lean Perspective	Partially Met	Not reported	Not reported
Nonclinical: Simple Rules and Access to Care	Partially Met	Not reported	Not reported
Nonclinical: Improving Access to Primary Care	Not conducted	Met	Not reported

Columbia United Providers

Table 23 displays the topics and scores of CUP's PIPs in the past three years. As shown, CUP submitted two clinical PIPs in 2010, related to immunizations and WCC, as required by contract. Although these topics were the same as those submitted in 2008 and 2009, CUP chose to restart these projects as news PIPs because of a change in the HEDIS data abstraction process. The nonclinical topic was new for 2010.

Strengths

- CUP clearly defined plans for conducting the clinical PIPs, including use of HEDIS measures to assess each PIP's impact.

Opportunities for improvement

- The clinical PIP documentation provided no baseline data and lacked specificity in many areas, including the description of interventions. CUP needs to submit baseline data and evidence of having implemented interventions.
- As designed, the nonclinical PIP does not relate to improving processes that affect patient outcomes.
- TEAMonitor recommended that CUP receive additional training or guidance on PIP selection and documentation.

Table 23. Columbia United Providers PIP topics and scores, 2008–2010.

Topic	2008	2009	2010
Clinical: Improving Early Childhood Immunization Rates	Partially Met	Partially Met	Not Met
Clinical: Improving Well-Child Visit Rates	Partially Met	Partially Met	Not Met
Clinical: Improving Management of Asthma as a Chronic Disease	Partially Met	Not reported	Not reported
Nonclinical: HEDIS Process Quality Improvement	---	---	Not Met
Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Partially Met	Not reported	Not reported
Nonclinical: Improving Member Understanding of Plan Benefits and Services	Partially Met	Not reported	Not reported

Group Health Cooperative

Table 24 displays the topics and scores of GHC's PIPs in the past three years. GHC carried over one clinical and one nonclinical PIP from 2008 to 2010. The WCC-related PIP was required by contract.

Strengths

- Both PIPs employed multiple additive interventions over time, with measures refreshed each year.
- TEAMonitor cited physician leadership on GHC's clinical PIP as a best practice.

Opportunities for improvement

- GHC's sampling approach and study methods for the nonclinical PIP failed to consider the Medicaid population uniquely. It is unclear whether the sample adequately represents Medicaid enrollees. Additional data on Medicaid service utilization might help dispel this concern.
- Survey response rates for Medicaid enrollees are low, possibly compromising the study conclusions. GHC may need to modify the study methods to improve response from this population.

Table 24. Group Health Cooperative PIP topics and scores, 2008–2010.

Topic	2008	2009	2010
Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Met	Met	Met
Clinical: Improving Childhood and Adolescent Immunization Rates	Met	Not reported	Not reported
Clinical: Ensuring Members Receive Recommended Prenatal Care	Met	Not reported	Not reported
Nonclinical: Improving Practitioner Communication with Members	Met	Not reported	Not Met
Nonclinical: Improving Member Utilization of Online Services	Partially Met	Not Met	Not reported

Kaiser Permanente Northwest

Table 25 displays the topics and scores of KPNW's PIPs in 2010 and 2009. The WCC-related PIP was required by contract.

Strengths

- KPNW's interventions with providers for the clinical PIP are a best practice and include the web-based Panel Support Tool, which graphically displays "care gaps" on an intranet website. Bundled incentives for providers target improvement in pediatric WCC measures.
- The nonclinical PIP is well designed and has implemented varied interventions over time in an effort to shorten call-wait times for enrollees, including increased staffing, targeted training, special interview techniques to identify employees most suited to the job, quality monitoring, and electronic messaging.

Opportunities for improvement

- Although KPNW's clinical PIP focuses on improving adolescent WCC visit rates, the PIP documentation does not make clear whether the incentive package includes care for adolescents. Visit rates for adolescents continue to show need for improvement.

Table 25. Kaiser Permanente Northwest PIP topics and scores, 2008–2010.

Topic	2008	2009	2010
Clinical: Improving Well-Child Visit Rates	*	Partially Met	Met
Nonclinical: Regional Appointment Center Call Answer Timeliness	*	Met	Met

*TEAMonitor did not review PIPs for KPNW in 2008, as the PIPs were not submitted timely.

Molina Healthcare of Washington

Table 26 displays the topics and scores of MHW's PIPs in the past three years. As shown, MHW carried over two clinical PIPs from 2008 to 2010, both required by contract, and carried over the nonclinical PIP from 2009.

Strengths

- MHW's use of tables linking the clinical PIP measures to key outcomes is a best practice. All PIPs list barriers and related interventions, and provide charts that describe key analytical elements, benchmarks, and goals.
- The childhood immunization PIP has demonstrated significant improvement from baseline. MHW refreshed its interventions in 2009 with a provider incentive as well as several more passive interventions.
- The nonclinical PIP achieved significant improvement in pharmacy turnaround times in early stages, and appears to have sustained this improvement over the three-year investigation period.

Opportunities for improvement

- As performance on the WCC measures has plateaued, additional active interventions (e.g., provider incentives) are needed to improve and sustain performance.
- MHW's PIP documentation did not clearly and succinctly provide information needed to evaluate the projects. TEAMonitor recommended that MHW provide staff training in this area.

Table 26. Molina Healthcare of Washington PIP topics and scores, 2008–2010.

Topic	2008	2009	2010
Clinical: Improving Childhood Immunization Rates	Met	Not reported	Met
Clinical: Improving Well-Child Visit Rates	Met	Met	Met
Clinical: Adolescent Immunization Status	Met	Not reported	Not reported
Nonclinical: Medicaid Pharmacy Authorization Turnaround Times	Not conducted	Met	Met
Nonclinical: Improving Member Knowledge of Benefits	Partially Met	Not reported	Not reported
Nonclinical: Pre-Service Authorization Dates	Partially Met	Not reported	Not reported

Regence BlueShield/ Asuris Northwest Health

Table 27 displays the topics and scores of RBS/ANH's PIPs in the past three years. As shown, RBS/ANH carried over the contractually required PIPs for immunizations and WCC from 2008 through 2010. RBS/ANH began its new nonclinical PIP in mid-2009.

Strengths

- TEAMonitor cited RBS/ANH's excellent use of data display (tables and charts) to report performance. Study rationales and study questions are well documented.
- The nonclinical PIP topic is well chosen and could be very useful in reducing health disparities among the MCO's Medicaid enrollees.

Opportunities for improvement

- The child immunization PIP reported Combo 3 data, rather than Combo 2 data as required by contract. RBS/ANH needs to report Combo 2 data and the results of statistical significance tests, which likely would show significant improvement from baseline.
- For the clinical PIPs, RBS/ANH needs to implement more active interventions to drive future improvement.

Table 27. Regence BlueShield/Asuris Northwest Health PIP topics and scores, 2008–2010.

Topic	2008	2009	2010
Clinical: Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Met	Not Met	Partially Met
Clinical: Improving the Rate of Child Immunizations	Met	Partially Met	Partially Met
Clinical: Improving Appropriate Medication Use for Members With Asthma	Met	Not reported	Not reported
Nonclinical: Improving Employees' Understanding of Cultural Competency and Health Disparities	Not conducted	Not conducted	Partially Met
Nonclinical: Improving Response Time of Pharmacy Prior-Authorization Denials	Partially Met	Partially Met	Not reported
Nonclinical: Improving Getting Help From Customer Service	Met	Not reported	Not reported

Washington Medicaid Integration Partnership Evaluation

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

The state contracts with MHW to conduct this pilot project in Snohomish County, with expansion planned as the pilot project matures, subject to legislative approval. 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 2010, WMIP enrollment totaled about 3,800.

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 measures for diabetes care and service utilization.

WMIP performance measures

For 2010, 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 ISCA tool and the NCQA HEDIS compliance audit. MHW also calculated four non-HEDIS measures for the WMIP—chronic dementia, falls, depression, and transition of care—the results of which are not analyzed in this annual report. In addition, MHW conducted the CAHPS survey to measure WMIP enrollee satisfaction.

Table 28 on the next page presents the WMIP results for comprehensive diabetes care over the past three years. In 2010, HbA1c testing for WMIP enrollees rose to its highest rate in four years. Except for HbA1c testing and HbA1c poor control, the 2010 rates were lower than the rates reported in 2009, though not significantly so. (Note: the higher rate for HbA1c poor control represents a worse result.)

Tables 29 and 30 present WMIP results for inpatient utilization, general hospital/acute care, and for inpatient nonacute care in reporting years 2008–2010. Table 31 presents the results for ambulatory care utilization in 2008–2010.

In 2010, total inpatient acute and nonacute care discharges and days declined from 2009, as did the average length of stay in nonacute care, but the declines were not statistically significant. The rate of outpatient care visits rose significantly.

Table 28. WMIP comprehensive diabetes care measures, 2008–2010.

	2008	2009	2010
HbA1c tests (percentage tested)	82.16	86.67	86.84
Enrollees with poor control of HbA1c levels (percentage >9.0%)	43.87	37.00	42.40
Enrollees with good control of HbA1c levels (percentage <8.0%)	N/A	N/A	50.58
Dilated retinal exams (percentage examined)	59.11	63.00	55.26
Lipid profile (LDL-C) performed (percentage profiled)	76.58	82.00	78.65
Lipids controlled (percentage with <100mg/dL)	35.32	39.00	31.58
Nephropathy monitored annually (percentage monitored)	82.16	84.67	81.58
Blood pressure control (percentage with <130/80 mm Hg)	38.66	37.00	32.46
Blood pressure control (percentage with <140/90 mm Hg)	65.80	67.67	61.11

No statistically significant differences in percentages from 2009 to 2010 ($p \leq 0.05$).

Table 29. WMIP inpatient utilization, general hospital/acute care measures, 2008–2010.

	Discharges/1000MM[a]			Days/1000MM[a]			ALOS[b]		
	2008	2009	2010	2008	2009	2010	2008	2009	2010
Total inpatient	14.87	15.86	15.14	70.92	80.71	76.73	4.77	5.09	5.07
Medical	8.37	9.18	8.48	32.56	32.27	32.79	3.89	3.51	3.86
Surgical	5.83	5.67	5.95	36.02	45.09	42.28	6.17	7.96	7.11

[a]1000MM = 1000 member months. [b]ALOS = average length of stay in days.
No statistically significant differences in percentages from 2009 to 2010 ($p \leq 0.05$).

Table 30. WMIP inpatient utilization, nonacute care measures, 2008–2009.

	Discharges/1000MM[a]			Days/1000MM[a]			ALOS[b]		
	2008	2009	2010	2008	2009	2010	2008	2009	2010
Total inpatient	1.43	0.84	0.76	28.50	25.38	14.78	19.98	30.30	19.36

[a]1000MM = 1000 member months. [b]ALOS = average length of stay in days.
No statistically significant differences in percentages from 2009 to 2010 ($p \leq 0.05$).

Table 31. WMIP ambulatory care measures, 2008–2010.

	2008	2009	2010
		Visits/1000MM[a]	
Outpatient visits	456.31	543.83	563.98 ↑
Emergency room visits	112.10	120.46	119.94
Surgery or procedures performed	13.47	22.53	24.09
		Stays/1000MM[a]	
Observation room stays resulting in discharge	1.20	0.87	0.46

[a]1000MM = 1000 member months.
↓↑ Indicates statistically significant difference in percentages from 2009 to 2010 ($p \leq 0.05$).

Tables 32 and 33 present WMIP results for behavioral health measures. The antidepressant medication management measure (Table 32) examines the percentage of patients beginning antidepressant drug treatment who received an effective acute-phase trial of medications (three months) and the percentage who completed six months of continuous treatment for major depression. The percentage of those receiving effective acute-phase treatment essentially held steady in 2010. The percentage receiving effective continuation-phase treatment increased slightly, but the change was not significant.

The follow-up measure (Table 33) looks at continuity of care—the percentage of enrollees who were hospitalized for selected mental disorders and were seen on by an outpatient mental health provider within 30 days or within 7 days after discharge from the hospital. The percentages of WMIP enrollees receiving timely follow-up care decreased in 2010; the decline in the 30-day follow-up rate was statistically significant.

Table 34 reports the percentage of enrollees age 65 or older who received at least one prescription for a high-risk medication, or at least two different prescriptions. The percentages for both indicators have dropped slightly each year since 2007, pointing to better management of these medications for WMIP enrollees.

Table 32. WMIP antidepressant medication management measures, 2008–2010.

	Effective acute-phase treatment			Effective continuation-phase treatment		
	2008	2009	2010	2008	2009	2010
Percentage of patients receiving medication management	41.46	52.08	52.78	39.02	33.33	36.11

No statistically significant differences in percentages from 2009 to 2010 ($p \leq 0.05$).

Table 33. WMIP follow-up after hospitalization for mental illness measures, 2008–2010.

	30-day follow-up			7-day follow-up		
	2008	2009	2010	2008	2009	2010
Percentage of patients receiving follow-up	47.37	69.81	48.84 ↑	28.95	47.17	32.56

↓↑ Indicates statistically significant difference in percentages from 2009 to 2010 ($p \leq 0.05$).

Table 34. WMIP use of high-risk medications for the elderly measures, 2008–2010.

	One prescription			At least two prescriptions		
	2008	2009	2010	2008	2009	2010
Percentage of patients receiving medication	18.43	16.16	12.81	4.10	3.01	2.23

No statistically significant differences in percentages from 2009 to 2010 ($p \leq 0.05$).

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 addressed by TEAMonitor's MCO compliance reviews, but examined a greater number of elements related to specific WMIP contract provisions. Table 35 reports the WMIP compliance scores for each of nine standards.

As shown, MHW fully met all elements for three of the nine standards, and met the majority of elements for most other standards.

MHW met only 4 of the 17 elements under Additional Services for Enrollees with Special Healthcare Needs (24 percent). That standard incorporates regulatory and contractual provisions related to coordination and continuity of care and the Patient Review and Coordination program. MHW failed to complete two required corrective actions regarding enrollee needs assessment and screening. The reviewers also identified issues related to provider documentation of enrollee treatment plans and assessments, monitoring of mental health intake evaluations, and completion of plans for care coordination.

Table 35. WMIP compliance scores, 2010.

Standard (# of elements)	Percentage of elements Met (M), Partially Met (PM), Not Met (NM)		
	M	PM	NM
Availability of Services (10)	**60**	30	10
Program Integrity (2)	**50**	50	0
Claims Payment (2)	**100**	0	0
Primary Care and Coordination (1)	**100**	0	0
Additional Services for Enrollees with Special Healthcare Needs (17)	**24**	35	41
Coverage and Authorization of Services/Emergency and Post-stabilization Services (8)	**75**	25	0
Enrollee Rights (33)	**70**	27	3
Practice Guidelines/Provider Selection (8)	**75**	25	0
QAPI Program (10)	**100**	0	0

WMIP PIP validation

For 2010, MHW submitted five PIPs targeting improvements in clinical care and nonclinical services for WMIP enrollees. Three projects were carried over from previous years, including two on chemical dependency topics, as required by contract. MHW also began two new clinical PIPs seeking to increase influenza vaccinations and depression assessments. Table 36 shows the PIP topics and the scoring by TEAMonitor.

Strengths

- **Project 2:** MHW added a third measure to track the percentage of enrollees referred for chemical dependency assessment who received treatment at an appropriate agency. Results for this measure have consistently exceeded MHW's goal.
- **Project 4:** This new PIP appears relevant and pertinent to WMIP enrollee needs and services. Assessment of CAHPS survey data (enrollee self-reported flu vaccine) is complemented by use of a pharmaceutical measure of flu vaccine administration. One of the two measures showed statistically significant improvement over time.

Opportunities for improvement

- All PIPs need to contain an analysis of inter-rater reliability between different data collection instruments; evidence of the qualifications and training of staff used to collect and analyze data; and evidence linking interventions with the targeted performance measures and outcomes.
- **Project 3:** Problems with data extraction resulted in low confidence in the reported PIP results. MHW needs to verify the accuracy and consistency of data before submitting the PIP; document the updated remeasurement periods; and provide documentation to demonstrate sustained improvement in the measures.
- **Project 4:** MHW needs to provide additional details on characteristics of the WMIP population to help support the need for this PIP.
- **Project 5:** MHW needs to present specific data or research supporting the focus of the PIP—i.e., the need to conduct depression screening. Analytical comparisons of annual and quarterly data called into question the validity of the study.

Table 36. WMIP PIP topics and scores, 2010.

Topic	Score
1. Clinical: Improving Compliance with Chemical Dependency Assessment and Follow-Up Referrals for Chemical Dependency	Not Met
2. Nonclinical: Improving Identification of Members at High Risk for Chemical Dependency Issues	Partially Met
3. Nonclinical: Increasing Successful Initial Contacts Between WMIP Members and the Care Coordination Team	Not Met
4. Clinical: Increasing Influenza Vaccine Participation (New)	Met
5. Clinical: Increasing Depression Assessments (New)	Not Met

CAHPS survey results

The annual CAHPS surveys, developed and managed by the Agency for Healthcare Research and Quality, are designed to measure patients' experiences with the health care system. MPA has required a satisfaction survey for the WMIP population since the inception of the program in 2005, and initiated satisfaction surveys for the FFS population in 2007. During 2010, the survey was administered to WMIP enrollees and to a comparison group of FFS enrollees.

As in 2008, the Medicaid FFS population responded to the 2010 survey at a higher rate (58 percent) than did the WMIP enrollee population (42 percent). For the most part, differences between the two groups' responses were not statistically significant. However, a significant difference emerged in the Rating of Health Plan category:

- WMIP enrollees rated their satisfaction with MHW **higher** than FFS enrollees rated their satisfaction with the state Medicaid agency.

In addition, WMIP enrollees in 2010 reported significantly higher levels of satisfaction with How Well Doctors Communicate, compared with their responses in 2008:

- In 2010, 90 percent of WMIP enrollees reported that their personal doctor explained things in a way that was easy to understand, compared with 83 percent of WMIP enrollees in 2008.
- In 2010, 90 percent of WMIP enrollees reported that their personal doctor listened carefully to them, compared to 85 percent in 2008.

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 were identified as top priorities for both survey populations, and obtaining needed information through Customer Service is a top priority for WMIP. An additional element of Getting Care Quickly—obtaining care when enrollees thought they needed care—was identified as a top priority for both WMIP and FFS enrollees.

Recommendations for WMIP

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

Performance measure results to date indicate steady progress in management of antidepressant medications and high-risk medications in the aged. With respect to diabetes care, however, the screening and utilization measures show mixed results, indicating that this complex population requires a high level of coordination to ensure that clinical guidelines are met.

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:[8,9]

- **Transitional care interventions** engage patients in the hospital 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. In successful interventions, advanced practice nurses and "transition coaches" had substantial amounts of in-person contact with their patients.

- **Self-management education interventions** engage patients in community-based programs (using medical and nonmedical professionals) designed to "activate" them in managing their chronic conditions. Patients learn to self-manage symptoms, participate 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 12 months; 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 help assess eligibility and arrange 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.

These studies suggest that the "optimal" care coordination model includes

- augmenting effective ongoing care coordination with transitional care
- offering group education on self-management, while tailoring educational materials to people with lower educational levels and assessing their comprehension
- establishing high-quality programs using the above-mentioned interventions

Acumentra Health offers this additional recommendation for WMIP:

- ***Conduct member-level analysis to "drill down" on performance measures and target specific areas of improvement.***

In May 2009, the Center for Health Care Strategies (CHCS) launched an initiative called Transforming Care for Dual Eligibles. Seven states will implement strategies to improve care and control costs for dual-eligible enrollees. Colorado, Maryland, Massachusetts, Michigan, Pennsylvania, Texas, and Vermont will receive in-depth technical assistance addressing program design, care models, contracting strategies, and financing mechanisms.[10] The findings, when they become available, are likely to prove useful for WMIP program managers.

In March 2010, CHCS introduced a Technical Assistance Tool entitled "Options for Integrating Care for Dual Eligible Beneficiaries."[11] Integration options are grouped into four broad categories: Special Needs Plans, Program for All-Inclusive Care for the Elderly, Shared Savings Models, and States as Integrated Care Entities. The toolkit discusses the elements necessary for implementing integrated care, including:

- strong patient-centered care based in accountable primary care homes
- comprehensive, multidisciplinary care teams that coordinate and provide the full range of medical, behavioral, and long-term support services
- robust data sharing and information systems to promote care coordination
- enhanced use of home- and community-based long-term care services
- financial alignment that impels integration of care
- strong consumer protections that ensure access to longstanding providers and involve consumers in program design

Other integration program information can be found on CHCS's website, www.chcs.org.

Discussion and Recommendations

This annual report summarizes the performance of Washington's MCOs and RSNs in measures of health care access, timeliness, and quality, and in meeting state and federal standards for Medicaid managed care. The synthesis of data from EQR activities is intended to provide a systems perspective that will help DSHS 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. This year's annual report presents the third year of data on mental health care delivered by the RSNs.

In the face of severe budget challenges, DSHS remains committed to integrating the delivery of physical and behavioral health care for Medicaid enrollees. The scope and focus of EQR activities already have changed in response to budget pressures and are likely to evolve further. Ultimately, the EQR is expected to evaluate medical and mental health services on a standardized basis, using similar measures and methodologies.

In 2010, the governor ordered a 6.3 percent across-the-board reduction in state agency expenditures. For DSHS, this represents a reduction of $113 million from October 2010 through June 2011, followed by a $521 million reduction from July 2011 through June 2013. Proposed cuts will result in the elimination or suspension of many service programs formerly offered by DSHS, in addition to ongoing layoffs of DSHS personnel. Thus, resource constraints facing the Washington Medicaid program are likely to affect the feasibility of many of the recommendations in this section.

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, mandated 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's recommendations for the Children's Healthcare Improvement System program are aimed at ensuring the delivery of care within a medical home.[12] 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.

Another 2007 law, **SSHB 1088**, declared the state's intent to improve children's mental health services through increased access, family-centered services, early identification and intervention, and greater reliance on evidence-based practices. The law directed DSHS to provide up to 20 outpatient therapy visits annually for Medicaid-enrolled children. **2SHB 1373**, enacted in 2009, extended those provisions beyond July 2010. A DBHR/MPA committee has been tasked with implementing 2SHB 1373.

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 medical homes in primary care settings. The agencies developed four payment options that may hold promise for payers, providers, and patients.[13]

E2SHB 2549 also directed the Department of Health to develop a medical home learning collaborative to promote adoption of medical homes. The collaborative, initiated in mid-2009, defines the changes that clinical practices need to make to demonstrate that they are medical homes,

as well as the data needed to measure those changes. Currently, 33 clinics are participating. Project work is scheduled to continue through September 2011.

SSB 5891, enacted in 2009, directed DSHS and HCA to implement and evaluate one or more medical home reimbursement pilot projects. The agencies must identify 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 pilot project, which is on track to be implemented in 2011.

To facilitate coordination of medical and mental health treatment, **HB 2025**, effective in July 2009, allows the release and sharing of mental health treatment records without the patient's consent among licensed professional providers and their support staff.

ESSB 6522, enacted in 2010, requires HCA to appoint a lead organization to support at least two accountable care organization (ACO) pilot projects to be implemented by 2012. The lead organization is to coordinate with existing medical home projects and report to the legislature by 2013 on the ACOs' progress. The law provides no state funding for this effort, but the lead organization may seek federal funds, grants, donations, and other funding sources.

Access to care. The medical MCOs generally are complying with federal and state standards for coverage, authorization, and availability of services, although TEAMonitor's 2010 review identified somewhat lower compliance scores than in 2009. The MCOs have strengthened their compliance with access standards for enrollees with special health care needs, but most MCOs still need to refine their care coordination/case management programs.

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 mental health specialists for children, but access to minority mental health specialists and child psychiatry remains 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, psychologists, and social workers affiliated with Seattle Children's Hospital deliver PAL consultation services. The project is available to providers statewide.

Several pilot projects are 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. NSMHA, SWRSN, and GHRSN are operating pilot sites. The wraparound pilots in Skagit, Cowlitz, and Grays Harbor counties served 71 families in 2010. The University of Washington's Evidence-Based Practice Institute is evaluating the pilots and providing technical assistance. A cross-system wraparound "summit" in the fall of 2010 brought together national researchers and trainers, county and state government officials, and family and youth stakeholders to discuss implementation techniques and funding mechanisms. A report will be submitted to DSHS Secretary Susan Dreyfus with recommendations for expanding the availability of wraparound services in Washington.
- **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.

Quality of care. TEAMonitor's 2010 review of MCOs found inconsistent compliance with federal and state standards related to quality. In particular, most MCOs failed to provide evidence of having incorporated mental/behavioral health into their utilization management programs and QI work plans. Many of the deficiencies relate to program documentation. However, all MCOs fully or substantially meet the requirements for provider selection (credentialing and recredentialing).

RSNs across the state continue to implement the Recovery Model of care, emphasizing enrollees' dignity, respect, and involvement in the design and delivery of mental health services. The RSNs use diverse strategies to monitor the quality and appropriateness of care delivered by mental health providers. All RSNs have implemented at least one evidence-based practice guideline, and many monitor their providers' fidelity in applying the guidelines. RSN enrollees generally would benefit from more timely comprehensive assessments, and from more consistent development and implementation of crisis plans.

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 norms for *diabetes care*, in terms of administering blood glucose testing and retinal examinations, and maintaining good blood-pressure levels among enrollees with diabetes. Three-quarters of Medicaid children are receiving *Combo 2 immunizations*, and this percentage has climbed steadily since 2002. These improvements have stemmed from focused QI efforts through health plan PIPs, MPA's special initiatives and partnerships, and contract incentives.

Performance measurement. MPA 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 look at performance across the Medicaid system as a whole, encompassing FFS and managed care.

Value-based purchasing. Since 2005, MPA'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. Several MCOs have passed these incentives downstream, either to providers for improving care or to enrollees for obtaining care. However, because of current budget constraints, the state legislature has defunded the incentive program.

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

Mental health specialists. The RSN system struggles with lack of access to minority mental health specialists. RSNs express a need for specialists in cultures that are not ethnic or age-related (e.g., sexual minorities). Most RSNs lack adequate access to geriatric mental health specialists. Some RSNs need specialists to work with Russian-speaking consumers and recent immigrants from Eastern Europe, and/or with consumers who are deaf or hearing-impaired.

- ***DBHR needs to work with the RSNs to ensure an adequate number of certified mental health specialists to provide consultations for enrollees in special populations, or revise the mental health specialist certification requirements.***

Culturally and linguistically appropriate services. Most RSNs report a shortage of bilingual and bicultural staff among their regional community mental health agencies.

- ***DBHR needs to work with the RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural.***

Services for children. Most RSNs report a lack of respite services and limited access to acute care services for children.

- ***DBHR needs to work with the RSNs and community mental health agencies to provide adequate community based services as an alternative to acute care for children in the RSN system.***

Services for transition-age youth. Most RSNs lack programs designed to meet the needs of transition-age youth (age 18–21), particularly young people aging out of the foster care system.

- ***DBHR needs to encourage RSNs to develop resources for transition-age youth.***

Services for geriatric consumers. Across the state, there is a scarcity of step-down resources for geriatric enrollees with dementia and co-occurring medical conditions. This leads to long stays in acute care settings.

- ***DBHR needs to coordinate with other state agencies and geriatric facilities to ensure that enrollees discharged from the State Hospital and community hospitals receive long term care.***

Consumer voice in system planning. Some RSNs struggle with recruiting and keeping QRT members. Several described the need to restructure, redirect and revitalize their QRTs. A few RSNs expressed difficulty with maintaining the balance between QRT members' independence and ensuring constructive input.

The majority of QRTs seek more involvement and influence in meetings and system decisions. Some teams feel that their suggestions and input are not pursued or taken seriously. QRT members in the focus group requested that the RSN contract incorporate stronger language related to QRTs.

- ***DBHR needs to facilitate discussion between the RSNs and QRTs to determine how to incorporate QRT input into the RSN delivery system.***

RSN board and committee representation. Several RSNs' boards and committees have little representation of consumers and family advocates. One RSN's advisory board includes no consumers. Most RSN's advisory boards do not represent all age groups, and most do not represent the ethnic and minority enrollee populations in their service area. One RSN's advisory board includes no representation from allied agencies, making it difficult to ensure coordination and continuity of care.

- ***DBHR needs to work with the RSNs to ensure that RSN advisory boards represent all enrollees and, as needed, represent allied agencies.***

Least restrictive environment. The RSNs are financially responsible for psychiatric inpatient care for enrollees of Healthy Options and of General Assistance for the Unemployed. The RSNs are not always involved in a consumer's services before inpatient admission, and thus cannot intervene to offer alternatives to hospitalization, if appropriate.

- ***DBHR needs to work with the RSNs and the Healthy Options MCOs to improve collaboration and ensure that Medicaid enrollees receive mental health care in the least restrictive environment.***

Some RSNs struggle to keep the census at the State Hospital below their designated caps. Penalties for census over the cap reduce revenue that RSNs could use to develop less restrictive local resources.

- ***DBHR needs to work with the RSNs to maintain a continuum of community-based services and alternatives to acute care to ensure that enrollees are served in the least restrictive environment.***

Only about half of the consumers in the focus group had crisis plans, and most of those consumers did not feel that their plans were helpful during crises. The vast majority of crisis plans reviewed in 2010 primarily listed mental health resources and services and did not include family and friends or techniques that consumers can use to calm themselves.

- ***DBHR needs to work with the RSNs, providers, and consumers to build consensus regarding effective crisis plans.***

A few RSNs have not implemented Crisis Intervention Training (CIT) for law enforcement.

- ***DBHR needs to encourage all RSNs to implement CIT to help ensure that law enforcement officers can intervene effectively with consumers in crisis.***

Recovery and resilience. Budget constraints have forced several RSNs to cut back on supported employment programs and peer-run services, which are highly valued by consumers.

- ***DBHR is encouraged to identify creative solutions, such as cross-system funding, to ensure the availability of supported employment programs and peer-run services.***

Timeliness of assessments. Acumentra Health's review of 1,274 clinical records found that only 60 percent of enrollees had had comprehensive assessments completed within the past two years. For 13 percent of enrollees, the most recent assessment was more than five years old. Comprehensive assessments need to be updated in a timely manner, since an enrollee's life skills, strengths, and needs change over time.

- ***DBHR needs to work with RSNs to ensure timely assessment of enrollees' skills, strengths, and needs.***

Response to 2009 recommendations

The 2009 EQR report offered numerous recommendations as to how DBHR and the RSNs could work together to improve access to mental health care and the quality and timeliness of care. Table 37 outlines DBHR's response to those recommendations to date.

Table 37. DBHR response to 2009 EQR recommendations for mental health.

2009 recommendation	DBHR response	EQRO comments
Network development		
Ensure that RSNs have accurate information about the Medicaid-eligible population in their service area, including demographic information, language needs, and geographic distribution.	Completed. RSNs now receive a weekly file from ProviderOne (the state MMIS) with enrollees' demographic information, language needs, and geographic distribution.	The EQRO considers this action responsive.
Second opinions		
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.	DSHS will take this recommendation under consideration as time and resources allow. The EQRO is requested to cite a reference for this requirement.	Not yet addressed. See 42 CFR §438.206(b)(3) and RSN Agreement 09–11, §13.2.
Out-of-network services		
(1) Require the RSNs to track all out-of-network services.	(1) DSHS will take this recommendation under advisement.	(1) Not yet addressed. See 42 CFR §438.206(b)(4)–(5).
(2) Information distributed to all enrollees by DSHS needs to describe how to obtain out-of-network services.	(2) Completed. This information was added to the Benefits Booklet, which is distributed to all Medicaid enrollees.	(2) The EQRO considers this action responsive.
Routine access		
(1) 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.	(1) Completed. Written notice was given to all RSNs in May 2010, and the Benefits Booklet, Service Encounter Reporting Instructions, and RSN contract were aligned with this definition.	(1) The EQRO considers this action responsive.
(2) Require RSNs to follow up on issues identified through monitoring, and initiate corrective action when RSNs fail to comply with routine access requirements.	(2) Completed. Corrective action was implemented during the 2009 contract year.	(2) The EQRO considers this action responsive.
(3) Establish continued-stay and discharge criteria to guide treatment and discharge planning as RSNs continue to implement the Recovery Model.	(3) DSHS will take this recommendation under consideration as time and resources allow. Health care reform will further guide the agency in this effort.	(3) The EQRO recommends that DBHR address this issue in collaboration with MPA.

Table 37. DBHR response to 2009 EQR recommendations for mental health.

2009 recommendation	DBHR response	EQRO comments
(4) 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. *(5) 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.*	(4) DSHS will take this recommendation under consideration as time and resources allow. Health care reform will further guide the agency in this effort. (5) Completed. RSNs currently have access to the ProviderOne and have worked out process with the State Hospital to preauthorize inpatient admissions.	(4) The EQRO recommends that DBHR address this issue in collaboration with MPA. (5) Care coordination between RSNs and MCOs remains an issue, as RSNs are responsible for inpatient care for MCO enrollees. The EQRO believes that further efforts are needed to strengthen coordination.
Timeliness issues		
(1) Clarify how DBHR expects RSNs to ensure that enrollees with specialized needs have access to specialists in a timely manner. *(2) Provide direction on defining authorization timelines, and take steps to ensure that the RSNs meet those timelines, including requiring corrective action for noncompliance.* *(3) Clarify the requirements for reporting on timelines for first available appointments, to ensure consistent reporting on availability of services.*	(1) DSHS has received recommendations in this area from TriWest Group, an external consultant,[14] and is in the process of reviewing and acting on those recommendations. (2) No response. (3) No response.	(1) The EQRO recommends that DBHR implement viable recommendations from the TriWest Group report. (2) Not yet addressed. (3) DBHR discussed this issue with RSNs during Encounter Data Validation training in 2010. Some RSNs have implemented PIPs on this topic.
Quality management programs		
(1) Require all RSNs to submit QM plans and annual evaluations. DBHR needs to review those plans and evaluations as part of its RSN certification process. *(2) Provide direction for the RSNs on expectations for monitoring for over- and underutilization of outpatient services.*	(1) All RSNs received corrective action in 2009 to address this. DBHR conducted additional statewide training in quality management in October 2010. (2) All RSNs received corrective action in 2009 to address this. DBHR will conduct additional statewide training in 2011. DSHS has implemented a new Fraud and Abuse tracking system that can monitor for under- and overutilization.	(1) Not fully addressed. The 2009 corrective action plans did not contain the requirement for RSNs to submit QM plans for state approval, per WAC §388-865-0280. (2) The EQRO considers this action responsive.

Table 37. DBHR response to 2009 EQR recommendations for mental health.

2009 recommendation	DBHR response	EQRO comments
Provider selection		
(1) Provide clear direction to the RSNs regarding credentialing of RSN staff and monitoring of provider agency credentialing. *(2) Clarify expectations regarding routine screening to ensure that RSN or provider staff are not excluded from participating in federal healthcare programs.*	Completed. DBHR provided clear direction to RSNs and implemented corrective action in 2009. DBHR amended contracts and provided additional training for RSN administrators and quality managers in April 2010. A letter from the DBHR director to all RSNs provided further clarification on excluded providers.	The EQRO considers this action responsive.
Oversight of delegated activities		
Provide direction to the RSNs regarding the definition of delegated activities and requirements for monitoring of delegated activities.	Completed. Corrective action was implemented during the 2009 contract year. DBHR conducted statewide training in April 2010.	The EQRO considers this action responsive.
Care for enrollees with specialized needs		
Clarify how DBHR expects RSNs to ensure that enrollees with specialized needs are appropriately assessed, and that treatment plans incorporate the recommendations of mental health specialists.	DSHS has received recommendations in this area from TriWest Group, an external consultant, and is in the process of reviewing and acting on those recommendations.	The EQRO recommends that DBHR implement viable recommendations from the TriWest Group report.
Quality monitoring		
Provide direction to the RSNs regarding how to incorporate clinical quality monitoring into quality management plans and annual evaluations.	All RSNs received corrective action in 2009 to address this. DBHR conducted additional statewide training in quality management in October 2010.	The EQRO considers this action responsive.
Enrollment data		
Provide RSNs with a process or method for removing duplicate enrollees from the eligibility files.	Completed. In March 2010, DBHR met with RSNs to distribute and discuss written instructions for requesting corrections to enrollment information.	The EQRO considers this action responsive.

The path to future improvements: Physical health care

Some recommendations presented in previous annual reports continue to apply. Acumentra Health offers these "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.

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

Technical assistance for providers. Training providers in QI principles will help them improve outcomes for enrollees. Acumentra Health recommends that MPA

- ***encourage MCOs to identify providers that need technical assistance with QI and to implement training at the clinic level***

Care coordination. MCO compliance scores declined for Primary Care and Coordination and for Emergency and Post-stabilization Services. Only one health plan, KPNW, fully met the Primary Care and Coordination standard. Other MCOs needed to refine their care coordination/ case management programs, or failed to document program outcomes sufficiently.

- ***MPA should consider requiring MCOs conduct a PIP focusing on Primary Care Coordination and Emergency and Post-stabilization Services.***
- ***To help facilitate coordination of care, MPA needs to work with DBHR to ensure that an MCO is notified when a Healthy Options enrollee receives inpatient mental health services through an RSN.***

Data completeness. This issue is relevant when MCOs deliver capitated services 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 for completeness and accuracy, and maintain formal reconciliation processes to ensure the integrity of data transfer between MCOs and their vendors***

MPA 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 reported data. In 2010, several MCOs categorized large percentages of enrollees as having "unknown" ethnicity and race. MCOs should consider capturing race and ethnicity data from the state's enrollment files or from alternative sources such as member surveys and enrollment applications to help ensure that the HEDIS measure accurately reflects the diversity of MCO enrollees.

- ***MPA 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 2009 recommendations

The 2009 EQR report offered recommendations as to how MPA and the MCOs could work together to improve access to physical health care and the quality and timeliness of care. Table 38 outlines MPA's response to those recommendations to date.

Table 38. MPA response to 2009 EQR recommendations for physical health.

2009 recommendation	MPA response	EQRO comments
Performance measure feedback to clinics		
Require the MCOs to provide performance measure feedback to clinics and providers on a frequent and regular schedule.	DSHS will take this recommendation under consideration as time and resources allow. Health Care Reform will further guide the agency in this effort.	Not yet addressed.
Provider incentives		
Encourage MCOs to support and reward high-performing provider groups—e.g., those that develop medical homes for enrollees and improve their quality indicators.	DSHS will take this recommendation under consideration as time and resources allow. Health Care Reform will further guide the agency in this effort.	Not yet addressed.
Data completeness		
(1) 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. *(2) Encourage MCOs to evaluate expected claims or encounter volumes by provider type to help identify missing data.* *(3) Encourage MCOs to 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.*	(1) Completed. Corrective action was implemented during the 2009 contract year. (2) Completed. Milliman obtains cost reports from MCOs; MPA compares reported costs with encounter data and audited financial data, and addresses any discrepancies before completion of rate setting. (3) Not addressed.	(1) The EQRO considers this action responsive. However, several MCOs are categorizing enrollee race and ethnicity as "unknown." (2) Not yet addressed. Our recommendation is intended to encourage MCOs to develop processes to ensure capture of complete and accurate data. For example, MCOs are collecting hybrid WCC or postpartum care data that should be submitted as an administrative data source. (3) Not yet addressed.
General		
(1) Explore opportunities to promote the WMIP program as a model that supports the medical or health home model. *(2) 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.*	(1) Currently in process. This is in line with the redesign of WMIP. MPA expects improvements in the care coordination model during 2011. (2) This has not been done. MPA is in the process of redesigning the WMIP and will need to finish that before taking on new challenges.	(1) The EQRO considers this action responsive. (2) Not yet addressed.

Table 38. MPA response to 2009 EQR recommendations for physical health.

2009 recommendation	MPA response	EQRO comments
(3) WMIP program managers within DSHS 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.	(3) Currently in process. MPA has met with DBHR and discussed the use of HEDIS measures for residential mental health.	(3) The EQRO considers this action responsive.
(4) 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.	(4) This has not been done. MPA is in the process of redesigning the WMIP and will need to finish that before taking on new challenges.	(4) Not yet addressed.

The path to future improvements: WMIP

Washington has established the goal of integrating primary care, mental health, chemical dependency, and long-term care services. As a fully integrated program, the WMIP can provide valuable lessons in integration to help the RSNs progress beyond initial steps toward that goal.

- ***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 MPA should meet with the EQRO's mental health team to share best practices in care coordination, discuss outcomes, and explore ways to improve care processes to meet the common needs of Medicaid service populations.***
- ***MHW should discuss with NSMHA or with 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 routine services after psychiatric hospitalizations.***

Acumentra Health offers this additional recommendation:

- ***MPA should explore opportunities to promote the WMIP program as an approach that supports the medical or health home model.***

The path to future improvements: EQR follow-up

The following recommendations from the 2009 EQR report continue to apply.

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

In the wake of DSHS's extensive personnel cuts, staff support for EQR program administration is underfunded and fragmented. This affects all QI activities, especially those that depend on a robust IT infrastructure. The current crisis, however, offers an opportunity for DSHS 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 the quality oversight committee, to review EQR recommendations and prioritize the actions that DSHS will take in response***
- ***realign DSHS's organizational structure to support the efficient administration of EQR program activities***

The above recommendations are intended to help DSHS 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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